STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

IN RE: MEDICAID REIMBURSEMENT RATE PROPOSED AND EXISTING RULE CHALLENGES _____/	Case Nos. 17-0467RP through 17-0474RP, 17-0496RP, 17-0558RP through 17-0560RP

FINAL ORDER

On February 23, 2017, a final hearing was held in these cases in Tallahassee before J. Lawrence Johnston, Administrative Law Judge, Division of Administrative Hearings (DOAH).

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STATEMENT OF THE ISSUES

The issues are whether proposed and existing Florida Administrative Code rules, both numbered 59G-6.030, are valid exercises of delegated legislative authority.

PRELIMINARY STATEMENT

In November 2016, numerous Florida hospitals filed petitions challenging the methodology used to determine the Medicaid outpatient reimbursement rate changes for state fiscal year 2016-2017 as a rule that was not adopted as required, and challenging the validity of existing rule 59G-6.030, which included the methodology used to determine the rates for fiscal year 2015-2016. Those petitions became DOAH cases 16-6398RX through 16-6414RX, which were consolidated. The final hearing scheduled for December 5 was continued, and the unadopted rule challenges were stayed when the Agency for Health Care Administration (AHCA) gave notice that it was proposing to amend rule 59G-6.030 to incorporate the methodology used to determine the reimbursement rates for fiscal year 2016-2017.

In January 2017, the hospitals filed petitions challenging proposed and existing rule 59G-6.030. Those petitions became DOAH cases 17-0467RP through 17-0474RP, 17-0496RP, and 17-0558RP through 17-0560RP, which were consolidated and scheduled for final hearing on February 23 and 24. The final hearing in the existing rule challenges in cases 16-6398RX through 16-6414RX was rescheduled to coincide on February 23 and 24. The stay of the unadopted rule challenges in those "RX" cases remained in effect.

On February 22, the parties filed their final joint pre-hearing stipulation, which focused the issues and established many of the pertinent facts. The final hearing was completed in one day, on February 23.

Joint Exhibits 1 through 34 were received in evidence. The Petitioners called three witnesses: John Owens, a healthcare consultant focusing on hospital reimbursement; Tom Wallace, who is AHCA's bureau chief for Medicaid program finance; and Jennifer Hinson, an attorney who works for Wellcare Health Plans, a managed care organization (MCO) that contracts with numerous hospitals to provide Medicaid plans for a large number of Medicaid patients. Petitioners' Exhibits 1, 2, 5, 6, 7, 9, 10, 16 through 24, 26, 27, and 28 were received in evidence. Ruling was reserved on relevance and hearsay objections to Petitioner's Exhibits 14 and 15. Those objections are overruled, and the

exhibits are received. Finally, Respondent's Exhibits 3, 4, and 6 were received in evidence.

The Transcript of the final hearing was filed on March 15. The parties' proposed final orders have been considered.

All statutory references are to the 2016 codification of the Florida Statutes, unless otherwise indicated.

FINDINGS OF FACT

1. The Petitioners are 120 hospitals--some not-for-profit, some for-profit, and some governmental--that are licensed under chapter 395, Florida Statutes, provide both inpatient and outpatient services, and participate in the Medicaid program. AHCA is the state agency authorized to make payments for services rendered to Medicaid patients.

2. Before 2013, all Medicaid outpatient services were provided and paid fee-for-service. Under the fee-for-service model, hospitals submit claims to AHCA, and AHCA reimburses the hospitals based on the established rate.

3. For many years, AHCA has set prospective Medicaid fee-for-service reimbursement rates for outpatient hospital services, either semi-annually or annually, based on the most recent complete and accurate cost reports submitted by each hospital; has re-published the Florida Title XIX Hospital Outpatient Reimbursement Plan (Outpatient Plan) that explained how the rates

were determined; and has adopted the current Outpatient Plan by reference in rule 59G-6.030.

4. In 2005, the Florida Legislature's General Appropriations Act (GAA) stated that the funds appropriated for Medicaid outpatient hospital services reflected a cost savings of $16,796,807 "as a result of modifying the reimbursement methodology for outpatient hospital rates." It instructed AHCA to "implement a recurring methodology in the Title XIX Outpatient Hospital Reimbursement Plan that may include, but is not limited to, the inflation factor, variable cost target, county rate ceiling or county ceiling target rate to achieve the cost savings."

5. AHCA responded by amending the Outpatient Plan to provide: "Effective July 1, 2005, a recurring rate reduction shall be established until an aggregate total estimated savings of $16,796,807 is achieved each year. This reduction is the Medicaid Trend Adjustment." The amended Outpatient Plan was then adopted by reference in rule 59G-6.030, effective July 1, 2005.

6. AHCA collaborated with the hospitals to determine how to accomplish the legislatively mandated reduction in a manner that would be fair to all the hospitals. It was decided to take the hospitals' unaudited cost reports from the most recent complete fiscal year and the number of Medicaid occasions of service from the monthly report of AHCA's Medicaid fiscal agent that

corresponded to the hospitals' fiscal years, and use an Excel spreadsheet program with a function called Goal Seek to calculate proportionate rate adjustments for each hospital to achieve the legislatively mandated aggregate savings. The resulting rate adjustments were incorporated in the hospital reimbursement rates, effective July 1, 2005.

7. In 2006, there was no further Medicaid Trend Adjustment (MTA) reduction. However, in accordance with the instructions in the 2005 GAA, the 2005 MTA reduction of $16,796,807 was treated as a recurring reduction and was applied again in the 2006 Outpatient Plan, which again stated: "Effective July 1, 2005, a recurring rate reduction shall be established until an aggregate total estimated savings of $16,796,807 is achieved each year. This reduction is the Medicaid Trend Adjustment." The 2006 Outpatient Plan also stated: "This recurring reduction, called the Medicaid Trend Adjustment, shall be applied proportionally to all rates on an annual basis." It also came to be known as the first cut or cut 1. It again was applied by taking the hospitals' most current unaudited cost reports and the corresponding occasions of service from the appropriate monthly report of the fiscal agent, and using the Excel spreadsheets and the Goal Seek function to calculate rate adjustments for each hospital. The cut 1 rate adjustments were incorporated in the hospital reimbursement rates, effective July 1, 2006.

8. In 2007, the GAA stated that the funds appropriated for Medicaid outpatient hospital services were reduced by $17,211,796 "as a result of modifying the reimbursement for outpatient hospital rates, effective July 1, 2008." This has been referred to as the second cut or cut 2. It instructed AHCA to "implement a recurring methodology in the Title XIX Outpatient Hospital Reimbursement Plan to achieve this reduction." The 2008 Outpatient Plan again applied the first cut as a recurring reduction and stated that it was to be "applied proportionally to all rates on an annual basis." It then made the second cut, which was to be "applied to achieve a recurring annual reduction of $17,211,796." These cuts were again applied by taking the hospitals' most current unaudited cost reports and the corresponding occasions of service from the appropriate monthly report of the fiscal agent, and using the Excel spreadsheets and the Goal Seek function to calculate rate adjustments for each hospital. The resulting rate adjustments were incorporated in the hospital reimbursement rates, effective July 1, 2008.

9. This process was repeated in subsequent years. The third cut (cut 3) was in 2008; it was a $36,403,451 reduction. The fourth cut (cut 4) was in 2009, during a special session; it was a $19,384,437 reduction; however, per the GAA that made the fourth cut, it was not applied to the rates of certain children's specialty hospitals, which were excluded from the reduction. In

addition, using language similar to what AHCA had been using in the Outpatient Plans, the 2009 GAA stated: "The agency shall reduce individual hospital rates proportionately until the required savings are achieved." The Legislature enacted cut 5 and cut 6 in 2009 and 2010. However, the GAAs stated that AHCA should not take these cuts if the unit costs before the cuts were equal to or less than the unit costs used in establishing the budget. AHCA determined that cuts 5 and 6 should not be taken. However, cuts 1 through 4 continued to be applied as recurring reductions, and rates were adjusted for cuts 1 through 4 in 2009 and 2010 in the same manner as before.

10. In 2011, the GAA enacted cut 7; it was for $99,045,233 and was added to the previous cuts for all but certain children's specialty and rural hospitals, which were excluded from the additional reduction.

11. In setting the individual hospitals' reimbursement rates, AHCA first applied cut 7 in the same manner as cuts 1 through 4. The result was a 16.5 percent rate adjustment for cut 7, which was much higher than for previous cuts. Some of the hospitals pointed this out to AHCA and to the Legislature and its staff. There was lots of discussion, and it was determined that the rate adjustment from cut 7 would be more like what the Legislature was expecting (about 12 percent), if budgeted occasions of service were used, instead of the number from the

fiscal agent's monthly report that corresponded to the most recent cost reports. AHCA agreed to change to budgeted fee-for-service occasions of service for cut 7, with the concurrence of the hospitals and the Legislature and its staff.

12. The year 2011 was also the year the Legislature instituted what became known as the "unit cost cap." In that year, the Legislature amended section 409.908, Florida Statutes, to provide: "The agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs effective July 1, 2011. Reimbursement rates shall be as provided in the General Appropriations Act." § 409.908(23)(a), Fla. Stat. (2011). This part of the statute has not changed. The GAA that year elaborated:

> In establishing rates through the normal process, prior to including this reduction [cut 7], if the unit cost is equal to or less than the unit cost used in establishing the budget, then no additional reduction in rates is necessary. In establishing rates through the normal process, if the unit cost is greater than the unit cost used in establishing the budget, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the unit cost used in establishing the budget.

13. "Unit cost" was not defined by statute or GAA. To calculate what it was in 2011, AHCA divided the total dollar amount of Medicaid payments made to hospitals by AHCA by the

number of Medicaid occasions of service for all hospitals. The result was $141.51.

14. Since 2011, AHCA has applied the unit cost cap with reference to the 2011 unit cost of $141.51. Since then, AHCA has compared the 2011 unit cost to the current cost, calculated by dividing the total dollar amount of Medicaid payments made to all hospitals by AHCA by the number of Medicaid occasions of service for all hospitals, except in children's and rural hospitals, to determine whether the unit cost cap would require a further rate reduction, after applying the MTA cuts. Using this comparison, the unit cost cap never has been exceeded, and no further rate adjustments ever have been required.

15. It is not clear why AHCA excluded Medicaid occasions of service for children's and rural hospitals from the unit cost calculations made after 2011. It could have been because those hospitals were excluded from cut 7 and cut 8.

16. Cut 8 was enacted in 2012; it was for $49,078,485 and was added to the previous cuts for all but certain children's specialty and rural hospitals, which were excluded from the additional reduction. In 2012, the Legislature specified in the GAA that budgeted occasions of service should be used in calculating the MTA reduction for inpatient hospitals. AHCA always treated inpatient and outpatient MTAs the same, and it viewed the specific legislative direction for the inpatient MTA

as guidance and indicative of legislative intent that it should continue to use budgeted occasions of service for the outpatient cut 7 and should also use them for the outpatient cut 8. Again, the hospitals did not object since the result was a higher reimbursement rate.

17. In 2014, the Florida Medicaid program began to transition Medicaid recipients from a fee-for-service model to a managed care model. Under the managed care model, AHCA pays a managed care organization (MCO) a capitation rate per patient. The MCOs negotiate contracts with hospitals to provide outpatient care at an agreed reimbursement rate per occasion of service.

18. Since August 2014, the majority of Medicaid recipients has been receiving services through MCOs, rather than through fee-for-service. Currently, about 75 to 80 percent of Medicaid outpatient hospital occasions of service are provided through managed care

19. In recognition of the shift to MCOs, the Legislature began to divide the Medicaid outpatient hospital reimbursement appropriation in the GAA between what AHCA reimburses directly to hospitals under the fee-for-service model and what it pays MCOs to provide those services under the MCO delivery system. This allocation of the budgets between fee-for-service and managed care necessarily accomplished a corresponding division of the recurring MTA reductions between the two delivery systems. The

Legislature did not enact any statutes or GAAs requiring AHCA to change how it applies MTA reductions to determine fee-for-service outpatient reimbursement rate adjustments, or make any other changes in response to the transition to MCOs.

20. There were no additional MTA reductions in 2015. The 2015 Outpatient Plan, which is incorporated in existing rule 59G-6.030, applied the previous cuts as recurring reductions. The evidence was confusing as to whether cuts 7 and 8 were applied using the occasions of service in the fiscal agent's monthly report corresponding to the hospitals' most current unaudited cost reports, or using budgeted occasions of service. If the former, the numbers did not yet reflect much of the shift to the managed care model because of a time lag in producing cost reports, and the evidence suggested that the numbers were approximately the same as the budgeted occasions of service used previously. Whichever numbers were used, the resulting rate adjustments were incorporated in the hospitals' reimbursement rates, effective July 1, 2015.

21. Leading up to the 2016 legislative session, there was a legislative proposal to determine prospective Medicaid outpatient reimbursement rates using a completely new method called Enhanced Ambulatory Patient Groups (EAPGs). EAPGs would eliminate the need to depend on hospital cost reports and complicated calculations to determine the effects of MTA reductions on

prospective hospital outpatient reimbursement rates, effective July 1, following the end of the legislative session each year. Hospitals, including some if not all of the Petitioners, asked the Legislature not to proceed with the proposed EAPG legislation until they had an opportunity to study it and provide input, and EAPGs were not enacted in 2016. However, section 409.905(6)(b) was amended, effective July 1, 2017, to require the switch to EAPGs. See note to § 409.905, Fla. Stat.; and ch. 2016-65, § 9, Laws of Fla. (2016).

22. When it became apparent that EAPGs would not be in use for prospective reimbursement rates for fiscal year 2016/2017, AHCA basically repeated the 2015/2016 process, but adjusted the occasions of service used for calculating the hospitals' rate reductions for cuts 7 and 8 by adding 14,000 occasions of service. At the end of July, AHCA published new rates effective July 1, 2016.

23. When the new rates were published, they were challenged by some of the Petitioners under section 120.57(1), Florida Statutes. Citing section 409.908(1)(f)1., AHCA took the position that there was no jurisdiction and dismissed the petitions. That decision is on appeal to the First District Court of Appeal.

24. The Petitioners also challenged the methodology used to calculate the new prospective reimbursement rates as a rule that was not adopted as required, and challenged the validity of

existing rule 59G-6.030, which incorporated the 2015 Outpatient Plan by reference. These challenges became DOAH cases 16-6398RX through 16-6414RX.

25. In response to DOAH cases 16-6398RX through 16-6414RX, AHCA adopted the 2016 Outpatient Plan by reference in proposed rule 59G-6.030.

26. The 2016 Outpatient Plan provides more detail than the 2015 version. AHCA's position is that the additional detail was provided to clarify the 2015 version. However, it changed the occasions of service used for calculating the hospitals' rate reductions for cuts 7 and 8, as indicated in Finding 22, as well as some other substantive changes.

27. The 2015 Outpatient Plan addressed the unit cost cap by stating: "Effective July 1, 2011, AHCA shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs." The 2016 Outpatient Plan elaborates and specifies the calculation AHCA has been using, as stated in Finding 14.

28. The 2015 Outpatient Plan provided that an individual hospital's prospective reimbursement rate may be adjusted under certain circumstances, such as when AHCA makes an error in the calculation of the hospital's unaudited rate. It also stated: "Any rate adjustment or denial of a rate adjustment by AHCA may be appealed by the provider in accordance with Rule 28-106,

F.A.C., and section 120.57(1), F.S." The 2016 Outpatient Plan deleted the appeal rights language from the existing rule.

29. The effect of the existing and proposed rules on the Petitioners through their effect on managed care contract rates is debatable. Those rates do not have to be the same as the fee-for-service outpatient reimbursement rates, although they are influenced by the fee-for-service rates, and it is not uncommon for them to be stated as a percentage of the fee-for-service rates. By law, managed care contract rates cannot exceed 120 percent of the fee-for-service rates unless the MCO gets permission from AHCA, as provided in section 409.975(6). Currently, rates paid by MCOs for Medicaid hospital outpatient services average about 105 percent of the fee-for-service reimbursement rates. AHCA has indicated that it would not expect or like to see the contract rates much higher than that. It is not clear whether that still is AHCA's position. If higher rates were negotiated, the impact of fee-for-services rate adjustments on managed care rates could be reduced or even eliminated.

30. The effect of the existing and proposed rules on the Petitioners through their effect on how fee-for-service reimbursement rates are calculated is not disputed. With the transition to managed care, the effect is greater and clearly substantial. The recurring MTA reductions enacted by the Legislature through 2014, which total $224,015,229 (after taking

into account $10,656,238 that was reinstated, and $4,068,064 that was added in consideration of trauma centers), are being spread over fewer fee-for-service occasions of service, especially for cuts 7 and 8, which significantly lowers the fee-for-service outpatient reimbursement rates calculated under the proposed rule.

31. The Petitioners' objections to the validity of the proposed and existing rules can be summarized as follows: a lack of legislative authority for recurring (i.e., cumulative) MTA reductions; a failure to adopt a fixed methodology to calculate individual hospital outpatient reimbursement rate adjustments resulting from MTA reductions; specifically, a failure to derive the number of fee-for-service occasions of service used in calculating individual hospital outpatient reimbursement rate adjustments in the same manner every year; conversely, a failure to increase the occasions of service used to calculate individual hospital outpatient reimbursement rate adjustments resulting from cuts 1 through 4; a failure of the unit cost cap in the existing rule to specify how it is applied; a failure of the unit cost cap in the proposed rule to compare the 2011 unit cost to the current cost, calculated by dividing the total dollar amount of Medicaid payments made to all hospitals by AHCA by the number of Medicaid occasions of service for all hospitals, including in children's and rural hospitals; and proposed rule's deletion of the language

in the existing rule stating that a rate adjustment or denial can be appealed in accordance with Florida Administrative Code Rule 28-106 and section 120.57.

CONCLUSIONS OF LAW

32. Any person who is substantially affected by a rule or proposed rule can petition DOAH for a final order that the rule or proposed rule is an invalid exercise of delegated legislative authority. § 120.56(1)(a), Fla. Stat. The Petitioners are substantially affected and have standing.

33. The Petitioners have the burden to prove by a preponderance of the evidence that the existing rule is invalid, in whole or in part, as to the objections raised in the petitions. § 120.56(3), Fla. Stat. AHCA has the burden to prove by a preponderance of the evidence that the proposed rule is not invalid, in whole or in part, as to the objections raised in the petitions; the proposed rule is not presumed to be valid or invalid. § 120.56(2), Fla. Stat.

34. The Petitioners contend that the existing and proposed rules are invalid exercises of delegated legislative authority because: they exceed the legislative grant of rulemaking authority; they enlarge, modify, or contravene the specific provisions of law implemented; they are vague; they fail to establish adequate standards for agency decisions, or vest unbridled discretion in the agency; and they are arbitrary (i.e.,

not supported by logic or the necessary facts) or capricious (i.e., adopted without thought or reason, or is irrational). § 120.52(8)(b) through (e), Fla. Stat.

35. As for the first ground for alleged invalidity, it is clear that neither existing nor proposed rule 59G-6.030 exceeds the grant of legislative authority. Section 409.919 authorizes AHCA to "adopt any rules necessary to comply with or administer" sections 409.901 through 409.920 "and all rules necessary to comply with federal requirements." Sections 409.905(6)(b), 409.908(1)(f)1., and 409.908 are statutes implemented by existing and proposed rule 59G-6.030 that specifically address the establishment of Medicaid hospital outpatient reimbursement rates. It is clear from the statutes that Medicaid hospital outpatient reimbursement is subject to limitations and directions in the GAAs. See §§ 409.902(1), 409.905(6)(b), and 409.908(2)(b), Fla. Stat.

MTA Reductions

36. As for the other grounds for alleged invalidity, with respect to the MTA reductions, the Petitioners seem to contend, on the one hand, that the implementing statutes and GAAs required AHCA to adopt a detailed, fixed methodology that would determine how it would apply each MTA reduction to individual hospital rates going forward. Specifically, they criticize AHCA for

making changes in the way individual hospital reimbursement rates were reduced in response to cuts 7 and 8.

37. Section 409.905(6)(b) requires AHCA to "implement a methodology for establishing base reimbursement rates for outpatient services for each hospital based on allowable costs, as defined by the agency." Section 409.908 requires AHCA to reimburse Medicaid providers "according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein." As reflected in the Findings of Fact, the GAAs directed AHCA to "implement a recurring methodology" and to "reduce individual hospital rates proportionately" until the required savings were achieved.

38. It is clear that the MTA reductions imposed by the GAAs were recurring in the sense that they were cumulative, but AHCA did not interpret the language in the statutes and GAAs to mean that AHCA was required to adopt a detailed, fixed methodology that could never change. The versions of rule 59G-6.030 adopted up to and including the existing rule did little more than restate language in the statutes and GAAs. The details incorporated in proposed rule 59G-6.030 apparently were introduced in an effort to address some of the objections raised in the petitions in DOAH cases 16-6398RX through 16-6414RX. The changes made in the calculations applied to cuts 7 and 8 to determine the individual hospital's reimbursement rate

adjustments from those cuts were done, without objection from the hospitals, to comply with legislative intent. Each version of rule 59G-6.030, with its incorporated Outpatient Plan, has been accepted and essentially ratified by the Legislature as being consistent with the legislative intent. Deference is given to an agency's long-standing statutory interpretations, especially those accepted and ratified by the Legislature year after year. See Jax Liquors v. Div. of Alcoholic Beverages & Tobacco, 388 So. 1306, 1308 (Fla. 1st DCA 1980); Austin v. Austin, 350 So. 2d 102, 104 (Fla. 1st DCA 1977), cert. den., 357 So. 2d 184 (Fla. 1978).

39. The Petitioners also contend, inconsistently, that the existing and proposed rules are invalid with respect to the MTA reductions because AHCA has not changed the calculations it always has applied to cuts 1 through 4 to determine the individual hospitals' reimbursement rate adjustments from those cuts. They contend that the provision of Medicaid outpatient services through MCOs has reduced fee-for-service reimbursement rates more than intended by the Legislature because the recurring and cumulative MTA reductions, especially in cuts 1 through 4, are being spread over fewer fee-for-service occasions of service.

40. In contrast to cuts 7 and 8, there has been no apparent legislative intent for AHCA to change the calculations it always has applied to cuts 1 through 4 to determine the individual

hospitals' reimbursement rate adjustments from those cuts. To the contrary, the actions of the Legislature in the 2016 session support and ratify the agency's interpretation of the legislative intent. Id.

41. Even if the legislative intent were less clear, and would allow for the interpretation of the statutes and GAAs proposed by the Petitioners, AHCA's interpretation is reasonable. Neither existing nor proposed rule 59G-6.030 enlarges, modifies, or contravenes the specific provisions of law implemented; nor is the existing or proposed rule arbitrary or capricious.

42. As for the other grounds for invalidity with respect to the MTA reductions, proposed rule 59G-6.030 clearly is not vague; does not fail to establish adequate standards for agency decisions; and does not vest unbridled discretion in the agency. See State Dep't of Fin. Servs. v. Peter R. Brown Constr., Inc., 108 So. 3d 723, 728 (Fla. 1st DCA 2013) (a rule is vague, fails to establish adequate standards for agency decisions, or vests unbridled discretion in the agency 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). Existing rule 59G-6.030 has less detail, making it more vulnerable to the Petitioners' arguments, but it essentially uses the language of the statutes and GAAs, and has

been accepted and ratified by the Legislature, which preserves its validity as to these objections.

Unit Cost Cap

43. In the existing rule, the unit cost cap language reiterates the language of the statutes and GAA verbatim. It does not enlarge, modify, or contravene the specific provisions of section 409.908 and the GAAs being implemented.

44. In the proposed rule, the unit cost cap language specifies how AHCA has been applying the unit cost cap since 2011. It is not clear from the evidence why AHCA made this choice, but it may have been done because the GAAs excluded children's and rural hospitals from the MTA reduction of cuts 7 and 8. There is no evidence to suggest that the Legislature disagreed with how AHCA has been interpreting the unit cost cap. To the contrary, the actions of the Legislature during the 2016 session support and ratify the agency's interpretation.

45. Deference is given to AHCA's interpretation of the unit cost cap. See Jax Liquors v. Div. of Alcoholic Beverages & Tobacco, supra; Austin v. Austin, supra. The unit cost cap language in the proposed rule does not enlarge, modify, or contravene the specific provisions of section 409.908 and the GAAs being implemented; and it is not arbitrary or capricious.

46. As for the other grounds for invalidity with respect to the unit cost cap, proposed rule 59G-6.030 clearly is not vague;

does not fail to establish adequate standards for agency decisions; and does not vest unbridled discretion in the agency. See State Dep't of Fin. Servs. v. Peter R. Brown Constr., Inc., supra. Existing rule 59G-6.030 has less detail, making it more vulnerable to the Petitioners' arguments, but it uses the language of the statutes and GAAs, and has been accepted and ratified by the Legislature, which preserves its validity as to these objections.

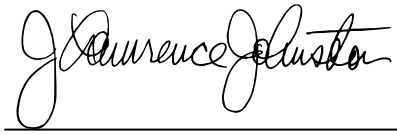
Appeal Rights

47. Proposed rule 59G-6.030 deletes the language in existing rule 59G-6.030 stating that a rate adjustment or denial can be appealed in accordance with rule chapter 28-106 and section 120.57. Regardless whether the appeal rights language is in the proposed rule, the available appeal rights will be determined based on the correct interpretation of rule chapter 28-106, chapter 120, and section 409.908(1)(f)1. That issue is now on appeal to the First District Court of Appeal. The deletion of the appeal rights language does not render the proposed rule invalid.

DISPOSITION

Based on the foregoing Findings of Fact and Conclusions of Law, the petitions are denied.

DONE AND ORDERED this 18th day of April, 2017, in Tallahassee, Leon County, Florida.



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NOTICE OF RIGHT TO JUDICIAL REVIEW

A party who is adversely affected by this Final Order is entitled to judicial review pursuant to section 120.68, Florida Statutes. Review proceedings are governed by the Florida Rules of Appellate Procedure. Such proceedings are commenced by filing the original notice of 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.