STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

FLORIDA LEAGUE OF HOSPITALS, INC., et al.,	)	
Petitioners,	)	
and	)	
HORIZON HOSPITAL, and CHARTER MEDICAL CENTER,	)	
vs.	)	CASE NO. 90-1036RP 90-1037RP
	)	90-1038RP 90-1045RP
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES,	)	90-1046RP 90-1047RP
	)	90-1048RP 90-1049RP
Respondent.	)	90-1050RP 90-1051RP
and	)	90-1052RP 90-1053RP
	)	90-1054RP 90-1055RP
HEALTH MANAGEMENT ASSOCIATES, INC., UNIVERSITY PAVILION HOSPITAL, and GLENBEIGH, INC.	)	90-1056RP 90-1057RP
	)	90-1058RP 90-1059RP
Intervenors.	)	90-1060RP 90-1061RP

FINAL ORDER

Rule 10-5.011(1)(o) and (p), Hospital Inpatient General Psychiatric Services.

Pursuant to notice, the Division of Administrative Hearings, by its duly designated Hearing Officer, Mary Clark, held a formal hearing in the above-styled cases on March 19-21, April 30, May 1-4, and June 25-27, 1990, in Tallahassee, Florida.

APPEARANCES

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NME HOSPITALS, INC., d/b/a HOLLYWOOD MEDICAL CENTER; NME HOSPITALS, INC., d/b/a WEST BOCA MEDICAL CENTER; PIA PSYCHIATRIC HOSPITALS, INC.; and PIA SARASOTA PALMS, Inc. d/b/a SARASOTA PALMS HOSPITAL	C. Gary Williams, Esquire Michael J. Glazer, Esquire Steven P. Seymoe, Esquire Ausley, McMullen, McGehee Carothers & Proctor Post Office Box 391 Tallahassee, Florida 32302
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SOUTH BROWARD HOSPITAL DISTRICT	Paul H. Amundsen, Esquire Terry Rigsby, Esquire Julie Gallagher, Esquire Blank & Amundsen 204-B South Monroe Street Tallahassee, Florida 32301
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FLORIDA MEDICAL CENTER, LTD.	Eric B. Tilton, Esquire 24l-B E. Virginia Street Tallahassee, Florida 32301

BAPTIST HOSPITAL	Ivan Wood, Esquire Wood, Lucksinger & Epstein Four Houston Center 1221 Lamar, Suite 1400 Houston, Texas 77010-3015
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HORIZON HOSPITAL	Darrell H. White, Jr., Esquire Chris Barclay, Esquire McFarlain, Sternstein, Wiley & Cassedy Post Office Box 2174 Tallahassee, Florida 32316-2174
CHARTER MEDICAL CENTER	Michael J. Cherniga, Esquire David Ashburn, Esquire Roberts, Baggett, LaFace & Richard 101 East College Avenue Tallahassee, Florida 32301

STATEMENT OF THE ISSUES

The issue in these consolidated cases is whether proposed amendments to Rule 10-5.011(1)(o), and (p) F.A.C. relating to certificates of need for hospital inpatient general psychiatric services, are invalid exercises of delegated legislative authority, as defined in Section 120.52(8), F.S.

PRELIMINARY STATEMENT

On January 19, 1990, the Department of Health and Rehabilitative Services (HRS) published its notice of intent to amend Rule 10-5.011(1)(q), F.A.C. Among other changes, the proposed amendments abolish the distinction between long and short-term services, change the bed need formula from a fixed- bed-need ratio to a utilization-based formula, establish separate need formulae for adult and children/adolescent services, modify the definition of substance abuse services, impose advertising restrictions, and create additional application requirements.

Various petitions were timely filed, challenging the validity of the proposed amendments pursuant to Section 120.54(4), F.S. Those petitions were assigned to Hearing Officer, Mary Clark.

On January 26, 1990, HRS published its notice of intent to adopt amendments to Rules 10-5.011(1)(o) and (p), F.A.C., relating to long-term and short-term hospital inpatient psychiatric services. The amendments proposed are similar to those described above for substance abuse services.

Petitions were timely filed in opposition to those amendments and were assigned to Hearing Officer, Diane Kiesling.

All of the petitions were consolidated in an order entered on March 13, 1990. Although identity of issues and evidence justifies the consideration of the validity of the substance abuse and psychiatric rule amendments in a single proceeding, at the request of the parties, including HRS, the Hearing Officer is entering separate final orders on the rules. These orders are substantially identical, as most of the evidence and argument by the parties was addressed to both sets of rule amendments.

Petitions to intervene were granted to Health Management Associates, Inc., University Pavilion Hospital, Horizon Hospital, Glenbeigh, Inc., and Charter Medical Center.

Over objections as to standing, leave to intervene was also granted to Tampa Bay Academy, but its petition was voluntary dismissed on March 22, 1990.

Some intervenors supported the rules, others challenged portions and supported other portions of the rules.

At the hearing the following testimony and evidence was presented:

NME/PIA presented the testimony of Robert Sharpe, John Robert Griffin, Elfie Stamm, Ivor Groves, Lucy Conditt, Larry Dougher, John Davis, Sharon Gordon-Girvin, Lanny J. Morrison, and Daniel J. Sullivan. Received into evidence were NME/PIA exhibits as follows: (1) Excerpt from FAW, Volume 16, No. 3, 1-19-90, pages 197-204; (2) Excerpt from FAW, Volume 16, No. 4, 1-26-90, pages 304-313; (3) Rules 10-5.011(1) (o) (p) and (q) ; (4) Minutes of HRS work group, August, 1988; (5) DSM-III Manual; (6) Two length of stay charts; (7) Analysis of insurance policies; (8) Excerpt from ICD-9, pages 55-66; (9) Memorandum from Ivor Groves to Bob Sharpe; (10) Psychiatric hospital discharge data reporting requirements; (11) Psychiatric case mix data; (12) Curriculum vitae of Lanny J. Morrison; (13) Curriculum vita of Daniel J. Sullivan; (14) Medicaid chart prepared by Daniel J. Sullivan; and (15) ALOS chart prepared by Daniel J. Sullivan.

During the hearing, Baptist presented the testimony of Nancy Ramos and Andrew Terry. Received in evidence were Baptist's exhibits as follows: (1) Curriculum vitae of Nancy Ramos; (2) Graph prepared by Nancy Ramos; (3) Curriculum vitae of Leonard Andrew Terry; (4) Analysis of recordkeeping costs, prepared by Leonard Andrew Terry; and (5) Psychiatric Rule Analysis Composites A, B, C, and D.

Florida Medical Center presented the testimony of Nancy Sutton-Bell, Thomas J. Konrad, Anthony Krayer, and James Whitaker. Received into evidence were Florida Medical Center exhibits as follows: (1) IRTF average length of stay reference sheet; (2) Long-term psychiatric occupancy Second Quarter, 1989; (3) EIS for psychiatric bed rule; (4) Curriculum vitae of Nancy Sutton-Bell (5) Chart-max.4 day coverage; and (6) District X bed survey.

Humana presented the testimony of Sharon Gordon-Girvin, John Davis, Robert Pannell, and Niels Vernegaard. Received into evidence were Humana exhibits as follows: (1) Preliminary inventory of psychiatric beds, as of 3-9-90; (2) Preliminary inventory of substance abuse beds; (3) Summary by Daniel J. Sullivan; (4) Information underlying NME Exhibit 15 and Humana Exhibit 13; (5) Preliminary estimate of need for adult psychiatric beds; (6) Long-term/short-term rule, FAW, 12-10-82; (7) Excerpt from FAW, 4-13-90; (8) Excerpt from FAW, 3-15-85; (9) Excerpt from FAW, 9-13-85; (10) HRS fixed pool publication, September 1989; (11) HRS fixed pool publication, March 1990; and (12) Current Glenbeigh Hospital License.

Adventist/Florida Hospital and Adventist/Medical Center Hospital presented the testimony of Barbara Lang, Ted Hirsch, Richard C. W. Hall and Wendy Thomas. Received into evidence were Florida Hospital exhibits as follows: (1) Curriculum vitae of Ted Hirsch; (2) License-2586; (3) Curriculum vitae of Richard C. W. Hall; and (4) Portion of Glenbeigh Application. Received into evidence were Medical Center Hospital exhibits as follows: (1) License, (2) Front page of CON.

Received into evidence was Health Management Associates Exhibit No. 1 -- Florida Medical Center's CON application.

South Broward Hospital District presented the testimony of Jon Bandes. Received into evidence was South Broward Exhibit No. 1 -- Curriculum vitae of Jon Bandes.

Indian River Memorial Hospital presented the testimony of Phillip Charles Brauening, Michael O'Grady, and Jim Tyler. Received into evidence were Indian River exhibits as follows: (1) 1-19-90 correspondence from HRS [taken under advisement and now admitted as a joint exhibit of Indian River/Glenbeigh] and (1) [sic] resume of Michael O'Grady.

JFK Medical Center, Inc. and Sarasota County Public Hospital Board presented the testimony of Michael Carroll. Received into evidence were JFK Medical Center/Sarasota exhibits as follows: (1) Curriculum vitae of Michael Carroll; (2-6) Bed need calculations. Charter Medical presented the testimony of Dr. Ronald Luke. Received into evidence was Charter Medical's exhibit No.- Curriculum vitae of Dr. Ronald Luke.

University Pavilion presented the testimony of Robert Patrick Archer and Eugene Nelson. Received into evidence were University Pavilion exhibits as follows: (1) Curriculum vitae for Dr. Archer; (2) Series of tables.

Glenbeigh presented the testimony of Richard Weedman. Received into evidence was Glenbeigh's exhibit No.-- Curriculum vitae of Richard Weedman.

HRS presented the testimony of Elfie Stamm. Received into evidence were HRS exhibits as follows: (1) Curriculum vitae of Elfie Stamm; (2) Work group minutes, composite; (3) Literature, composite; (4) Comments on psychiatric rule; (5) Comments on substance abuse rule; (6) Transcript of substance abuse rule public hearing; and (7) Transcript of psychiatric rule public hearing.

Three stipulations entered by the parties during the course of the proceeding are included in the record as "Hearing Officer exhibits": Hearing Officer exhibit #1 is the Joint Prehearing Stipulation filed by the parties on March 16, 1990. Hearing Officer exhibit #2 is an agreement and amendment to prehearing stipulation entered on May 1, 1990, wherein the parties withdrew all challenges to HRS' proposed rule amendments categorizing eating disorders as

psychiatric diseases. In return HRS agreed to "grandfather" certain eating disorder programs in acute care hospitals. Hearing Officer exhibit #3 is a second agreement, entitled Amendment to Prehearing Stipulation, executed by all parties and effecting a number of changes in the text of the proposed rules. The parties have agreed that the amendments reflected in the second agreement are technical in nature, do not affect the substance of the rules, are supported by the record of the public hearing held in this matter, or are in response to written material received by HRS within 21 days after the notice required by Section 120.54(1), F.S. To the extent this material is found in the petitions which are the subject of this proceeding, those petitions shall (if not already included) be made a part of the record of the rule making proceeding. See Section 120.54(13)(b), F.S. and Florida Medical Center, etc. v. Department of Health and Rehabilitative Services, 11 FALR 3904 (Final order dated 6/29/89).

On August 16, 1990, the parties filed a correction to the second agreement (Hearing Officer exhibit #3) correcting a scrivener's error in attachment B to the exhibit.

This Final Order is based on the proposed rules as amended by the second agreement, except for the following provisions which, by agreement of the parties, are based on the text as originally published:

Rule 10-5.011(1) (o)

4.e. (III), 4.h. (III),11.b.

Rule 10-5.011(1) (q)

4.e.(III),11.b.

After the formal hearing adjourned, and a 19-volume transcript was filed, the parties were given a deadline extension of August 27, 1990, for filing proposed orders, briefs, and similar documents.

The findings of fact proposed by the parties are addressed in the attached appendix.

FINDINGS OF FACT

Metamorphosis of the Rules

1. Prior to 1983, hospitals were not separately licensed, and certificates of need (CON) were not required for the designation of beds for psychiatric and substance abuse services. In 1983, statutory amendments to Chapter 381, F.S. addressed psychiatric beds as reviewable projects in the CON program.

2. In 1983, HRS adopted rules establishing four new categories of beds, now found in Rules 10-5.011(1)(o), (p), and (q), F.A.C.: Short-term psychiatric, long-term psychiatric, and short and long-term substance abuse.

At the time that the categories were created, HRS conducted an inventory of the hospitals, asking how many beds were designated in each category. Based on the responses, published in the Florida Administrative Weekly, future projections of need were made and applications were considered for CONs.

3. Another category of psychiatric beds was not included in the 1983 rules. Intensive residential treatment programs for children and adolescents were created by statute in 1982, and are defined in Section 395.002(8), F.S. as:

> a specialty hospital accredited by the Joint Commission on Accreditation of Hospitals which provides 24-hour care and which has the primary functions of diagnosis and treatment of patients under the age of IS having psychiatric disorders in order to restore such patients to an optimal level of functioning.

These facilities, called IRTFs, may become licensed as hospitals pursuant to Section 395.003(2)(f), F.S., but as hospitals they must obtain CON approval pursuant to Sections 381.702(7) and (12), F.S. and Section 381.706(1) (b), F.S.

4. IRTFs have no statutory or regulatory restrictions on length of stay and were approved by HRS at one time under an unwritten policy that there be one such facility available in each HRS planning district, without regard to the availability of other long or short term psychiatric programs.

5. In 1985, HRS proposed a rule amendment which would have eliminated the short and long term distinction, as well as the distinction between psychiatric services and substance abuse services.

Six months later, the proposed rule amendment was withdrawn. It was highly controversial; several challenges were filed; objections were made by various local health councils; and a new administrator took over. The agency decided to rework its proposed change~;.

6. The agency next began the process of revision in 1987, and in 1988 convened a workshop group to review an issue paper prepared by agency staff. Another work group met in 1989 to consider the consolidation of psychiatric and substance abuse rules. HRS staff reviewed literature on the subjects of substance abuse and psychiatric services, including literature relating to access by indigent patients and the provision of services to children and adolescents.

Staff prepared rule drafts which were circulated in- house, including the alcohol, drug abuse and mental health program office; and to such outside groups as the Association of Voluntary Hospitals of Florida, the Florida Hospital Association and the League of Hospitals.

7. The proposed rule amendments which are the subject of this proceeding were filed on January 19, 1990 (substance abuse), and on January 26, 1990 (inpatient psychiatric services) in the Florida Administrative Weekly.

The Parties

8. HRS administers the CON program pursuant to Section 381.701, et seq., F.S. (1989). The CON program regulates entry into the Florida health care market by providers through review and approval of certain capital expenditures, services and beds.

9. The petitioner, Florida League of Hospitals, Inc. is a nonprofit corporation which is organized and maintained for the benefit of investor-owned hospitals which comprise its membership. The remaining petitioners and intervenors are current providers of hospital inpatient psychiatric services, long and short term, and of inpatient substance abuse services, long and short term.

10. The petitioners and intervenors are all substantially affected by the proposed rules and have stipulated to the standing of all parties in this proceeding.

Abolishing Distinctions Between Long-Term & Short-Term Psychiatric Beds

11. "Short term hospital inpatient psychiatric services" is defined in existing rule 10-5.011(1)(o)1, FAC, as follows:

> 1. Short term hospital inpatient psychiatric services means a category of services which provides a 24-hour a day therapeutic milieu for persons suffering from mental health problems which are so severe and acute that they need intensive, full-time care. Acute psychiatric inpatient care is defined as a service not exceeding three months and averaging length of stay of 30 days or less for adults and a stay of 60 days or less for children and adolescents under 18 years.

"Long term psychiatric services" is defined in existing rule 10-5.011(1)(p)1., FAC as

> a category of services which provides hospital based inpatient services averaging a length of stay of 90 days.

12. Neither rule addresses services to adults with an average length of stay (ALOS) of 30-90 days, or services to children and adolescents with a 60-90 day ALOS.

Because of this, and the "averaging" process, long term hospitals legitimately serve "short term" patients and short term hospitals may serve "long term" patients. One party has calculated than a long term facility could legally provide short term services for 80% of its patients, and long term services for only 20% of its patients and still have an ALOS of 90 days.

13. Under the existing rules a facility must file a CON application to convert from long term to short term beds, or vice versa, and is subject to sanctions for failure to comply with the designation on its CON.

The proposed changes would repeal rule 10-5.011(1) (p), FAC regarding long term services, and would amend rule 10- 5.011(1) (o), FAC to delete the definition of short term services, thereby permitting facilities to serve patients without regard to length of stay.

14. The proposed changes are supported by several factors upon which a reasonable person could rely.

Substantial changes have occurred in the last decade in clinical practices and in third party reimbursement to reduce the ALOS for hospital inpatient psychiatric care.

Prior to the 1960s, there was no distinction between long and short term care, as all hospital based care was long term with an emphasis on psychoanalytic therapy.

Beginning in the 1960s, the concept of community mental health programs evolved with an emphasis on deinstitutionalization of patients in large public "asylums" and with a goal of treatment in the least restrictive environment. In more recent years the trend has spread to the private sector.

Improvements in the availability and use of psychiatric drugs, the use of outpatient care or partial hospitalization, and improved follow up care have led to a dramatic decrease in ALOS.

15. Long term care is costly, and whether third party payors have been a driving force, or are merely responding to the trends described above, long term inpatient reimbursement is virtually nonexistent. During the 19805, most insurance companies imposed a 30-day limit on psychiatric inpatient care or imposed monetary limits which would have effectively paid for less than a 90-day term. CHAMPUS, the program providing insurance to military dependents, was providing long term coverage in 1982, but by 1986 its coverage was rarely available for more than 30-60 days, and today, under CHAMPUS' case management system, 30 days is a "luxurious amount".

Other large third-party payors such as Blue Cross/Blue Shield have similar limits or aggressively use case management (the close scrutiny of need on a case by case basis) to limit reimbursement for inpatient care.

16. Of the two or three long term facilities in existence at the time that HRS' rules were originally adopted, only one, Anclote Manor still reported an ALOS of over 90 days by 1989, dropping from an ALOS of 477.9 days in 1986 to 145.4 days in 1989. At the same time its occupancy rate dropped below 50%.

17. There is an interesting dialogue among experts as to whether there still exists a clinical distinction between long term and short term inpatient psychiatric care. Studies at the Florida Mental Health Institute found no difference in rate of rehospitalization over a 12 month period between patients who were in a nine week program and patients from Florida State Hospital with a 500 day length of stay. Some mental health practitioners are looking now at treating the chronic psychiatric patient with repeated short term hospital stays and less intensive care between episodes, rather than a single long term inpatient stay. Other practitioners maintain that a long term psychiatric problem is behavioral in nature and requires a total life readjustment and longer length of stay.

Whichever practice may be preferable, the facts remain that fewer and fewer mental patients are being treated with long term hospitalization.

18. The proposed rules would not foreclose any facility from providing long term care, if it finds the need.

To the extent that a clinical distinction exists between short and long term care, the existing rules do not address that distinction, except from a wholly arbitrary length of stay perspective. The existing rules no longer serve valid health care objectives.

19. Existing providers with short term CONs are concerned that the allowing long term facilities to convert will further glut an underutilized market and will result in an increase in vacant beds and a rise in the cost of health services, contrary to the intent of the CON program.

Intensive residential treatment facilities (IRTFs), which will be folded into the need methodology for children and adolescent beds, have no current restrictions on length of stay and may already compete with impunity with the short term providers.

Moreover, long term facilities are also providing substantial short term care as a result of the trends discussed above. HRS has not consistently enforced the length of stay restrictions of long term providers' CONs. Whether those CONs were improvidently granted is beside the point. The capital costs have already been incurred; the beds are available; and the beds are being used, in part, for short term services.

Abolishing the distinction is a rational approach to current conditions. And in determining that all existing providers would be placed in the same position regarding length of stay, HRS avoids the regulatory nightmare of trying to enforce limitations on existing providers and approving new beds without limitations.

Creating a Distinction Between Adult and Children/Adolescent Beds

20. Rule 10-5.011(1)(o)3.c. creates a CON distinction between general psychiatric services for adults, and those services for children and adolescents. Rule 10-5.011(1)(o)4., as proposed, would create separate need criteria for hospital inpatient general psychiatric services for adults and for children/adolescents. Adolescents are defined in Rule 10- 5.011(1)(o)2.a., as persons age 14 through 17 years. Persons over 17 years are adults, and under 14 years are children.

21. There are valid clinical reasons to distinguish between programs fob the separate age groups. Although there is some overlap, differing therapies are appropriate with different ages. The types of services offered to adults are not the same as those which are offered to children. Children, for example, often receive academic educational services while being hospitalized. Adults receive career or vocational counseling and marriage counseling.

22. The required separation by age categories would remove some flexibility from providers. However, this is offset by the Department's valid need to track for planning purposes inpatient services to children and adolescents separately from those provided to adults. Based on anecdotal evidence, HRS' Office of Alcohol, Drug Abuse and Mental Health Program Office is concerned about the possible overutilization of hospital inpatient services for children and adolescents and the potential that when insurance reimbursement expires they are discharged without clinical bases.

Taking Inventory

23. Under the proposed rule, in order to separately regulate adult and children/adolescent beds, HRS will fix an inventory of uses as of the time that the rule takes effect.

24. For facilities with CONs which already allocate beds between the two groups, the proposed rule will have no effect. For facilities without a designation, as long as adults and children/adolescents are kept in separate programs, the allocation can now be mixed and changed at will. The rule amendment will freeze that use in place.

25. HRS has conducted a preliminary survey to determine the existing uses of psychiatric, substance abuse and residential treatment program beds. The survey of approximately 120 facilities is complete, but is not intended to limit those facilities unless their CON already provides a limit. A final inventory will be taken after the proposed rules become effective. The inventory will be published, and providers will be given an opportunity to contest its findings.

The ultimate outcome will be amended CONs and licenses which reflect each facility's mix of adult and children/adolescent beds.

The process is a fair and reasonable means of commencing separate regulation of services to these age groups.

The Definitions

26. Proposed rules 10-5.011(1)(o)2.1., 2.p., and 2.t.) define "hospital inpatient general psychiatric services", "psychiatric disorder" and "substance abuse", respectively. Each of these provisions defines the terms by reference to classifications contained in the Diagnostic and Statistical Manual of Mental Diseases (DSM-III-R Manual) and equivalent classifications contained- in the International Classification of Diseases (ICD-9 Codes). The rule as originally proposed included the phrase "or its subsequent revisions", after incorporating the manuals by reference. In testimony, and in the parties second agreement (Hearing Office exhibit 3) the phrase is deleted. However, it still appears in proposed rule 10-5.011(1) (o)2.1., perhaps inadvertently.

The DSM-III-R is a generally recognized manual for the classification of mental disorders and is widely used by clinicians and medical records professionals to categorize the conditions of patients. The ICD-9 codes are broader than just mental disorders, but they have a section on mental disorders with numbers that are identical to those in the DSM-III-R.

27. Although the manuals are complex and subject to interpretation, clinicians are accustomed to their use and they provide a reasonable guide as to the services which may be provided in an inpatient substance abuse program, as distinguished from an inpatient psychiatric program.

Advertising Limited

28. Proposed rule 10-5.011(1)(o)3.d. (as amended in the parties second agreement, Hearing Officer exhibit #3), provides:

> D. Advertising of services. The number of beds for adult or for children and adolescent hospital inpatient general psychiatric services shall be indicated on the face of the hospital's license. Beds in intensive residential treatment programs for children and adolescents which are licensed as specialty hospital beds will be indicated as intensive residential treatment program beds on the face of the hospital's license. Only hospitals with separately-licensed hospital inpatient general psychiatric services, including facilities with intensive residential treatment programs for children and adolescents which are licensed as specialty hospitals, can advertise to the public the availability of hospital inpatient general psychiatric services. A hospital with separately licensed hospital inpatient general psychiatric services that does not have a certificate of need for hospital inpatient substance abuse services may advertise that they [sic] provide services for patients with a principal psychiatric diagnosis excluding substance abuse and a secondary substance abuse disorder.

29. The Department does not currently have CON, licensure, or other rules which limit the ability of a health care provider to advertise its services, and has never used advertising as a factor in conducting CON review for any proposed services.

30. HRS included provisions regarding advertising in its proposed rules because it had evidence that existing facilities have used misleading advertisements. The evidence came from other providers, rather than consumers. However, it is the consumer whom the agency feels may be confused by advertising which implies that services are available when such services cannot be legally provided under the facility's license.

31. The advertising provision is prospective in nature, seeking to prevent licensed providers from advertising services for which they are not licensed. The provisions do not relate to CON review, and the staff is unclear as to how the rule would be implemented. Licensing and CON review are two separate functions within the agency.

32. Although the term is not defined in the proposed rule, advertising broadly includes word of mouth referrals and public presentations by professionals in the community, as well as traditional media and written advertisements. Properly utilized, advertising helps consumers exercise choice and gain access to needed services. Improper advertising is subject to the regulation of federal and state agencies other than the department.

New Need Methodology, with Preferences

33. Proposed Rule 10-5.011(1)(o)4., deletes the existing population ratio methodology and creates a need formula based upon use rate, for adult and children/adolescent inpatient psychiatric services. Certain preferences are also described.

34. Rule 10-5.011(1) (o)4.e.(III) provides:

> In order to insure access to hospital inpatient general psychiatric services for Medicaid-eligible and charity care adults, forty percent of the gross bed need allocated to each district for hospital inpatient general psychiatric services for adults should be allocated to general hospitals.

The same provision for children and adolescent services is found in rule 10-5.011(1)(o)4.h.(III).

Medicaid reimbursement is not available for inpatient services in a specialty hospital.

35. Rule 10-5.011(1)(o)4.i. provides:

> 1. Preferences Among Competing Applicants for Hospital Inpatient General Psychiatric Services. In weighing and balancing statutory and rule review criteria, preference will be given to applicants who:
> I. Provide Medicaid and charity care days as a percentage of its total patient days equal to or greater than the average percentage of Medicaid and charity care patient days of total patient days provided by other hospitals in the district, as determined for the most recent calendar year prior to the year of the application for which data are available from the Health Care Cost Containment Board.
> II. Propose to serve the most seriously mentally ill patients (e.g. suicidal patients; patients with acute schizophrenia; patients with severe depression) to the extent that these patients can benefit from a hospital-based organized inpatient treatment program.
> III. Propose to service Medicaid-eligible persons.
> IV. Propose to service individuals without regard to their ability to pay.
> V. Provide a continuum of psychiatric services for children and adolescents, including services following discharge.

36. The preferences are similar to those in CON rules relating to other types of health services and are intended to implement, in part, the legislative mandate that the agency consider an applicant's ". . . past and proposed provision of health care services to medicaid patients and the medically indigent." Section 381.705(1) (n), F.S.

37. Under Medicaid reimbursement general hospitals are paid a set per diem based on a variety of services provided to all Medicaid patients, regardless of actual cost of the individual service. As psychiatric services are generally less costly than other services on a per diem basis, hospitals may recoup a greater percentage of their costs in serving Medicaid psychiatric patients.

38. This and the fact that public hospitals receive some governmental subsidies do not obviate the need for incentives in the CON program. Not all of the charity care provided by these hospitals is funded and a large amount is written off. Although Petitioners argue that the preferences are not needed, or are too generous, none provide competent evidence that the facilities who do not enjoy the preferences are unduly prejudiced.

39. The 40% allocation of bed need to general hospitals is a guideline, not a maximum, as applied by the agency, and presumes that there are general hospitals competing in any batch in question. It is not intended to frustrate a separate section of the rule which allows a hospital with at least an 85% occupancy rate to expand regardless of need shown in the formula and the occupancy rate district-wide. See 10- 5.011(1) (o)4.d. and g.

"Evaluation of Treatment Outcomes"

40. The proposed rules contain three provisions relating to a hospital's evaluation of its patients' treatment outcomes. Rule 10-5.011(1) (o)3.i, includes among "required services", ". . . an overall program evaluation of the treatment outcomes for discharged patients to determine program effectiveness."

Rule 10-5.011(1)(o)8.j., requires in the application,

> A description of the methods to be used to evaluate the outcome of the treatments provided and to determine the effectiveness of the program, including any summary evaluation outcome results for hospital inpatient psychiatric services provided at other facilities owned or operated by the applicant in Florida and other states. The data shall exclude patient specific information.

Rule 10-5.011(1)(o)9.e., imposes a similar additional requirement in applications from providers seeking more beds:

> A summary description of any treatment outcome evaluation of the hospital inpatient general psychiatric services provided at the facility for which additional beds are requested, for children, adolescents or adults as applicable to the facility for the

12-month period ending six months prior to the beginning date of the quarter of the publication of the fixed bed need pool.

41. The purpose of these requirements, according to HRS, is to insure that hospitals will know whether its patients are better off when they leave than when they were admitted to the program. Most hospitals have such knowledge.

42. The terms, "outcome determination", "summary evaluation outcome results", "summary description of treatment outcome evaluation" and "overall program evaluation of treatment outcomes", are nowhere defined in the proposed rules, and the department intends to leave to each applicant or provider the methodology for determining whether its patients are "better off" for having been in its program.

43. Hospitals do not routinely evaluate their patients after discharge and such follow up would be difficult and costly. Most hospitals do, however, establish a treatment plan upon admission, continue to review and revise that plan as needed throughout treatment, and determine the patients' readiness for discharge based on the goals successfully attained. This is the process described by Florida Hospital's Center of Psychiatry Administrative Director.

44. The rules require no more than a description similar to that provided by Florida Hospital. The rules set no standards and do not dictate that follow-up of discharged patients be accomplished, even though post discharge evaluation may be of value and is generally accepted as the best tool for measuring treatment effectiveness.

45. The measurement of treatment outcome is an inexact process and relies on a series of subjective standards which need to be described. HRS does not intend to set those standards and, other than have its applicants demonstrate that a process is in place, the agency has no idea how the required information will impact its CON review. Without definitions and standards, the agency will have no way of comparing one applicant's information with another's.

46. Without specificity and more guidance the rules fail to apprise the applicant of what is required and will provide no meaningful information to the agency in its CON review function.

Miscellaneous Provisions

A. The Non-Physician Director.

47. The proposed definition of "Hospital Inpatient General Psychiatric Services" in Rule 10-5.011(1) (o)2.1. includes

services provided under the direction of a psychiatrist or clinical psychologist

48. In drafting this definition, agency staff relied on advice from experts at their workshops and on advice from the agency's own Alcohol, Drug Abuse and Mental Health Program Office, to the effect that professionals, other than physicians, are qualified to direct the units.

B. Interpretation and Application.

49. It is not the intention of HRS that its rules be interpreted to override good medical practice or the sound judgement of treating physicians.

Thus, the rules would not prohibit stabilization of a patient who is presented to the emergency room of a hospital without a CON for substance abuse or psychiatric services. Stabilized Alzheimers patients may be housed in nursing homes. Nor do the rules prohibit or subject to sanctions the occasional admission of a psychiatric or substance abuse patient to a non-substance abuse or psychiatric bed so long as this occurs infrequently in a hospital without psychiatric or substance abuse programs. "Scatter" beds are not eliminated. Those beds would continue to be licensed as acute-care beds, as they would not be considered part of an organized program, with staff and protocols, to provide psychiatric or substance abuse services.

50. Proposed rule 10-5.011(1)(o)4.h.(v) provides that applicants for IRTPs for children and adolescents seeking licensing as a specialty hospital must provide documentation that the district's licensed non-hospital IRTPs do not meet the need for the proposed service.

The department is not seeking specific utilization data in this regard, as such is not available. General information on the availability of alternatives to inpatient hospital services is obtainable from local health councils and mental health professionals in the community.

C. Quarterly Reports.

51. Proposed rule 10-5.011(1)(o)10. requires:

> Facilities providing licensed hospital inpatient general psychiatric services shall report to the department or its designee, within 45 days after the end of each calendar quarter, the number of hospital inpatient general psychiatric services admissions and patient days by age and primary diagnosis ICD-9 code.

52. The Health Care Cost Containment Board (HCCCB) is already collecting similar quarterly data from providers. The reporting system is being updated and improved but in the meantime HRS is experiencing problems with the type and accuracy of the data it receives from HCCCB.

One problem is that HCCCB collects its data with regard to all discharges in a psychiatric or substance abuse diagnostic category, whereas HRS is interested only in data from a psychiatric or substance abuse program. Until the system improves, HRS needs the information it seeks from the providers in order to plan and apply the need methodology.

53. The agency intends to designate local health councils to collect the data and has already worked with them to set up a system. If reports provided to the HCCCB comply with the proposed requirement, HRS has no problem in receiving a duplicate of those reports.

The Economic Impact Statement

54. Pursuant to Section 120.54(2), F.S., HRS prepared an economic impact statement for the proposed rule.

It was authored by Elfie Stamm, a Health Services and Facilities Consultant Supervisor with HRS. Ms. Stamm has a Masters degree in psychology and has completed course work for a Ph.D. in psychology. She has been employed by HRS for 13 years, including the last ten years in the Office of Comprehensive Health Planning. She is responsible for developing CON rules, portions of the state health plan, and special health care studies.

55. It was impossible for Ms. Stamm to determine how the rule could impact the public at large. The economic impact statement addresses generally the effect of abolishing the distinction between long and short term services and acknowledges that the rule will increase competition among short term service providers. The impact statement also addresses a positive impact on current long term providers.

CONCLUSIONS OF LAW

56. The Division of Administrative Hearings has jurisdiction over the parties and subject matter in these consolidated proceedings pursuant to Section 120.54(4), F.S.

57.

> Any substantially affected person may seek an administrative determination of the invalidity of any proposed rule on the grounds that the proposed rule is an invalid exercise of delegated legislative authority.
>
> Subsection 120.54(4) (a), F.S.

As providers of the services regulated by the proposed rules, the hospital petitioners are "substantially affected." As an association of providers, Florida League of Hospitals, Inc., is similarly "substantially affected." Florida Home Builders Assn. et al V. Department of Labor and Employment Security, 412 So.2d 351 (Fla. 1982) The parties have stipulated to standing for all petitioners and intervenors.

58. "Invalid exercise of delegated legislative authority" is defined in Section 120.52(8)F.S. as:

> action which goes beyond the powers, functions- and duties delegated by the Legislature. A proposed or existing rule is an invalid exercise of delegated legislative authority if any one or more of the following apply;
> (a) The agency has materially failed to follow the applicable rulemaking procedures set forth in S. 120.54;
> (b) The agency has exceeded its grant of rulemaking authority, citation to which is required by S. 120.54(7);

> (c) The rule enlarges, modifies, or contravenes the specific provisions of law implemented, citation to which is required by S. 120.54(7);
> (d) The rule is vague, fails to establish adequate standards for agency decisions, or vests unbridled discretion in the agency; or
> (e) The rule is arbitrary or capricious.

59. Those who seek to invalidate the proposed rules have the burden of showing that:

> the agency, if it adopts the rule, would exceed its authority; that the requirements of the rule are not appropriate to the ends specified in the legislative act; that the requirements contained in the rule are not reasonably related to the purpose of the enabling legislation or that the proposed rule or the requirements thereof are arbitrary and capricious.
> Agrico Chemical Co. V. State Dept. of Environmental Regulation, 365 So.2d 760, 763 (Fla. 1st DCA 1979)

60. An agency has wide discretion in its rulemaking authority. Austin v. Department of Health and Rehabilitative Services, 495 So.2d 777 (Fla. 1st DCA 1986). When an agency construes a statute in its charge in a permissible way, that interpretation must be sustained even though another may be possible, or even, in the view of some preferable. HRS v. Framat Realty, Inc., 407 So.2d 238, 241 (Fla. 1st DCA 1981).

61. With few exceptions, the challengers have failed to sustain their burden of proof.

Deregulating length of stay and Regulating Services by Age

62. Section 381.704(3), F.S. requires the department to establish by rule, uniform need methodologies for health services and health facilities. Health services is defined in Section 381.702(9) F.S. to include ". . . alcohol treatment, drug abuse treatment, and mental health services."

Section 38l.706(1)(l), F.S. requires CON review for "[a] change in the number of psychiatric or rehabilitation beds."

Nothing in the enabling legislation requires that there be any subdivision of substance abuse or psychiatric beds, and in retrospect the creation of separate categories may have been injudicious. The facts exposed in this proceeding amply establish the rationale for abolishing the distinction now.

63. In contrast, there is a rational basis to separately regulate adult and children/adolescent programs to serve both clinical and health planning objectives. The challengers failed to demonstrate that the inventory process described in the rule is arbitrary or capricious or otherwise invalid. It is necessarily based on the providers' actual use of beds as of the effective date of the rule.

Incorporation by Reference

64. Within the definition of the phrase, "Hospital Inpatient General Psychiatric Services," in proposed rule 10- 5.011(1)(o)2.1. is the reference to the Diagnostic and Statistical Manual of Mental Disorders and the parenthetical, "(DSM-III-R, or its subsequent revisions)". This appears to be an oversight, as the "subsequent-revisions" reference has been deleted from other sections of the rules. As it remains here, it is invalid.

Incorporation by reference of future revisions is plainly prohibited by Section 120.54(8), F.S. and Department of State rule 15-1.005, F.A.C.

Advertising

65. Proposed rule 10-5.011(1)(o)3.d. addresses the hospital's advertising activity as a "general provision" among criteria against which the CON applications will be evaluated.

The rule on its face and the evidence at hearing demonstrate that there is no connection between the advertising limits and the certificate of need program. The agency has received some unspecified complaints from providers about other providers' advertising and is trying to respond to those complaints. Agency staff has no idea how the prohibition will be applied in the CON program.

66. The rulemaking authorities cited by the agency in its notice of the proposed amendments relate generally to rules implementing the agency's CON responsibilities. None of these authorities directly or by implication authorize the regulation of advertising, nor does advertising activity fit within any of the statutory CON review criteria in Section 381.705, F.S.

67. Proposed rule 10-5.011(1)(o)3.d. is invalid as it exceeds the agency's authority and is not reasonably related to the purpose of the enabling legislation. Agrico, Supra. This conclusion obviates the necessity of addressing the parties' various constitutional challenges to this rule.

Outcome Determination

68. Rule 10-5.011(1) (o)3.i, 8.j, and 9.e, requiring treatment outcome evaluations, are vague and fail to establish adequate standards for agency decisions. Beyond a notion that hospitals should be determining whether their patients are better off as a result of their treatment, the agency is unable to articulate what implementation will be required of the providers or how the new requirement will be applied in its CON review. Providers can only guess what must be done and risk arbitrary enforcement. These rules are an invalid exercise of delegated legislative authority.

Preference and Miscellaneous Provisions

69. The need methodology preferences and the reporting requirements, as well as the provision regarding who may direct the program are supported by facts and logic and are reasonable related to several purposes of the act, such as access to services, quality of care, and planning for future needs.

The challengers have failed to prove that these remaining provisions are invalid.

Economic Impact Statement

70. The failure to provide an adequate statement of economic impact is a ground for holding a rule invalid. Subsection 120.54(3)(d), F.S.

What constitutes an "adequate" statement has been liberally construed by the courts:

> A rule will not be declared invalid merely because the economic impact statement may not be as complete as possible; any deficiency in the statement must be so grave as to have impaired the fairness of the proceedings. Health Care and Retirement Corporation of America v. Department of Health and Rehabilitative Services, 463 So.2d 1175, 1178 (Fla. 1st DCA 1985)

71. While hardly a "model of economic forecasting", the agency's impact statement addresses the considerations mandated in subsection 120.54(2)(b), F.S. The agency acknowledges an impact on existing providers without computing a specific numeric impact. Such specificity is neither required nor possible. Department of Natural Resources v. Sailfish Club, 473 So.2d 261 (Fla. 1st DCA 1985).

The challengers have failed to prove that any deficiencies in the economic impact statement impaired the fairness of the proceeding.

ORDER

Based on the foregoing, it is hereby

ORDERED:

Proposed amendments to Rule 10-5.011(1)(o), and (p) FAC are not an invalid exercise of delegated legislative authority, with the following exceptions, which are found to be invalid:

a. 10-5.011(1)(o)2.1., to the extent that it incorporates "subsequent revisions" to DSM-III-R.

b. 10-s.5.011(1)(o)3.d.; and

c. 10-5.011(1)(o)3.i. as to the requirement for evaluation of treatment outcomes, 8.j., and 9.e.

DONE and ORDERED this 28th day of September, 1990, in Tallahassee, Florida.

MARY CLARK
Hearing Officer
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-1550
(904) 488-9675

Filed with the Clerk of the
Division of Administrative Hearings
this 28th day of September, 1990.

APPENDIX TO FINAL ORDER

The following constitute rulings on the findings of fact proposed by the parties. Unless otherwise designated, the paragraph reference is to the order related to Rule 10-5.011(1)(q), Hospital Inpatient Substance Abuse Services. Paragraph references to the psychiatric rule order are designated *. Proposed Final Order 10-5.011(1)(q)i. by NME, etc/PIA, etc. [Paragraphs 1, and 3-11 are included in the Preliminary Statement.] 2. Adopted in paragraph 10. 12. Adopted in paragraph 11. 13.-l7. Adopted in substance in paragraphs 11-19. 18.-19. Adopted in paragraph 26. 20. Adopted in part in paragraph 27, otherwise rejected as unsubstantiated by the evidence. 21. Rejected as unsubstantiated by the record. 22. Rejected as unnecessary. 23. Adopted in paragraph 28. 24.-25. Rejected as unnecessary or unsupported by the evidence.

The amendments in Hearing Officer Exhibit #3 appear to permit advertising of services which the facility is allowed to provide. 26.-29. Rejected as unnecessary. 30.-37. Adopted in part in paragraphs 33.-39.; otherwise rejected as contrary to the weight of evidence. 38.-40. Adopted in substance in paragraphs 40.-46. 41.-43. Adopted in part in paragraphs 5l.-53., otherwise rejected as unnecessary. 44.-45. Adopted in part in paragraph 50, otherwise rejected as contrary to the weight of evidence. 46.-48. Adopted in part in paragraphs 23.-25., otherwise rejected as contrary to the weight of evidence. 49.-50. Adopted in paragraphs 54. and 55.

Proposed Final Order 10-5.011(1)(o) & (p)1 by NME, etc./PIA, etc.

[paragraphs 1, and 3-10 are adopted in the Preliminary Statement] 2. Adopted in *paragraph 10. 11. Adopted in *paragraphs 11 and 13. 12.-17. Adopted in substance in *paragraphs 12-19. l8.-23. Adopted in *paragraphs 26 and 27, otherwise rejected as unnecessary. 24.-26. Adopted in *paragraphs 28-32. 27.-30. Rejected as unnecessary. 31.-38. Adopted in part in *paragraphs 33-39; otherwise rejected as contrary to the weight of evidence. 39.-41. Adopted in substance in *paragraphs 40-46. 42.-44. Adopted in part in *paragraphs 51-53; otherwise rejected as unsupported by the evidence. 45.-46. Adopted in part in paragraph 50; otherwise rejected as contrary to the weight of evidence. 47.-49. Adopted in part in *paragraphs 23-25; otherwise rejected as contrary to the weight of evidence. 50.-5I. Adopted in *paragraphs 54 & 55.

Proposed Final Order by Florida League of Hospitals.

1. Adopted in paragraph 1. 2.-3. Adopted in Preliminary Statement. 4.-5. Adopted in paragraph 10. 6.-32. Adopted in substance in paragraphs 28-32. 33.-60. Adopted in substance in paragraphs 40-46. 6l.-105. Adopted in part, otherwise rejected as unnecessary or immaterial. The "preferences" in the rule are a clear example of agency discretion. While there may be other and better ways of accomplishing the goals, the method selected by the agency is not arbitrary or an excess of authority or otherwise invalid.

Proposed Final Order by Adventist Health System, Inc.

1.-2. Included in summary in paragraph 9.
3.-17. Adopted in part in paragraphs 11-19 and *paragraphs 11-19, as to a summary discussion of the clinical distinctions and background of the rules; otherwise rejected as unnecessary or contrary to the weight of evidence.
18.-24. Rejected as immaterial or contrary to the weight of evidence.
25.-26. Rejected as contrary to the weight of evidence.
27.-28. Rejected as unsubstantiated by competent evidence.
29.-31. Rejected as contrary to the weight of evidence.
32. and 37. Adopted in part (as to the preference) in paragraphs 33-35 and *paragraphs 33-35; otherwise rejected (as to the conclusion that the criteria are "irrational".)
33.-35. Rejected as unnecessary (these provisions have been removed-see parties' 2nd agreement).
36. Partially adopted in paragraphs 51-53, otherwise rejected as immaterial.
38.-39. Adopted in paragraphs 28-32.
40.-41. Adopted in part in paragraphs 20-22, otherwise rejected as immaterial.
42.-44. Adopted in substance in paragraphs 40-46.
45. Rejected as contrary to the weight of evidence (as to the conclusion that the proposal is arbitrary and violates health planning principles.)

Proposed Final Order of Horizon Hospital.

1. Adopted in summary in paragraphs 9 and 10.
2. Rejected as an improper conclusion.
3.-22. Adopted in part in paragraphs 11-19 and *paragraphs 11-19 (as to distinction between the two programs and some impact on existing providers), otherwise rejected as immaterial or unsubstantiated by competent evidence (as to the ultimate increase in health care costs, and the conclusion that the proposal is illogical or otherwise invalid.)

Proposed Final Order by Baptist Hospital.

1. Rejected as an improper conclusion.
2.-4. Rejected as immaterial.
5.-9. Adopted in general in *paragraphs 11-19.
10.-12. Rejected as immaterial.
13.-15. Adopted in general in *paragraphs 11-19.
16.-21. Rejected as unnecessary.
23.-25. Adopted in general in *paragraphs 40-46.

Proposed Final Order by Humana.

1.-4. Adopted in summary in paragraphs 1-7, otherwise rejected as unnecessary or immaterial.
5. Rejected as an improper conclusion.
6.-36. Adopted in part in *paragraphs 11-19 and 11-19, rejected for the most part as immaterial or improper conclusions.
37.-41. Rejected as unsupported by the evidence or improper conclusions, except for the summary of the rule provisions, which is addressed in paragraphs 20-25.
42.-44. Adopted in paragraphs 28-32, except that the changes seem to allow advertising of services which may legally be provided.
45.-47. Rejected as unnecessary.
48.-50. Adopted in paragraphs 40-46.
51.-53. Rejected as contrary to the evidence and improper conclusions.
54. Rejected as an improper conclusion.

Proposed Final Order by JFK Medical Center and Sarasota Co. Public Hospital.

1. Rejected as unnecessary.
2. Adopted in paragraph 23.
3.-17. Rejected as unnecessary.
18.-19. Adopted in Preliminary Statement.
20.-30. Rejected as unnecessary or immaterial.

Proposed Final Order by So. Broward Hospital District.

1.-2. Adopted in Preliminary Statement and paragraph 1.
3. Adopted in part in Preliminary Statement, otherwise rejected as immaterial.
4.-5. Rejected as immaterial.
6. Adopted in *paragraph 17.
7.-17. Rejected as unnecessary or immaterial.
18.-19. Adopted in *paragraph 19.
20.-25. Rejected as unsupported by competent evidence or an improper conclusion.
26.-29. Rejected as unnecessary or unsupported by competent evidence.

Proposed Final Order by Morton Plant Hospital.

1. Adopted in preliminary statement and in *paragraph 15.
2. Rejected as unnecessary.
3. Rejected as contrary to the evidence.
4. Rejected as an improper conclusion. 5.-6. Rejected as unnecessary.
7. Adopted in *paragraph 4.
8. Adopted in substance in *paragraph 17.
9. Adopted in *paragraph 14.
10. and 11. Rejected as unsupported by the weight of evidence.

Proposed Final Order by Charter Medical.

1.-5. Addressed in Preliminary Statement, except that standing is addressed in paragraph 10.
6.-63. Adopted, in substantially abbreviated form in paragraphs 40-46, and *paragraphs 40-46.
64.-1l6. Adopted, in substantially abbreviated form in paragraphs 11-19 and *paragraphs 11-19.

Proposed Final Order by University Pavilion.

1.-3. Adopted in Preliminary Statement and conclusions of law.
4. Rejected as unnecessary.
5. Adopted in *paragraph 18.
6. Adopted in *paragraph 19.
7. Adopted in Preliminary Statement.
8. Adopted in paragraph 5.
9.-11. Rejected as unnecessary.
12.-14. Adopted in *paragraph 14.
15. Adopted in *paragraph 17.
16. Rejected as unnecessary.
17. Adopted in *paragraph 14.
18.-19. Addressed in *paragraph 17.
20.-21. Adopted in *paragraph 14.
22. Adopted in paint in *paragraph 16.
23. Rejected as unnecessary.
24. Adopted in *paragraph 12.
25.-26. Rejected as unnecessary.
27. Adopted in *paragraph 15.
28.-30. Rejected as unnecessary.
31. Adopted in *paragraph 19.
32.-38. Rejected as cumulative and unnecessary.
39. Adopted in conclusions of law.
40.-41. Addressed in paragraphs 1-6.

Final Order Proposed by Glenbeigh/Indian River Memorial.

1.-146. Adopted in substance, in substantially abbreviated form in paragraphs 11-19 and *paragraphs 11-19, otherwise rejected as immaterial, cumulative or argumentative.

Final Order Proposed by HMA.

1.-3. Adopted in paragraphs 1-7.
4. Adopted in *paragraph 12.
5. Adopted in *paragraph 18.
6.-8. Rejected as unnecessary.
9. Adopted in *paragraph 14.
10. Adopted in *paragraph 17.
11. Addressed in *paragraph 17.
12. Adopted in *paragraph 15.
13.-14. Addressed in *paragraph 17.
15. Rejected as unnecessary.
16. Adopted in *paragraph 16.
17.-26. Rejected as unnecessary.
27. Adopted in *paragraph 18.
28.-54. Rejected a- cumulative or unnecessary.

Proposed Final Order by HRS.

1.-13. Adopted in summary in paragraph 1-7.
14. Rejected as unnecessary.
15.-16. Adopted in Preliminary Statement.
17.-19. Rejected as unnecessary.
20.-23. Adopted in paragraphs 26-27.

24. Rejected as unnecessary.
25. Adopted in paragraph 48.
26.-29. Adopted in substance in paragraph 49.
30. Rejected as unnecessary.
3l.-32. Adopted in substance in paragraph 49.
33. Adopted in paragraph 22.
34. Adopted in paragraph 30.
35.-38. Rejected as immaterial.
39.-44. Adopted in substance in paragraphs 33-39.
45.-46. Adopted in paragraph 50. 47. Adopted in paragraph 38.
48.-57. Rejected as unnecessary.
58.-67. Addressed in paragraphs 40-46. However, adoption of the findings does not result in a conclusion that the requirements are valid. 68. Rejected as unnecessary.
69.-71. Adopted in paragraphs 51-53.
72.-78. Adopted in paragraphs 23-25.
79.-123. Adopted in substance in paragraphs 11-19 and *paragraphs 11-19, although in substantially abbreviated form.
124.-127. Adopted in substance in paragraphs 3, 4 and 19.
128. Adopted in paragraphs 54 and 55.

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NOTICE OF RIGHT TO JUDICIAL REVIEW

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 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 APPEAL MUST BE FILED WITHIN 30 DAYS OF RENDITION OF THE ORDER TO BE REVIEWED.

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DISTRICT COURT OPINION
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IN THE DISTRICT COURT OF APPEAL
FIRST DISTRICT, STATE OF FLORIDA

SARASOTA COUNTY PUBLIC HOSPITAL BOARD, d/b/a MEMORIAL HOSPITAL, SARASOTA, and PSYCHIATRIC HOSPITALS of AMERICA, INC., d/b/a HORIZON HOSPITAL,

Appellants,

NOT FINAL UNTIL TIME EXPIRES TO FILE MOTION FOR REHEARING AND DISPOSITION THEREOF IF FILED,

CASE NO. 90-3140/3195
DOAH CASE NO. 90-1036RP

v.

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES, PIA PSYCHIATRIC HOSPITALS, INC., and PIA SARASOTA PALMS, INC., d/b/a SARASOTA PALMS HOSPITAL, UNIVERSITY PAVILION, GLENBEIGH, INC., INDIAN RIVER MEMORIAL HOSPITAL, CHARTER MEDICAL-OCALA, INC., HEALTH MANAGEMENT ASSOCIATES, INC.,

Appellees.
_____/

Opinion filed September 24, 1991.

An appeal from the Division of Administrative Hearings, Mary Clark, Hearing Officer., Judge.

For appellants:

Eric B. Tilton, Tallahassee for Florida Medical Center, Ltd.

Robert A. Weiss and John M. Knight, Tallahassee for Memorial Hospital.

Gerald B. Sternstein, Charles A. Stampelos and Darrell White of McFarlane, Bobo, Sterstein, Cassedy and Wiley, P.A., Tallahassee for Horizon Hospital.

For appellees:

No appearance for the Department of Health and Rehabilitative Services.

C. Gary Williams, Michael J. Glazer and R. Stan Peeler of Ausley, McMullen, McGehee, Carothers & Proctor, Tallahassee for Sarasota Palms Hospital.

Donna H. Stinson, Moyle, Flanigan, Katz, Fitzgerald & Sheehan, Tallahassee for University Pavilion.

Kenneth F. Hoffman and W. David Watkins of Oertel, Hoffman, Fernandez & Cole, P.A., Tallahassee for Glenbeich, Inc. and Indian River Memorial Hospital.

Michael J. Cherniga of Roberts, Bagett, LaFace & Richard, Tallahassee for Charter Medical-Ocala, Inc.

Robert S. Cohen of Haben, Culpepper, Dunar & French, P.A., Tallahassee for Health Management Associates.

PER CURIAM.

AFFIRMED.

BOOTH, MINER and ALLEN, JJ., CONCUR.

MANDATE
From
DISTRICT COURT OF APPEAL OF FLORIDA
FIRST DISTRICT

To the Honorable Mary Clark, Hearing Officer

WHEREAS, in that certain cause filed in this Court styled:

FLORIDA LEAGUE OF HOSPITALS, INC., et al
and
HORIZON HOSPITAL, and CHARTER MEDICAL CENTER

v. Case No. 90-3140

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
and
HEALTH MANAGEMENT ASSOCIATES, INC., UNIVERSITY PAVILLION HOSTIPAL, and GLENBEIGH, INC.

Your Case Nos. 90-1036RP, 90-1037RP, 90-1038RP, 901045RP, 90-1046RP, 90-1047RP, 90-1048RP, 90-1049RP, 90-1050RP, 90-1051RP, 90-1052RP, 90-1053RP, 90-1054RP, 90-1055RP, 90-1056RP, 90-1057RP, 90-1058RP, 90-1059RP, 90-1060RP, 90-1061RP

The attached opinion was rendered on September 24, 1991.

YOU ARE HEREBY COMMANDED that further proceedings be had in accordance with said opinion, the rules of this Court and the laws of the State of Florida.

WITNESS the Honorable James D. Joanos

Chief Judge of the District Court of Appeal of Florida, First District and the Seal of said court at Tallahassee, the Capitol, on this 25th day of October, 1991.

_____

Clerk, District Court of Appeal of Florida,
First District