STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

BAYFRONT MEDICAL CENTER, INC.;
BETHESDA HEALTH, INC., d/b/a
BETHESDA MEMORIAL HOSPITAL;
CAPE MEMORIAL HOSPITAL, INC.,
d/b/a CAPE CORAL HOSPITAL;
CGH HOSPITAL, LTD., d/b/a CORAL
GABLES HOSPITAL, ET AL.,

Petitioners,

vs. Case No. 14-4758RU

AGENCY FOR HEALTH CARE
ADMINISTRATION,

Respondent.
_____/

FINAL ORDER

Administrative Law Judge John D. C. Newton, II, with the Division of Administrative Hearings heard this case on a stipulated record on February 10, 2015, in Tallahassee, Florida.

APPEARANCES

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STATEMENT OF THE ISSUES

A. Is the practice of Respondent, Agency for Health Care Administration (Agency), limiting Medicaid reimbursement for services provided to undocumented aliens determined by the Department of Children and Families (DCF) to be eligible for Medicaid services for the duration of a medical emergency an "agency statement of general applicability that implements, interprets, or prescribes law or policy or describes the procedure or practice requirements of an agency"[1/] that section 120.54, Florida Statutes (2014),[2/] requires the Agency to adopt as a rule?

B. Are Agency rules 59G-4.160(2) and 59G-5.020 invalid because they exceed the Agency's delegated authority and contravene the statute which the rule implements?[3/ & 4/]

PRELIMINARY STATEMENT

This proceeding is the inevitable sequel to a dispute in 2012 between many of the Petitioners (Hospitals) and the Agency in Bayfront Medical Center, et al. v. Agency for Health Care Administration, Case No. 12-2757RU (Fla. DOAH Dec. 21, 2012), Agency for Health Care Administration v. Bayfront Medical Center, et al., Case No. 1D13-224 (Fla. 1st DCA 2013) (appeal voluntarily dismissed July 16, 2014) (Bayfront I). In that case, the Hospitals challenged the Agency's use of a "stabilization standard" to determine whether to pay Medicaid claims for

emergency services provided to undocumented aliens. The Final Order of Bayfront I determined that the "stabilization standard" was an unadopted rule and that the Agency could not use it unless the Agency adopted it as a rule.

After dismissing its appeal of the Final Order following oral argument, the Agency embarked upon a course of action plainly intended to be its best effort to conduct retrospective and prospective reviews of hospital claims for Medicaid payments for medical services provided undocumented aliens relying only on existing statutes and rules. The Hospitals maintain that the Agency's best is not good enough and that it is again using a policy that amounts to a rule that should have been adopted. They argue alternatively that the involved Agency's rules are invalid.

On October 13, 2014, the Hospitals, a group of 31 acute care hospitals enrolled as providers in the Florida Medicaid program, filed a Petition for Determination of Invalidity of Non-Rule Policy or in the Alternative for Determination of the Invalidity of a Rule. The Hospitals were permitted to amend their Petition. The Amended Petition still challenged the Agency's interpretation and application of an existing rule as an unadopted rule and challenged the existing rule as invalid.

On October 21, 2014, the undersigned conducted a scheduling conference. That same day, a notice setting the final hearing for November 12 and 13, 2014, issued.

On October 28, 2014, the Hospitals moved for a continuance. The Agency filed its reply in opposition on October 29, 2014. The Hospitals supplemented their motion on October 30, 2014. Then, on November 4, 2014, the parties filed a Joint Notice of Agreement to Continued Hearing. The hearing was continued to November 24 and 25, 2014. A case status hearing was held November 21, 2014. As a result of the parties' agreement during the conference, the hearing was rescheduled to January 12 and 13, 2015.

On January 6, 2015, the parties jointly moved to submit the case on a record of exhibits (including deposition transcripts), followed by proposed orders and oral argument from the parties. The motion was granted. The Hospitals filed eight notebooks containing 170 exhibits, including deposition transcripts. The Agency filed seven notebooks containing 109 exhibits, including deposition transcripts. The parties each noted objections to many of the other party's exhibits. All objections by both parties are overruled. The Hospitals' Exhibits 1 through 170 are accepted into evidence. The Agency's Exhibits 1 through 109 are accepted into evidence. The parties' exhibits and proposed orders demonstrate, as had become apparent during the course of

proceedings, that their dispute was not so much about the evidence, but about what to infer from the evidence and the application of the law to the facts established by the evidence.

The undersigned heard oral argument on February 10, 2015. The Agency filed the Transcript of the argument on February 19, 2015. The Agency filed a Notice of Supplemental Authority on March 3, 2015. The parties also provided the undersigned with USB flash drives with various documents, including authorities cited, some exhibits, and a copy of the proposed order (on the Hospitals' flash drive). The proposed orders and oral arguments have been considered in the preparation of this Final Order.

FINDINGS OF FACT

The Parties

1. Title XIX of the Social Security Act establishes Medicaid as a collaborative federal-state program in which the state receives federal financial participation (FFP) from the federal government for services provided to Medicaid-eligible recipients in accordance with federal law. The state also provides funding for the Medicaid program.

2. Section 409.902(1) designates the Agency to administer Florida's Medicaid program. The program provides medical care for indigent people in Florida. Federal and state laws, federal regulations, and state rules, including Medicaid handbooks

incorporated by reference into the rules, govern eligibility for, participation in, and payment by the program.

3. The Hospitals are acute care hospitals enrolled as providers in the Florida Medicaid program that provide emergency medical services. They have obtained, and intend to seek in the future, Medicaid compensation for emergency services provided to undocumented aliens. To participate in the Medicaid program, the Hospitals have agreed to a Medicaid Provider Agreement with the Agency. The agreement governs the terms under which the Medicaid program will compensate hospitals for services provided to individuals. Those terms include multiple state and federal statutes and rules discussed below. The Agency makes payments to Hospitals subject to its right to later audit the claims for payment and recoup payments if the Agency determines that they were not authorized.

The Medicaid Program and Undocumented Aliens Until 2010

4. Federal law prohibits compensating a state through federal financial participation under the Medicaid program "for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law [undocumented aliens]." 42 U.S.C. § 1396b(v)(1). It permits federal financial participation for services provided to otherwise eligible undocumented aliens that "are necessary to treat an emergency

medical condition as defined in paragraphs (b)(1) and (c)," if the individual otherwise meets the conditions for participation in the Medicaid program. 42 C.F.R. § 40.255(a). See also 42 U.S.C. § 1396b(v)(2).

5. For purposes of eligibility of undocumented aliens, 42 U.S.C. § 1396b(v)(3) defines "emergency medical condition" as:

> [A] medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in-- (A) placing the patient's health in serious jeopardy, (B) serious impairment to bodily functions, or (C) serious dysfunction of any bodily organ or part.

6. Florida statutes and rules, with minor variations, incorporate the federal standards limiting the eligibility of undocumented aliens to treatment for emergency medical conditions. Federal laws and regulations do not impose a defined endpoint or quantitative limit on the duration of the eligibility due to the emergency medical condition. Sections 409.902 and 409.904 address Medicaid services for undocumented aliens. Section 409.904(4) establishes the criteria for the limited Medicaid eligibility of undocumented aliens. Section 409.902(1) designates the Agency "as the single state agency authorized to make payments for [Medicaid services]." Section 409.902(1) makes [DCF] "responsible for Medicaid eligibility determinations."

Section 409.902(2) restricts Medicaid eligibility to United States citizens and lawfully admitted noncitizens who meet the Medicaid eligibility criteria for "qualified noncitizens" for temporary cash assistance.[5/]

7. Section 409.902(2)(b) limits use of state funds to provide medical services to individuals who do not meet the requirements of the subsection. It permits an exception for use of state funds to provide medical services that are necessary "to treat an emergency medical condition."

8. The Florida Medicaid Hospital Services Coverage and Limitations Handbook, June 2011 (Hospital Handbook), incorporated by reference into the Agency's rule 59G-4.160(2), states on page 2-7 the limits on reimbursement for services provided undocumented aliens as follows:

> The Medicaid Hospital Services Program reimburses for emergency services provided to aliens who meet all Medicaid eligibility requirements except for citizenship or alien status.
>
> Eligibility can be authorized only for the duration of the emergency. Medicaid will not pay for continuous or episodic services after the emergency has been alleviated.

9. The Florida Medicaid Provider General Handbook, 2012 (Provider Handbook), incorporated by rule 59G-5.020, repeats this limitation. Earlier versions of the Handbooks have essentially the same requirements and limitations.

10. Section 409.904(4) authorizes DCF to find an undocumented alien eligible for Medicaid, but limits the duration of the eligibility for undocumented aliens. It states:

> A low-income person who meets all other requirements for Medicaid eligibility except citizenship and who is in need of emergency medical services. The eligibility of such a recipient is limited to the period of the emergency, in accordance with federal regulations.

11. From 2005 to 2012, the definitions of section 409.901 for "emergency medical condition" and "emergency services and care" have remained unchanged, although the subsection numbering for them has changed.

12. "Emergency medical condition" is defined as:

> (a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
>
> 1. Serious jeopardy to the health of a patient, including a pregnant woman or a fetus.
>
> 2. Serious impairment to bodily functions.
>
> 3. Serious dysfunction of any bodily organ or part.
>
> (b) With respect to a pregnant woman:
>
> 1. That there is inadequate time to effect safe transfer to another hospital prior to delivery.

2. That a transfer may pose a threat to the health and safety of the patient or fetus.

3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

13. "Emergency services and care" are defined as:

> [M]edical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists and, if it does, the care, treatment, or surgery for a covered service by a physician which is necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

14. DCF's Emergency Medical Services for Aliens, rule 65A-1.715, provides:

> (1) Aliens who would be eligible for Medicaid but for their immigration status are eligible only for emergency medical services. Section 409.901(10), F.S., defines emergency medical conditions.
>
> (2) The Utilization Review Committee (URC) or medical provider will determine if the medical condition warrants emergency medical services and, if so, the projected duration of the emergency medical condition. The projected duration of the emergency medical condition will be the eligibility period provided that all other criteria are continuously satisfied.
>
> (3) Emergency services are limited to 30 consecutive days without prior approval. For continued coverage beginning with the 31st day prior authorization must be obtained from the Agency for Health Care Administration (Medicaid Program Office).

15. DCF's rule 65A-1.702(2)(c), implementing Title XIX, in its provisions for establishing a patient's date of eligibility, states: "Coverage for individuals eligible for the Emergency Medicaid for Aliens program begins the first day of a covered emergency and ends the day following the last day of the emergency medical situation."

16. Until July 1, 2010, neither DCF nor the Agency had a system, procedure, or practice for determining when the duration of an undocumented alien's emergency ended or when the emergency was alleviated, other than the initial determination of eligibility.

17. DCF's consistent practice was to make its eligibility determination based upon a review of the information provided by healthcare providers on DCF Form 2039 after discharge of the patient. The providers usually provided additional information and documents, including information about the diagnosis and treatment and the projected or actual duration of the emergency.

18. DCF's practice, since 2002, has been to routinely accept the information and documents submitted by the provider and base the eligibility determination on them. DCF's consistent practice was to not allow providers to submit any documentation until after the patient was discharged. Consequently, the

information upon which DCF based its eligibility determination for undocumented aliens was actual, not projected.

19. DCF notifies providers of the eligibility decision by sending a completed DCF Form 2039 or making the information available online. The information contains the specific period of eligibility for the undocumented alien, including the beginning and ending date of the eligibility period. This is the duration of the emergency medical condition.

20. Until July 1, 2010, under previous administrations, the Agency did not make any consistent or meaningful effort to determine if the services for which a hospital billed Medicaid were for the emergency medical conditions that were the predicate for DCF's determination of emergency eligibility.

21. The Agency's automatic process for reviewing Medicaid claims kicked out claims for services to undocumented aliens eligible because of an emergency medical condition. These claims were manually reviewed by just two nurses. The system allowed two choices, "approve" or "deny." Sometimes the nurses reviewed requests for Medicaid reimbursement from providers solely to determine if the services provided were medically necessary. This is the same standard used to determine if Medicaid will pay for services provided to citizens and documented aliens.

22. The process and the number of claims overwhelmed the two nurses conducting the review. A huge claims backlog

developed. This resulted in the review becoming more minimal and intermittent. Hospitals complained about the resulting payment delay. The Agency worried about it, too.

23. On September 9, 2009, Dyke Snipes, deputy director of Medicaid, released all the backlogged claims for payment without review. Later, he sent the hospitals a memorandum stating the claims would be paid without further review subject to later audit and claims for recoupment. However, from July 1, 2005, through June 30, 2010, the Agency did not audit any of the claims for payment for hospital services provided to undocumented aliens.

24. In 2002, as required by statute, the Agency began a prior authorization program for Medicaid inpatient hospital services. The purpose was to determine, before payment, if services were medically necessary.

25. The Agency contracted with KePRO to perform the prior authorization reviews for medical necessity. In the case of services to undocumented aliens, the prior authorization review and medical necessity determination was not made, despite the name, until the patient was discharged.

26. The Agency's Bureau of Medicaid Services performed a separate review of claims for payment of services to undocumented aliens to determine if the services were for the treatment of an emergency medical condition. The Bureau conducted this review

after the Department had determined that the patients were eligible for Medicaid and after KePRO had authorized the services.

27. Nurses employed by the Agency reviewed the claims and accompanying records to determine if the services were for treatment of an emergency medical condition. The review did not include judgments about the number of days appropriate for treatment, the relationship between services provided, and the emergency or the duration of the emergency.

28. Before July 1, 2010, the Agency, to the extent that it did anything, implemented and applied the rule, statute, and regulation provisions permitting payment for emergency medical services to eligible undocumented aliens by paying claims for the period of eligibility determined by the Department for services that KePRO determined were medically necessary and that the Bureau had determined to be necessary for treatment of an emergency medical condition.

29. The Agency did not conduct a targeted review to determine when the emergency ended or when the emergency was alleviated.

30. Altogether, the Agency was just not enforcing the statutory and rule limitations upon payment for emergency medical services to persons that DCF determined eligible.

Federal Audit

31. Eventually, Florida's failure to enforce the limitations came to the attention of the federal government. On August 25, 2009, the federal Centers for Medicare and Medicaid Services (CMS) presented the Agency with the report of its Financial Management Review of Florida's Medicaid Payments for Emergency Services to Undocumented Aliens. The transmittal letter asked Florida "to retroactively review claims for emergency medical services provided to undocumented aliens for proper eligibility determinations. We will defer these claims until the State has reviewed the claims." The federal government said that payment of the FFP to Florida for emergency medical services for undocumented aliens was in question, but it would delay deciding while Florida conducted the requested review. In plainer words, the federal government said it would hold up on recouping FFP paid for services to undocumented aliens.

32. CMS "determined that the Agency for Health Care Administration (AHCA) claimed Federal Financial Participation (FFP) for emergency services to beneficiaries that did not meet the Federal Definition of undocumented alien. In addition, AHCA claimed FFP for additional medical services that did not qualify as emergency care after the patient was stabilized."

33. Finding number 2 of the report stated: "AHCA is claiming FFP for emergency medical services to undocumented

aliens provided beyond what Federal statutes and regulations define to be an emergency."

34. Recommendation number five stated:

> AHCA should review all emergency services for undocumented alien amounts claimed for FFP during Federal Fiscal Years 2005, 2006 and 2007 and re-determine allowability of these claims utilizing the required Federal criteria. Based on this review and re-determination, AHCA should revise previous FFP amounts claimed on the Form CMS-64 quarterly statement of expenditures report to reflect only emergency services to undocumented aliens (supported by SAVE and IVES research) up to the point of stabilization. Upon completion, please report the results of your review to CMS.

35. Recommendation number 6 stated that: "AHCA [should] promptly implement the necessary system edits so that services provided as emergent care can be differentiated from services provided after the point the patients are stable, and then bill to the proper Federal programs."[6/]

36. The audit identified the Agency's electronic claims system's lack of system edits needed to account and separate claims for costs incurred "during emergent care and costs past stabilization" as a contributing factor.

37. CMS concluded that it believed Florida's claims for payment for emergency medical services were "significantly overstated." The report stated: "During our review, we found that AHCA is claiming costs for emergency services for

undocumented aliens, during the patients' entire hospital stay, and beyond the emergency or stabilization point as defined by Federal statutes and regulations." It asked Florida to conduct "re-reviews of claims for emergency medical services provided undocumented aliens."

38. CMS did not recommend that Florida change its statutes or rules governing Medicaid eligibility of undocumented aliens. It only recommended that Florida enforce existing law.

39. In September 2010, the Office of Inspector General for the United States Department of Health and Human Services released its "Review of Medicaid Funding for Emergency Services Provided to Nonqualified Aliens [by Florida]." This review observed that the Agency "relied upon two medical staff to review approximately 4,000 such claims per month, and this limited review was not sufficient to prevent some unallowable claims from being paid." The review also noted the problem with the system edits that the Agency was using. The system just identified claims for services to undocumented aliens and kicked them out for review by the two nurses who were not capable of properly reviewing the claims because of the overwhelming volume. The review observed that the system had an edit which could classify claims under five options: emergency, urgent, elective, newborn, and information not available. The review stated: "If active,

this edit may have ensured that the State Agency properly claimed Federal reimbursements."

40. The audit and the review, as well as the testimony of Johnnie Shepherd, the Agency administrator, convincingly establish that up to 2010, the Agency was not applying or enforcing federal or Florida statutory and rule requirements limiting medical services to undocumented aliens for emergency conditions.

The Agency Reacts to the Audit and Review

41. The Agency began working to implement the recommendations. KePRO presented a proposal to expand the scope of its services that it described in this fashion:

> It is our understanding that the Agency for Health Care Administration used internal resources to conduct such [emergency care for undocumented aliens] reviews. Previously, cases were authorized for payment using medical necessity criteria verses [sic] "point of stabilization." Approximately 12,000 cases dating back to 2006 fall into this category. This presents the Agency with an opportunity to recoup payments for hospital days that exceeded the "point of stabilization."

42. The Agency amended its contract with KePRO to include review of claims for emergency services to undocumented aliens to determine if the services continued beyond the duration of the emergency.

43. The Agency and KePRO began the review process. The requirements are included in the Agency's contracts with KePRO's successor, eqHealth Solutions.

44. The Agency began advising providers of the coming changes in review and authorization of Medicaid services for undocumented aliens. The Agency's campaign incorporated use of "stabilization" from the CMS reviews. "Stabilization" did not appear in any pertinent Florida statutes or rules.

45. A July 1, 2010, letter to all Medicaid providers from the chief of the Bureau of Medicaid Services advised of upcoming changes to the Agency's procedure and practice for reviewing claims for undocumented aliens. It is representative of the Agency's approach. The letter stated:

> **Beginning July 1, 2010,** the Keystone Peer Review Organization (KePRO), Medicaid's contractor for utilization management of inpatient services, will implement revised review processes for inpatient admissions for undocumented aliens. KePRO will review these requests to determine whether conditions requiring hospitalization are an emergency, defined in 42 CFR 440.255 as follows:
>
> The sudden onset of a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
>
> - Placing the patient's health in serious jeopardy;
> - Serious impairment to bodily functions; or

- Serious dysfunction of any bodily organ or part.

Medicaid will not pay for continuous or episodic care after the emergency has subsided and the patient is stabilized.

46. The letter also stated:

Professional services provided to an inpatient alien on or after the date that the patient has been stabilized will not be reimbursed by Medicaid. From the point of patient stabilization, the patient may continue to require medically necessary treatment; however, Medicaid cannot reimburse medically necessary treatment for aliens, only emergency treatment.

47. Hospitals, including many of the challengers here, brought an action claiming the Agency was using a new "stabilization" standard that amounted to a rule that had not been adopted. They prevailed. That action was Bayfront I.

48. The Final Order in Bayfront I found that "the 'point of stabilization' standard was an interpretation or an implementation of the existing statutes and rules and not merely a restatement of them." Bayfront I, DOAH Case No. 12-2757RU, at ¶ 54. It concluded that the "Agency's 'stabilization' standard for determining which services to un-documented aliens Medicaid will pay for is a statement of general applicability meeting the definition of a rule that has not been adopted pursuant to section 120.54(1)(a)." Bayfront I, DOAH Case No. 12-2757RU, at ¶ 74. The Final Order required the Agency to

"immediately discontinue all reliance upon the 'stabilization' standard or any substantially similar statement as a basis for agency action."

Since Bayfront I

49. The Agency complied with the Final Order by discontinuing all reliance on a "stabilization standard" (or any other unadopted standard) as a basis for agency action. It did not abandon its efforts to review past, present, and future hospital claims for Medicaid payment for emergency services provided to undocumented aliens.

50. The Agency developed new instructions for peer reviewers evaluating claims and amended affected contracts. It provided reviewers the language of the governing rules and statutes to use in evaluations. The material included the provisions of the Florida Medicaid Handbooks that have been incorporated by reference into the Agency's rules.

51. The Agency emphasized, as Shevaun Harris, bureau chief, Bureau of Medicaid Services, testified:

> [Peer reviewers should] no longer use stabilize, to use--to use that terminology anymore, and that they should follow the policy. The policy--the handbook provides instruction to readers in terms of which words they need to go back to the glossary. And then words that are not defined are its plain--should be used--should be applied using its plain meaning.

(Pet. Ex. 130, pp. 29 & 30).

52. The Agency expected the reviewers to apply their education, clinical expertise, and experience to determine if services provided were "emergency services or treatment," as defined in section 409.901(11) for an "emergency medical condition," as defined in section 409.901(10).

53. A January 28, 2013, memorandum to peer reviewers from Johnnie Shepherd, AHCA Administrator, Medicaid Program Integrity, is a representative example of the Agency's instructions to peer reviewers. It told the reader of the result of Bayfront I and stated that the Agency "will cease to rely upon the 'stabilization' standard or any substantially similar statement as a basis for determining the duration of the emergency." The Agency attached applicable excerpts from statutes and rules. It also advised the importance of reports "of sufficient detail and complexity to clearly support any claims payment adjustments based upon the medical determination and the application of Medicaid rules." (P. Ex. 130, AHCA Bates No. 463).

54. Similarly, the Agency advised other "vendor[s] to make sure that they were using terminology as found in the rules that are promulgated and that their determinations are consistent with the rules as they are promulgated." (Pet. Ex. 130, p. 15). The vendors advised their employees and agents accordingly.

55. Exhibit 2 to the desposition[7/] of Carol Roberts, program manager for the Fee for Service Rules Unit, is a representative

example of these instructions. The Power Point slides for a presentation reproduced the statutory definition for "emergency medical condition" and "emergency services and care." A March 7, 2013, internal eqHealth e-mail from Naveen Gande to Mary McPhee demonstrates that the vendors followed the instructions. It states that the "stabilization" standard should not be used and that reviewers should refer to the Agency handbooks.

56. Likewise an e-mail exchange between Mr. Shepherd and Eileen Bechkes of Vendor Health Integrity demonstrates the Agency's reliance upon statutes and rules. Ms. Bechkes relayed a question from Winter Haven Hospital asked during an audit entrance conference. It asked to "explain the difference between the standard of 'stabilization of the emergency condition' and the standard of 'emergency condition is relieved or eliminated.'" (Pet. Ex. 119[B], p. 3).[8/]

57. Mr. Shepherd's response states the Agency position frankly.

> Thanks for this question. Our positon is to direct the provider to the Medicaid Provider's general Handbook and the other references mentioned in the audit letters. Since this question has been brought up prior to the other letters conveying the references to the provider, we should simply tell them to read the Medicaid policy reference for the limited coverage category that pertains to Medicaid for Aliens as found in the Medicaid Provider General Handbook. Also, the General Handbook

> includes definitions for Emergency Services and Care and Emergency Medical Condition.
>
> Finally, we are asking the peer reviewers to apply their education, experience and judgment in reviewing the respective medical records to determine if an emergency medical condition existed, and if it did at what point was the emergency medical condition alleviated or eliminated per the definitions found in the Medicaid references.

58. The instructions to Agency or vendor employees reviewing the claims for payment for emergency medical services to undocumented aliens consistently emphasized that all participants were to apply only the applicable statutes and rules and that "stabilization" was not a criterion.

59. The Hospitals rely heavily upon the wording of the post-Bayfront I amendment to the eqHealth contract (P. Ex. 89) and Ms. Harris's testimony about it. (P. Ex. 130, p. 117, ll. 19-22). These things, the hospitals argue, prove that the Agency is still attempting to determine the length of the period of eligibility and that this is a new interpretation of the rules and statutes.

60. The existing language provided that the vendor would review the cases to time the point at which the emergency no longer existed and the patient's condition was stable. The amendment said: "The Vendor shall review these cases to determine the point at which the emergency no longer exists, in accordance with state and federal statutes." Ms. Harris's

testimony on page 119 of Petitioner's Exhibit 30 clarifies that the amendment was referring to "the Agency's obligation to pay for services for undocumented aliens or individual who met all other requirements for Medicaid, except citizenship." The weight of the evidence, including training materials and written communications, proves that despite poor wording in the amendment, the parties to the contract stayed focused on determining whether the Agency was being asked to pay for services that state and federal law permitted it to, not determining the length of the emergency medical condition.

61. The Agency was resolute in its commitment to only apply the standards and definitions of statutes and rules in the evaluation of claims for payment for emergency medical services to undocumented aliens. The Agency's resolve was tested in meetings with provider representatives, inquiries from vendors, and internal questions. Agency representatives repeatedly said that the rules and statutes determine the standards and people should apply the plain meaning of their words. Agency documents did the same. The Agency did not succumb to the temptation, as it did with "stabilization," to explain in different words the words of statute and rule.

62. The weight of the evidence convincingly established that after entry of the Final Order in Bayfront I, the Agency's statements of general applicability implementing the law

governing Medicaid reimbursement for emergency medical services to undocumented aliens were only quotes from or references to governing statutes and rules.

CONCLUSIONS OF LAW

63. The Division of Administrative Hearings has jurisdiction over the parties and the subject matter of this proceeding pursuant to sections 120.56(1)(c), 120.56(4), 120.569 and 120.57(1), Florida Statutes.

Unadopted Rule Challenge

64. An "unadopted rule challenge" under section 120.56(4) presents a narrow, limited issue. The issue is whether an agency has, by declaration or action, established a statement of general applicability that is a "rule," as defined in section 120.52(16), without going through the required public rulemaking process required by section 120.54. The Hospitals bear the burden of proving by a preponderance of the evidence both the terms of the alleged Agency statement and that the challenged Agency statement is an unadopted rule. See Dravo Basic Material Co., Inc. v. Dep't of Transp., 602 So. 2d 632 (Fla. 2d DCA 1992); Fla. Dep't of Transp. v. J.W.C. Co., 396 So. 2d 778 (Fla. 1st DCA 1981). The Hospitals have not carried that burden.

65. The Hospitals have not proven by quotation, text, or description a statement that they contend is an unadopted rule. They argue the fact that the Agency is now enforcing the law when

its past practice was to not enforce it, amounts to a statement meeting the definition of rule. To support their argument the Hospitals cite: Coventry First, LLC v. Office of Insurance Regulation, 38 So. 3d 200 (Fla. 1st DCA 2010); Department of Revenue v. Vanjaria Enterprises, 675 So. 2d 252, 255 (Fla. 5th DCA 1996); Cleveland Clinic v. Agency for Health Care Administration, 679 So. 2d 1247 (Fla. 1st DCA 1996); and Courts v. Agency for Health Care Administration, 965 So. 2d 154, 159 (Fla. 1st DCA 2007). The cases do not support the Hospitals' position.

66. Coventry held that statements which create rights require compliance with the statement or otherwise have the direct and consistent effect of law meet the definition of rule. The Agency's statements and actions are not creating rights. The rights and obligations already exist. Statutes and rules created them long ago. The Agency is just requiring compliance with the statutes and rules. These facts are much like those of Coventry where the Office of Insurance Regulation's internal guidelines included an outline that tracked the language of the statute. The Agency is doing the same here, only more so. It consistently offers the statutes and rules as the guidelines.

67. The Hospitals maintain that Cleveland Clinic stands for the proposition that if an agency abruptly changes its established practice, going from non-enforcement to enforcement,

it must engage in rulemaking. First, describing the Agency's actions as abrupt is not accurate. It provided notice of its plans many times in many ways.

68. Cleveland Clinic involved extraordinary review of decisions on efforts of other hospitals to require that the Cleveland Clinic's replacement hospital's certificate of need application for Broward County be competitively reviewed with their hospital certificate of need applications for Broward County. It was not an unadopted rule case. For years the Agency had interpreted a statute exempting certain capital expenditures from batched certificate of need review with other applications to include replacement hospitals, so long as the licensed bed capacity did not change. The Agency changed its interpretation and determined that the Cleveland Clinic replacement hospital had to be competitively reviewed in a batch with other applicants proposing a hospital in Broward County. The court described this as a radical turnabout from the Agency's previous interpretations of the statute. It held that the Agency could not change its interpretation and application of statute without going through rulemaking.

69. The facts here do not fit the facts or holding in Cleveland Clinic. The Agency is not changing an interpretation or way of applying a statute or its rules. It is just starting

to enforce them, as they are written, after years of neglecting to enforce them.

70. Courts involved an appeal from an Agency decision eliminating an award of two weeks of 24-hour companion care approved under a Medicaid waiver and denying a request for an additional two weeks. This was a manifestation of the Agency implementing a new policy limiting the service an individual could receive to six hours per day. Before that, the Agency interpreted the waiver statutes and rules to allow 50 hours of companion care to Courts per week, plus an additional 236 hours on an as-needed basis. The Agency explained its actions by saying it had changed its mind. Once again, the facts here differ. The Agency is not changing its mind about what the statutes and rules require. It is just finally enforcing them.

71. Vanjaria Enterprises involved the Department of Revenue's use of a square-footage-based formula to allocate property revenue to taxable or nontaxable categories. The statute directed the Department to determine the portion of a property's rental revenue that was exempt from taxation. The Department's decision to use a square-footage formula, rather than another method, such as a revenue-percentage formula, was not direct application of the statute. It was a statement interpreting and applying the statute which had to be adopted as a rule. In this instance, the Agency is directly applying the

statutes and rules. Vanjaria Enterprises supports determining that the Agency's actions do not amount to an unadopted rule. See also, Ag. for Health Care Admin. v. Custom Mobility, Inc., 995 So. 2d 984 (Fla. 1st DCA 2008).

72. The Agency is simply now enforcing statutes and rules that it had not been enforcing. Its actions are consistent with the statutes and rules. For that reason, the Hospitals have not proven the Agency has or is using an unadopted rule. See State Bd. of Admin. v. Huberty, 46 So. 3d 1144, 1147 (Fla. 1st DCA 2010); St. Francis Hosp., Inc. v. Dep't of HRS, 553 So. 2d 1351, 1354 (Fla. 1st DCA 1989).

Challenge to Existing Rules as Unauthorized

73. The Hospitals assert that the Agency's rules exceed its grant of rulemaking authority and contravene the specific provisions of the law implemented. §§ 120.52(8)(b) and (c), Fla. Stat. The Hospitals bear the burden of proving the challenged rules invalid by a preponderance of the evidence. § 120.56(1)(e) and (3)(a), Fla. Stat.; Vuong, et al. v. Fla. Dep't of Law Enf., 149 So. 3d 174 (Fla. 4th DCA 2014).

74. The challenge here is to two Agency rules. The first is rule 59G-4.160(2) that adopts the Hospital Services Coverage Handbook, 2011, through an internet link. The challenged language appears on page 2-7 beneath the heading, "Emergencies:

Medicaid for Alien." The pertinent part states with emphasis supplied:

> The Medicaid Hospital Services Program reimburses for emergency services provided to aliens who meet all Medicaid eligibility requirements except for citizenship or alien status.
>
> Eligibility can be authorized only for the duration of the emergency. Medicaid will not pay for continuous or episodic services after the emergency has been alleviated. Dialysis is considered an emergency service.

75. The second is rule 59G-5.020, which adopts the Florida Medicaid Provider Handbook, 2012, through an internet link. The challenged language appears on page 3-22 under the heading, "Emergency: Medicaid for Aliens." The language is identical, except that the Hospital Services Handbook refers to the "Medicaid Hospital Services Program" and the Provider General Handbook refers to "program." They are the same.

76. The recent opinion in United Faculty of Florida v. Florida State Board of Education, 2015 Fla. App. Lexis 2037, at * 3; 157 So. 3d 514 (Fla. 1st DCA 2015), neatly summarizes the standards for a rule challenge under section 120.52(8)(b) claiming an agency has exceeded its grant of rulemaking authority.

> A rule is invalid under section 120.52(8)(b) if the agency "exceed[s] its grant of rulemaking authority." A grant of rulemaking authority is the "statutory language that explicitly authorizes or requires an agency

to adopt [a rule]." § 120.52(17), Fla. Stat. The scope of an agency's rulemaking authority is constrained by section 120.536(1) and the so-called "flush-left paragraph" in section 120.52(8), which provide that an agency may only adopt rules to "implement or interpret the specific powers and duties granted by the [agency's] enabling statute"; that an agency may not adopt rules to "implement statutory provisions setting forth general legislative intent or policy" or simply because the rule "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"; and that "[s]tatutory 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."

Section 120.536(1) and the flush-left paragraph in section 120.52(8) require a close examination of the statutes cited by the agency as authority for the rule at issue to determine whether those statutes explicitly grant the agency authority to adopt the rule. As this court famously stated in Save the Manatee Club, [773 So. 2d 594 (Fla. 1st DCA 200)] the question is "whether the statute contains a specific grant of legislative authority for the rule, not whether the grant of authority is specific enough. Either the enabling statute authorizes the rule at issue or it does not." 773 So. 2d at 599 (emphasis in original). Accord Bd. of Trs. of the Internal Improvement Trust Fund v. Day Cruise Ass'n, Inc., 794 So. 2d 696, 700 (Fla. 1st DCA 2001) ("[A]gencies have rulemaking authority only where the legislature has enacted a specific statute, and authorized the agency to implement it . . . ."); see also Fla. Elections Comm'n v. Blair, 52 So. 3d 9, 12-13 (Fla. 1st DCA 2010) (explaining that the definition of "rulemaking authority" in

> section 120.52(17) does not further restrict agency rulemaking authority beyond what is contained in the flush-left paragraph in section 120.52(8), as construed by this court in Save the Manatee Club and subsequent cases).

77. Both rules identify section 409.919 as providing rulemaking authority for the handbooks. And both identify section 409.902, among others, as the law implemented by the handbooks.

78. Section 409.919 states:

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

79. Sections 409.901 to 409.920 are most, but not all, of the sections of chapter 409, Part III, titled "Medicaid." Section 409.919 does not include the other five parts of chapter 409 in its grant of rulemaking authority. It is specific to the Medicaid program.

80. Section 409.902(1) states: "The Agency for Health Care Administration 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." The plain meaning of these provisions is that AHCA is to determine what medical services to pay for undocumented aliens who DCF has determined eligible for Medicaid services because of an emergency medical condition.

81. Section 409.902(2)(b) prohibits using state funds "to provide medical services to individuals who do not meet the requirements of this subsection unless the services are necessary to treat an emergency medical condition . . . . Such services are authorized only to the extent provided under federal law and in accordance with federal regulations as provided in 42 C.F.R. s. 440.255."

82. The limitations on using state funds to provide medical services to undocumented aliens, "unless the services are necessary to treat an emergency medical condition," can only be fairly interpreted as a mandate to the Agency to review the medical services provided to an undocumented alien eligible for Medicaid because of an emergency medical condition. It must do that to determine if state funds may be used to pay for the services. Section 409.902 is one of the statutes for which section 409.919 authorizes rulemaking. The plain words of the grant of authority in section 409.919 require the Agency to adopt rules that comply with and administer section 409.902. The grant

is explicit and specific. The challenged rules pass the test articulated in United Faculty.

83. The certainty of this conclusion is demonstrated by comparing this case to the opinion in Lamar Outdoor Advertising v. Florida Department of Transportation, 17 So. 3d 799 (Fla. 1st DCA 2009). The court found that the challenged rules of the Department of Transportation, governing the height above ground level of outdoor signs, exceeded the scope of the rulemaking authority granted. The authority was to "do all things necessary to cooperate . . . in the construction of roads." Lamar at 803. The grant was specific to road construction. Signs were not road construction. Therefore, the rule was invalid. Here, the grant is specific to administering identified Medicaid statutes. The rules are within the authority the Legislature granted the Agency. The Hospitals did not carry their burden.

84. Section 120.52(8)(c) defines invalid rule as one that enlarges, modifies, or contravenes the specific provisions of the law implemented. The Hospitals maintain that the rules are invalid under this definition. The foregoing analysis disposes of that proposition. The Agency's rules link directly to the statutes that they administer. The Hospitals have not proven that the challenged rules enlarge, modify, or contravene the statutes implemented.

Are the Rules Vague?

85. The Hospitals maintain that the rules are invalid because they are vague, fail to establish adequate standards for Agency decisions, and vest unbridled discretion in the Agency. § 120.52(8)(d), Fla. Stat. The issue is the facial validity of the rules not whether they are or will be properly applied in a factual or hypothetical situation. Fairfield Communities v. Fla. Land and Water Adjudicatory Comm'n, 522 So. 2d 1012, 1014 (Fla. 1st DCA 1988) ("An administrative rule is invalid under section 120.52(8)(d), Florida Statutes, if it forbids or requires the performance of an act in terms that are so vague that persons of common intelligence must guess at its meaning and differ as to its application. Generally, where words or phrases are not defined, they must be given their common and ordinary meaning. The plain and ordinary meaning of a word can be ascertained by reference to a dictionary."). Dep't of Fin. Servs. v. Peter Brown Construction, Inc., 108 So. 3d. 723, 728 (Fla. 1st DCA 2013) (citations omitted). The Hospitals focus their vagueness arguments on the rules' use of the word "alleviate."

86. "Alleviate" has a plain and ordinary meaning. For instance, Merriam-Webster Dictionary defines it as "to reduce the pain or trouble of (something); to make (something) less painful, difficult, or severe." Merriam-Webster Dictionary, http://www.merriam-webster.com/dictionary/alleviate. Cambridge

Dictionaries Online defines "alleviate" as "to make pain or problems less severe." Cambridge Dictionaries Online, http://dictionary.cambridge.org/us/dictionary/american-english/alleviate. The Medicaid Program statutes use "alleviate" frequently without explication. See, e.g., § 409.913(1)(d), Fla. Stat. (defining "medical necessity" as "goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice") (emphasis added); § 409.906(1)(a), Fla. Stat. (authorizing AHCA to pay for "medically necessary, emergency dental procedures to alleviate pain or infection") (emphasis added); § 409.9131(2)(b), Fla. Stat. (defining "medical necessity" or "medically necessary" as "any goods or services necessary to palliate the effects of a terminal condition or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice"). (emphasis added).

87. The Hospitals' contention that Agency representatives Harris and Shepherd cannot explain the meaning of "alleviate" is not supported by the citations to their deposition transcripts. The questioning cited involved repeated efforts to tie the representatives to the "stabilization" standard rejected as an unadopted rule. When the meaning of "alleviated" was not tied to the Agency's previous position, the witnesses were consistent that the dictionary meaning should apply.

88. Transcripts of the depositions of various peer reviewers demonstrate some differences in individual interpretations of the provisions of the rules and statutes, particularly of when an emergency condition is alleviated. Individual variances by the number of people applying the rules and statute are predictable. They do not, however, change the fact that the Agency is striving to apply the rules and statutes. Individual discrepancies may be addressed through the rights created by section 120.57 if they are not resolved in the audit process.

89. The Hospitals also argue that "alleviate" is vague because the Agency is bound by the losing argument it made in Bayfront I that "alleviate" and "stabilize" were interchangeable. The argument is not persuasive. That was a legal theory which has been rejected. If the argument were valid, it would cut both ways. In Bayfront I, the Hospitals based their successful

arguments on the proposition that "alleviate" and "stabilize" were not the same.

90. The Hospitals have not proven that the rules are vague.

Standing

91. Paragraph 26 of the Agency's proposed order states:

> The parties have stipulated to Petitioners' standing to challenge AHCA's existing rules under section 120.56(3). As enrolled Medicaid providers, Petitioners are persons "substantially affected" by AHCA's existing rules.

92. Standing is not an issue in this proceeding.

ORDER

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

A. The Petitioner Hospitals have not proven that the Agency for Health Care Administration has made or is enforcing a statement that should have been adopted as a rule, but was not.

B. The Petitioner Hospitals have not proven that the handbook provisions adopted by the Agency for Health Care Administration, rules 59G-4.160(2) and 59G-5.020, are invalid due to exceeding or contravening the rulemaking authority granted the Agency.

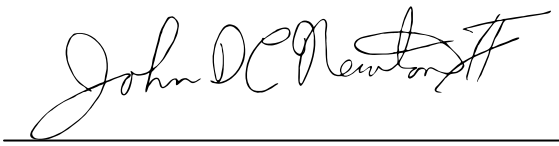
C. The Petitioner Hospitals have not proven that the handbook provisions adopted by the Agency for Health Care

Administration, rules 59G-4.160(2) and 59G-5.020, are invalid due to vagueness.

D. The Division of Administrative Hearings reserves jurisdiction to determine if the Agency for Health Care Administration is entitled to an award of reasonable costs and reasonable attorney's fees, and, if so, how much.

E. The Amended Petition is denied.

DONE AND ORDERED this 20th day of April, 2015, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 20th day of April, 2015.

ENDNOTES

[1/] Section 120.52(16), Fla. Stat. (2014).

[2/] All references to the Florida Statutes are to the 2014 codification.

[3/] This issue is gleaned from the Petitioners' arguments and statements that fulfill the requirement of section 120.56(1)(b)

that rule challenges "must state with particularity the provisions alleged to be invalid."

[4/] This language appears in two agency rules. The first is Florida Administrative Code Rule 59G-4.160(2), which adopts the Florida Medicaid Hospital Services Coverage and Limitations Handbook, 2011, through an internet link. The challenged language appears on page 2-7 beneath the heading, "Emergencies: Medicaid for Aliens." The second is rule 59G-5.020, which adopts the Florida Medicaid Provider General Handbook, 2012, through an internet link. The challenged language appears on page 3-22 under the heading, "Emergency Medicaid for Aliens."

[5/] The criteria are found at section 414.095(3), Florida Statutes.

[6/] The report also found fault with the Department's eligibility determinations. It said: "DCF was not able to support their eligibility/immigration determinations as required by federal regulations. This condition occurred because DCF: (1) did not ensure that DCF employees conducted due diligence in determining Medicaid eligibility and/or immigration status; (2) did not document; and (3) did not maintain eligibility files with all the required documentation."

[7/] P. Ex. 133.

[8/] Mr. Shepherd's e-mail, like many Agency-generated documents, refers to the probability of litigation involving determinations and instructions about emergency services. He emphasizes the importance of using caution in statements and writings. This is not an indication of deceit or subterfuge. It is a prudent, realistic observation about a likely development.

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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 administrative appeal with the agency clerk of the Division of Administrative Hearings within 30 days of rendition of the order to be reviewed, and a copy of the notice, accompanied by any filing fees prescribed by law, with the clerk of the District Court of Appeal in the appellate district where the agency maintains its headquarters or where a party resides or as otherwise provided by law.