STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

BIG BEND HOSPICE, INC.,	)	
	)	
Petitioner,	)	
	)	
vs.	)	Case No. 01-4415CON
	)	
AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
	)	
Respondent,	)	
	)	
and	)	
	)	
COVENANT HOSPICE, INC.,	)	
	)	
Intervenor.	)	
	)	

RECOMMENDED ORDER

A formal hearing was conducted in this case on June 10-14 and 17-21, 2002, and July 18, 2002, in Tallahassee, Florida, before Suzanne F. Hood, Administrative Law Judge with the Division of Administrative Hearings.

APPEARANCES

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STATEMENT OF THE ISSUE

The issue is whether Respondent properly determined that there is a numeric need for one additional hospice program in health planning Service Area 2B for the January 2003 planning horizon pursuant to a revised fixed need pool projection.

PRELIMINARY STATEMENT

On or about July 27, 2001, Respondent Agency for Health Care Administration (AHCA) published the fixed need pool projections for additional hospice programs for the January 2003 planning horizon. The fixed need pool projections indicated that there was no numeric need for hospice programs in Service Area (SA) 2B.

On or about August 17, 2001, AHCA published revised fixed need pool projections for the same batch cycle in the Florida Administrative Weekly, Volume 27, Number 33. The revised fixed need pool projections indicated that there was a numeric need for one additional hospice program in SA 2B.

By letter dated August 24, 2001, Petitioner Big Bend Hospice, Inc. (BBH), advised AHCA of what BBH believed was an error in the determination of the need for one additional hospice program in SA 2B. AHCA responded in a letter dated

August 27, 2001, that the revised fixed need pool would not be reversed.

By letter dated August 29, 2001, Intervenor Covenant Hospice, Inc. (Covenant) advised AHCA that Covenant intended to file an application for a Certificate of Need (CON) to establish a hospice program in SA 2B. Covenant filed the letter of intent pursuant to the notice of the revised fixed need pool as published in the Florida Administrative Weekly, Volume 27, Number 33, on August 17, 2001.

Covenant filed its application with AHCA on September 6, 2001. The application was assigned CON Action No. 9475 (CON 9475).

BBH filed a Petition for Formal Administrative Proceeding with AHCA on September 6, 2001. The Petition challenged the validity of the revised fixed need pool for one additional hospice program in SA 2B.

On or about November 14, 2001, AHCA referred BBH's challenge to the revised fixed need pool to the Division of Administrative Hearings (DOAH). The matter was assigned DOAH Case No. 01-4415CON.

On December 3, 2001, BBH filed a Response to Initial Order in DOAH Case No. 01-4415CON. The response included an unopposed request to place the case in abeyance. An Order Placing Case In Abeyance was entered that same day.

On December 20, 2001, BBH filed an unopposed Motion for Continued Abeyance. The undersigned granted the motion in an Order dated December 24, 2001.

On or about December 28, 2001, Covenant filed a Petition to Intervene in DOAH 01-4415CON. The undersigned granted Covenant's Petition to Intervene on January 10, 2002.

On or about December 28, 2001, AHCA announced its preliminary agency action approving Covenant's application for CON 9475. AHCA published notice of its decision in the Florida Administrative Weekly, Volume 27, Number 52, December 28, 2001.

On January 17, 2002, BBH filed a Petition for Formal Administrative Proceeding with AHCA. The petition contested AHCA's preliminary approval of CON 9475.

On January 24, 2002, the parties filed a Joint Motion for Continued Abeyance in DOAH Case No. 01-4415CON. The motion was granted on January 25, 2002.

On February 5, 2002, AHCA referred BBH's challenge to the preliminary approval of CON 9475 to DOAH. The case was assigned DOAH Case No. 02-0455CON.

On February 6, 2002, Covenant filed a Petition for Administrative Hearing with AHCA. Covenant filed the petition in support of CON 9475.

On February 11, 2002, the undersigned issued an Order of Consolidation. The Order consolidated DOAH Case Nos. 01-4415CON and 02-0455CON.

On February 18, 2002, the parties in DOAH Case Nos. 01-4415CON and 02-0455CON filed a Joint Response to Initial Order. After a telephone conference on February 19, 2002, the undersigned issued a Notice of Hearing dated February 20, 2002. The notice scheduled DOAH Case Nos. 01-4415CON and 02-0455CON for hearing on June 10-14 and 17-21, 2002.

On March 2, 2002, AHCA referred Covenant's Petition for Administrative Hearing to DOAH. The Petition was assigned DOAH Case No. 02-0880CON.

On March 12, 2002, the parties in DOAH Case No. 02-0880CON filed a Joint Response to Initial Order. The response included a request to consolidate DOAH Case Nos. 01-4415CON, 02-0455CON and 02-0880CON.

On March 19, 2002, the undersigned issued a Second Order of Consolidation. The order consolidated DOAH Case Nos. 01-4415CON, 02-0455CON, and 02-0880CON for hearing purposes. An Amended Notice of Hearing scheduled the cases for hearing on June 10-14 and 17-21, 2002.

On April 2, 2002, BBH filed a Motion to Bifurcate Final Hearing. Covenant and AHCA filed responses in opposition to the

motion on April 18, 2002. The motion was denied by Order dated April 23, 2002.

On May 21, 2002, BBH filed a Motion for Continuance or, in the Alternative, Motion in Limine. Covenant and AHCA filed responses in opposition to the motions. By Order dated June 3, 2002, the undersigned denied both motions with leave for BBH to address the issues raised in its Motion in Limine in its proposed recommended order.

On June 7, 2002, BBH filed a Motion in Limine and Request for Oral Argument. During the hearing, the undersigned reserved ruling on the motion.

During the hearing, Covenant presented testimony from the following witnesses: (a) Dale O. Knee, expert in hospice and healthcare administration; (b) Paula Montgomery, M.D., expert in medical care and hospice medical direction; (c) Autumn Caughey, expert in healthcare quality improvement; (d) Pam Edwards, expert in hospice nursing; (e) Delia Leslie, expert in hospice program development; (f) Anthony Martinez, expert in hospice volunteer program development; (g) Chetta McCart, expert in hospice AIDS program development; (h) Wayne Ralph, expert in hospice chaplaincy; (i) Janet Wilkie, expert in hospice social work and special programs; (j) Charles Lee, expert in hospice education, outreach programs, and program development; (k) Mary Cummins, expert in hospice nursing and education; (l) Julie

Patton, expert in hospice staff training, curriculum development, and education; (m) Eric Rost, M.D., expert in radiation oncology; (n) Amy Bajjaly, expert in human resource management; (o) Carolyn Burbank, expert in hospice community education; (p) Jay Daniel Cushman, expert in health planning; (q) Christopher Comeaux, expert in hospice financial management; and (r) Darryl Weiner, expert in healthcare finance and financial feasibility analysis. With the exception of Covenant's Exhibit Nos. C13 and C22, which were withdrawn, Covenant offered Exhibit Nos. C1 through C121 that were admitted into evidence.

AHCA presented the testimony of the following witnesses: (a) Jeffrey N. Gregg, expert in healthcare planning and healthcare regulation; and (b) Laura MacLafferty, expert in health planning. AHCA did not offer any exhibits for admission into evidence.

BBH presented the testimony of the following witnesses: (a) Elaine Bartelt, expert in hospice administration; (b) Jessie V. Furlow, M.D., expert in general medicine and general surgery; (c) James Everett, M.D., expert in family practice medicine; (d) James Mabry, M.D., expert in internal medicine, medical oncology, hematology, hospice medicine, and administration of hospice medical programs; (e) Carol Vanderford, R.N., expert in nursing and hospice nursing

administration; (f) Diane Tomasi, expert in community relation and development; (g) Lisa Kalaf, expert in hospice administration; (h) James McKnight, expert in healthcare administration; (i) Lynne Mulder, expert in healthcare planning; and (j) Robert Beiseigel, expert in healthcare finance.

BBH offered Exhibit Nos. BB1 through BB102 that were received into evidence. BBH's exhibits included the following deposition transcripts: (a) Dr. Julie Schindler; (b) Dr. John Mackay; (c) Eugene Gesner; (d) Regina Compton; (e) Dr. Nancy Chorba; (f) Joseph Brown; (g) Charles McClellan; (h) Dr. Dale Wickstrum; (i) Dr. Diane Haisten; (j) Marlane Williams; (k) Claire Benjamin; and (l) John Davis.

At the conclusion of the hearing, the parties were directed to file separate proposed recommended orders for DOAH Case No. 01-4415CON involving the revised fixed need pool projection and DOAH Case Nos. 02-0455CON and O2-0880CON involving the preliminary approval of Covenant's CON application. Pursuant to the agreement of the parties, the proposed recommended orders were due to be filed on or before September 30, 2002.

The complete Transcript of the hearing was filed on the following dates: (a) Volumes I-VI and IX on July 16, 2002; (b) Volumes VII-VIII and XI-XX on September 4, 2002; and (c) Volumes XXI-XXII on September 6, 2002. The hearing Transcript does not contain a Volume X.

BBH filed Proposed Recommended Orders in DOAH Case No. 01-4415CON and DOAH Case Nos. 02-0455CON and 02-0880CON on September 30, 2002. BBH also filed a Memorandum of Law in Support of Proposed Recommended Order on September 30, 2002.

Covenant and AHCA filed a joint Proposed Recommended Order in DOAH Case Nos. 02-0455CON and 02-0880CON on September 30, 2002. Covenant and AHCA timely served a joint Proposed Recommended Order in DOAH Case No. 01-4415CON on BBH. However, due to an oversight, Covenant and AHCA failed to file the latter proposed order with the Division of Administrative Hearings until October 8, 2002. For the reasons set forth in Covenant's letter dated October 11, 2002, Covenant's and AHCA's joint Proposed Recommended Order in DOAH Case No. 01-4415CON is hereby deemed timely filed.

On October 10, 2002, BBH filed a Motion to Supplement the Record and for Official Recognition. The motion seeks official recognition of AHCA's Notice of Hospice Program Fixed Need Pool as published in the Florida Administrative Weekly, Volume 28, Number 41, October 11, 2002. The notice indicates that the fixed need pool projection for hospice programs planned for January 2004 in SA 2B is zero. On October 22, 2002, Covenant filed a response in opposition to the motion, which is hereby denied.

The record in its entirety is inextricably shared between DOAH Case No. 01-4415CON and DOAH Case Nos. 02-0455CON and 02-0880CON. Therefore, except for the respective Proposed Recommended Orders, all orders, pleadings, volumes of Transcript, and exhibits are located in DOAH Case No. 01-4415CON.

DOAH Case No. 01-4415CON, relating to AHCA's fixed need pool determination, and DOAH Case Nos. 02-0455CON and 02-0880CON, related to Covenant's CON application, are hereby deconsolidated for purposes of issuance of separate recommended orders in the respective cases. Rulings on BBH's pending motions in limine and other issues raised in BBH's memorandum of law are denied for reasons set forth in the Conclusions of Law section of the Recommended Order in DOAH Case Nos. 02-0455CON and 02-0880CON.

FINDINGS OF FACT

The Parties

1. AHCA is the state agency that is responsible for administering the CON program and laws in Florida. In conjunction with these duties, AHCA determines, on a semi-annual basis, the net numeric need for new hospice programs pursuant to Rule 59C-1.0355(4), Florida Administrative Code (the Rule). AHCA then publishes such need in the Florida Administrative Weekly.

2. Community volunteers began organizing BBH in 1981. After its incorporation in 1983 as a not-for-profit community organization, BBH commenced operation under a license that authorized it to provide hospice services only in SA 2B, consisting of the following eight counties: Franklin, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor, and Wakulla. On average, BBH serves 162 patients per day. Its main office is located in Tallahassee, Florida, but it operates the following branch offices and/or community centers: Franklin County at Carrabelle, Florida; Gadsden County at Quincy, Florida; Jefferson County at Monticello, Florida; Madison County at Madison, Florida; and Taylor County at Perry, Florida. BBH also operates a twelve-bed inpatient facility, The Hospice House, located in Tallahassee, Florida.

3. Covenant, formerly known as Hospice of Northwest Florida, is a not-for-profit community organization that was founded by a committee in 1982. Covenant began treating its first patients in 1984 and is currently licensed to provide hospice services in SA 1 and SA 2A. The following counties are located in SA 1: Escambia, Santa Rosa, Okaloosa, and Walton. The following counties are located in SA 2A: Holmes, Washington, Jackson, Calhoun, Bay and Gulf. Covenant also is licensed to provide hospice services in 26 southern Alabama counties. On average, Covenant serves 429 Florida hospice

patients per day. Its main office and its eight-bed inpatient facility are located in Pensacola, Florida. Covenant operates the following Florida branch offices: Okaloosa County at Niceville, Florida; Jackson County at Marianna, Florida, and Bay County at Panama City, Florida. Covenant operates Florida community centers in Okaloosa County at Crestview, Florida, and in Walton County at Destin, Florida.

The Hospice CON Rule and Need Methodology

4. The Rule establishes criteria and standards for assessing the need for new hospice programs. The Rule includes a numeric need formula for determining whether a new hospice is needed in a particular SA. In this case, AHCA used the following data sources to produce need projections: (a) population projections from the Executive Office of the Governor; (b) mortality data as reported in the applicable Florida Vital Statistics Annual Report from the Department of Health's Office of Vital Statistics; and (c) utilization data based on the number of hospice patients served by all licensed hospice programs in the SA as reported by licensed hospice programs.

5. Under the Rule, numeric need is demonstrated if the projected number of unserved patients who would elect a hospice program is 350 or greater. The Rule targets 350 as the minimum

number of patients that should be admitted to a hospice program in a 12-month period.

6. Pursuant to the Rule, AHCA calculates need for additional facilities and services every six months or twice annually. The numeric need formula contained in the Rule is a conditional formula, which works as follows: If HPH minus HP is equal to or greater than 350, then a net numeric need exists.

7. HPH is the projected number of patients who will elect hospice services in a particular SA during the 12-month period beginning in the planning horizon. Specifically, HPH is the sum of (U65C X P1) + (65C X P2) + (U65NC X P3) + (65NC X P4).

8. U65C is the projected number of SA resident cancer deaths under age 65. U65C is calculated by dividing the current annual number of cancer deaths under age 65 by the current annual total of resident deaths, and multiplying the result by the SA's projected annual total of resident deaths at the planning horizon. P1 is the projected proportion of U65C who will be hospice patients. P1 is calculated by dividing the current 12-month statewide total of hospice admissions under age 65 with cancer by the current statewide total of deaths under age 65 from cancer.

9. 65C is the projected number of SA resident cancer deaths age 65 and over. 65C is calculated by dividing the current annual number of cancer deaths age 65 and over by the

current annual total of resident deaths, and multiplying the result by the SA's projected annual total of resident deaths at the planning horizon. P2 is the projected proportion of 65C who will be hospice patients. P2 is calculated by dividing the current 12-month statewide total of hospice admissions age 65 and over with cancer by the current statewide total of deaths age 65 and over from cancer.

10. U65NC is the projected number of SA resident deaths under age 65 from all causes except cancer. U65NC is calculated by dividing the current annual number of deaths under age 65 from all causes except cancer by the current annual total of resident deaths, and multiplying the result by the SA's projected annual total of resident deaths at the planning horizon. P3 is the projected proportion of U65NC who will be hospice patients. P3 is calculated by dividing the current 12-month total of hospice admissions under age 65 with diagnoses other than cancer by the current statewide total of deaths under age 65 from causes other than cancer.

11. 65NC is the projected number of SA resident deaths age 65 and over from all causes except cancer. 65NC is calculated by dividing the current annual number of deaths age 65 and over from all causes except cancer by the current annual total of resident deaths, and multiplying the result by the SA's projected annual total of resident deaths at the planning

horizon. P4 is the projected proportion of 65NC who will be hospice patients. P4 is calculated by dividing the current 12-month statewide total of hospice admissions age 65 and over with diagnoses other than cancer by the current statewide total of deaths age 65 and over from causes other than cancer.

12. In other words, HPH is a projection of the number of persons who will elect hospice care in a particular SA, irrespective of their normal place of residence. It is a compilation of projected hospice usage for four age and diagnostic classes. Thus, the need methodology and need projection is specific to the particular demographics and diagnostic experiences of a SA.

13. HP represents the number of admissions to hospice programs serving a SA during the most recent 12-month period ending on June 30 or December 31. The number is derived from reports on standardized forms submitted to AHCA by licensed hospice programs every six months.

14. The Rule uses a statewide use rate as a normative standard for each age and diagnostic category. The use rate is a ratio of the hospice admissions in a particular age and diagnostic class to deaths in the same age and diagnostic class for the state as a whole. When applied to any particular hospice SA, the use rate projects what the hospice admissions should be in that SA, based upon the performance of the state as

a whole, rather than the actual historical penetration rate in the SA. The need methodology thus provides that the hospice penetration rate in a SA should equal the state average penetration rate.

15. The need methodology does not assume that the level of hospice services being provided in a particular area is sufficient to meet the needs of the area. This is appropriate because hospice is a fast-growing and relatively new service that has been widely available only since the early 1980s. Not only has there been a rapid increase in hospice penetration rates but also there is a wide variation in hospice penetration from SA to SA.

16. The numeric need formula set forth in the Rule provides a reasonable and appropriate methodology to project need for additional hospice services. In this case, AHCA's procedures for collecting and analyzing data and for calculating numeric need were consistent with the Rule.

Publication of the Fixed Need Pools

17. AHCA initially published the "Florida Need Projections for Hospice Programs: Background for Use in Conjunction with the July 2001 Batching Cycle for the January 2003 Hospice Planning Horizon." The initial publication resulted a numeric need in SA 2B of 340. In other words, there was no net numeric need for an additional hospice program in SA 2B.

18. AHCA subsequently published a revision to the fixed need pool after it was notified of some errors in the data used in the numeric need calculation. The errors principally involved AHCA's failure to update the population data from a previous batching cycle.

19. The necessity of a revised publication created an opportunity for hospices to submit revised admissions data, which was then incorporated into the second computations of the need methodology. Several hospices took advantage of this opportunity.

20. Using the revised data, AHCA determined that the projected number of hospice admissions in SA 2B would be 1209 patients (HPH = 1209). AHCA also determined that the number of patients served by SA 2B's licensed provider, BBH, for the relevant period was 858 patients (HP = 858). The difference between these calculations was 351, indicating a need for an additional hospice program in SA 2B. AHCA published the revised fixed need pool determination on August 17, 2001.

Counting Admissions

21. At issue here is the definition and use of the term "admissions" on AHCA's semiannual utilization report form (report form). Item 1 on the report form indicates that hospice providers should show the "[n]umber of patients admitted to your program (unduplicated) for the following categories . . . ."

The reporting block also indicates that the data to be included are "New Patients Admitted."

22. The term "unduplicated" means admissions in the reporting period, exclusive of those from a prior reporting period. In other words, the same admission is not counted and reported twice. For example, a patient initially admitted in one reporting period, subsequently discharged, and readmitted in the following reporting period should be reported as an admission in the prior reporting period and as an admission in the following reporting period. Likewise, a patient who initially is admitted, discharged, and subsequently readmitted in the same reporting period is counted as two admissions. This is true whether the second admission occurs in the same SA or in a different SA and whether the second admission is to the same or a different hospice provider. The second admission relates to the same patient but is counted as a "new patient admitted" each time the patient is admitted as long as the same admission is not counted twice on a report form.

23. The counting of unduplicated admissions is consistent with the language of the Rule, which requires hospice providers to "indicate the number of new patients admitted during the six-month period . . . ." It also is consistent with the language of the Rule that requires the report form to show "[t]he number

of admissions during each of the six months covered by the report by service area of residence."

24. The "service area of residence" is not defined by the Rule. AHCA interprets the term to mean the location of patients when they are admitted regardless of the place that they consider their permanent residence. AHCA's interpretation of the term "service area of residence" is reasonable and appropriate. The fact that admissions are counted for each SA regardless of a patient's normal place of residence, while resident death data is derived from information contained in death certificates showing the deceased person's permanent residence (no matter where the death occurred) does not change this result or improperly skew the hospice use rates.

25. In the course of treatment, a hospice patient may account for two or more admissions to the same or another hospice, in the same or another service area, during a period of time that covers two reporting periods. This could happen for a number of reasons, including but not limited to the following: (a) a patient may temporarily decide that he or she no longer desires hospice services resulting in an admission, a discharge, and second admission to the same or another hospice in the same or another SA; (b) a patient may decide to relocate and receive services in another SA with the same or another hospice resulting in separate admissions in both SAs; and (c) a patient

may elect to transfer from one hospice to another hospice in the same SA resulting in a separate admission for each hospice.

26. All Florida hospices, including BBH, count a patient as having generated two admissions when the patient is admitted, discharged, and readmitted to the same hospice in the same SA. They also count a patient as having generated a second admission when the patient transfers or relocates to their hospice from another hospice in the same or another SA.

27. AHCA's report form requires hospices that serve multiple SAs to separate their admissions by SA to enhance the verisimilitude of the counts. Twelve hospice providers, including Covenant, serve multiple SAs in Florida. Under the Rule, multiple SA providers, like Covenant and unlike BBH, count admissions when a patient transfers from the provider's program in one SA to the same provider's program in another SA.

28. The ability to count an admission in both SAs when a patient transfers from one SA to another SA but continues to receive services from the same hospice, does not result in impermissible "double counting" or give multiple SA providers a competitive edge. To the contrary, it is consistent with AHCA's interpretation of an unduplicated admission. More importantly, AHCA's methodology of counting of such admissions is consistent with the method that Medicare uses to count admissions and with

the way AHCA counts admissions in determining numeric need for nursing homes, hospitals, and open-heart programs.

29. For the reporting period at issue here, Covenant reported zero admissions based on transfers of its patients between SA 1 and SA 2A. Moreover, there is no persuasive evidence that allowing any multiple SA provider to count transfers of its patients from one of its SAs to another of its SAs as two separate admissions has adversely impacted the fixed need pool determination in this case.

30. Covenant is not the only hospice provider in SA 1 and SA 2A. No doubt, some patients in one of Covenant's SAs transferred to and from Covenant and the alternate providers in SA 1 and SA 2A or other Florida SAs with no corresponding death being recorded in one of Covenant's SAs. Covenant surely served some Alabama patients who sought hospice care in Florida but whose deaths were not counted as resident deaths in any Florida SA. At least for the calendar years 1999 and 2000, Covenant experienced a net in-migration of patients while BBH experienced a net out-migration of patients for the same periods. Even so, there is no persuasive evidence that in-migration and out-migration of patients has affected the validity of the numeric need at issue in this proceeding.

31. AHCA consistently has counted admissions in this manner since the Rule was adopted and implemented. Counting

admissions by "service area of residence" as interpreted by AHCA ensures that all patients served are counted, even those who are homeless or have a permanent residence in another state.

32. AHCA's interpretation of an admission based on "service area of residence" also is consistent with Section 400.601(6), Florida Statutes, which provides that hospice services may be provided in "a place of temporary or permanent residence used as the patient's home . . . ." Thus, a patient's residence could be a private home, an assisted living facility, a nursing home, or a hospital regardless of the location of the patient's legal or permanent residence.

33. The State of Florida has an interest in knowing how much hospice care is provided in each SA. The application of the Rule promotes that interest because HPH projects the number of patients in a particular SA who will choose hospice care in the applicable time frame. HP is the number of patients admitted to hospice programs during the most recent 12-month period. HPH and HP measure the utilization of hospice care in a SA and not the number of residents of an SA who will elect hospice care or who are admitted to hospice care.

34. In calculating the numeric need in this case, the number of admissions was based on data for the year ending June 2001. The resident deaths were based on data for the period ending December 2000. The time periods do not match

because the Rule requires AHCA to use the most recent mortality data from the Department of Health's Office of Vital Statistics. The time periods are never the same and can differ from six months to one year. Thus, there is no intent under the Rule to have a one-to-one correspondence between the deaths that are used in determining the P factors and the admissions that are multiplied by the factors. Every SA in the state is treated consistently. No SA is disadvantaged by this characteristic of the Rule's need methodology.

35. The batching cycle at issue here is the only one since the Rule was implemented that showed a fixed need for another hospice program in SA 2B. Until now, AHCA has never preliminarily approved any applicant where the net numeric need was only 351. The numeric need projection made in April 2002 showed no fixed need in SA 2B for another hospice program. None of these facts serve to undermine the validity of AHCA's determination of numeric need in this case.

The Revised Fixed Need Pool Determination

36. The initial fixed need pool projection published by AHCA did not indicate that there was a numeric need for an additional hospice in SA 2B. However, the initial publication was based on incorrect population projections.

37. AHCA published a revised fixed need pool projection based, in part, on the updated and most current population data.

That revision alone would have resulted in a numeric need for an additional hospice program in SA 2B, i.e. HPH - HP equaled 350.

38. However, other corrections also were made based on revisions to semiannual utilization reports of several hospices. BBH's revised report form increased its HP number by four. Another hospice, Hospice of Southwest Florida, reported a substantial revision. The total revisions resulted in a numeric need for one additional hospice program in SA 2B because HPH - HP equaled 351.

39. The revised fixed need pool determination was correctly calculated in accordance with AHCA's application and interpretation of all rules relating to fixed need pool determination. AHCA's interpretation and application of the rules is reasonable and appropriate. Therefore, the fixed need pool projection at issue here is valid and correct. As discussed below, there is no persuasive evidence that BBH over-reported its admissions.

BBH's Reported Admissions

40. An admission consists of several components: (a) a physician's diagnosis and prognosis of a terminal illness; (b) a patient's expressed request for hospice care; (c) the informed consent of the patient; (d) the provision of information regarding advance directives to the patient; and (e) performance of an initial professional assessment of the patient. At that

point, the patient is considered admitted. A patient does not have to sign an election of Medicare benefits form for hospice care prior to being deemed admitted.

41. BBH reported 858 admissions for the July 2000 through June 2001 reporting period. These admissions included patients who had completed the admission process outlined above.

42. For accounting and billing purposes only, BBH separates its admissions into patients who have authorized the election of Medicare benefits and those who have not made that election. For the latter group, BBH uses the acronym WAP as a billing code. BBH provides WAP patients with services but does not bill them for those services because BBH is unable to report them to Medicare for reimbursement. BBH does not bill patients for services that it has no intention of collecting.

43. In fact, BBH's billing department initially logs all patients in as WAPs. BBH's admission policy states that patients who will not be accepting services immediately should be entered as a WAP with reasons and follow-up dates to initiate regular services. The admission specialist at BBH enters a patient as a WAP then gets the attending physician's signature on the interdisciplinary care plan and certification of terminal illness. The admission specialist also requests the patient's medical record and completes the other admission steps. The WAP designation is not removed until the admission process is

complete and the patient has elected the Medicare benefit. The WAP patient is not counted as an admission for purposes of reporting to AHCA until the admission process is complete.

44. Occasionally, a WAP patient dies before the admission process is complete. In that case, the patient is not counted as an admission. Sometimes a WAP patient dies after completing the admissions process but before electing the Medicare benefit or receiving any additional hospice services. It is not necessary for a hospice to develop a plan of care in order for a patient to be considered admitted. An admitted patient has a right to choose or refuse additional services. In such a case, the patient is still counted as an admission for purposes of reporting to AHCA.

45. BBH's practice of including WAP patients who have completed the admission process in its count of admissions is consistent with AHCA's interpretation of the Rule. AHCA's interpretation of the Rule is reasonable and appropriate in this regard. The fact that 10 percent of BBH's admissions are WAP patients while Covenant has no such patients does not change this result.

46. BBH's financial department also is responsible for submitting reports to the Department of Elder Affairs (DEA). Therefore, BBH has filed reports with DEA consistent with its Medicare reports and has not included the WAP patients.

CONCLUSIONS OF LAW

47. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of these proceedings. Sections 120.569 and 120.57(1), Florida Statutes.

Hospice Care in General

48. Section 400.6005, Florida Statutes, sets forth the Legislature's findings and intent regarding terminally ill persons who are no longer seeking curative treatment and their families. First, they "should have the opportunity to select a support system that permits the patient to exercise maximum independence and dignity during the final days of life." Section 400.6005, Florida Statutes. Second, "hospice care provides a cost-effective and less intrusive form of medical care while meeting the social, psychological, and spiritual needs" of the patients and their families. Id.

49. Section 400.601, Florida Statutes, states as follows in relevant part:

> (6) "Hospice services" means items and services furnished to a patient and family by a hospice, or by others under arrangement with such a program, in a place of temporary or permanent residence used as the patient's home for the purpose of maintaining the patient at home; or, if the patient needs short-term institutionalization, the services shall be furnished in cooperation with those contracted institution or in the hospice inpatient facility.

* * *

> (9) "Plan of care" means a written assessment by the hospice of each patient's and family's needs and preferences, and the services to be provided by the hospice to meet those needs.

50. Hospices must provide services that are "tailored to specific needs and preferences of the patient and family at any point in time throughout the length of care for the terminally ill patent and during the bereavement period." Section 400.609, Florida Statutes. The core services include "nursing services, social work services, pastoral or counseling services, dietary counseling, and bereavement counseling services." Section 400.609(1)(a), Florida Statutes. Other services, such as physical therapy, home health aide services, provision of medical supplies and durable medical equipment, and funeral services must be provided or arranged for by hospices, as needed, to meet the palliative and support needs of the patient and family. Section 400.609(1)(a), Florida Statutes.

51. "Hospice care and services provided in a private home shall be the primary form of care." Section 400.609(2), Florida Statutes. However, hospices also may provide services in a residential setting other than the home and in an inpatient facility such as a hospital. Sections 400.609(3) and 400.609(4), Florida Statutes. Thus, it is clear "that a patient may be admitted legally to hospice while in the hospital no

matter where the patient resides or the location of the patient's permanent residence." Hernando-Pasco Hospice, Inc. v. Agency for Health Care Administration and LifePath, Inc., DOAH Case No. 00-1067 (Recommended Order, May 18, 2002)(hereinafter referred to as LifePath).

Admissions and Resident Deaths

52. Section 400.6095, Florida Statutes, governs patient admissions and states as follows in pertinent part:

> (2) Admission to a hospice program shall be made upon a diagnosis and prognosis of terminal illness by a physician licensed pursuant to chapter 458 or chapter 459 and shall be dependent upon the express request and informed consent of the patient.
> (3) At the time of admission, the hospice shall inquire whether advance directives have been executed pursuant to chapter 765, and if not, provide information to the patient concerning the provision of that chapter. The hospice shall also provide the patient with information concerning patient rights and responsibilities pursuant to s. 381.206.
> (4) The admission process shall include a professional assessment of the physical, social, psychological, spiritual, and financial needs of the patient. This assessment shall serve as the basis for a plan of care.

53. Section 400.6095, Florida Statutes, goes on to describe the plan of care. The statute does not make "reference to the existence of a plan of care or initiation of care for the patient as a prerequisite to the patient having achieved the status of 'admission' to the hospice." LifePath. Under the

statute, "it appears that the admission process is considered complete once the appropriate assessments have been conducted in the form of a professional assessment." LifePath.

54. LifePath has resolved some of the questions at issue here. First, admissions should be counted based on the patient's location at the time of admission and not in the SA of his or her usual place of residence. This conclusion is supported by AHCA's interpretation of the Rule, which requires admissions to be reported by "service area of residence." Rule 59C-1.0355(9)(a)2, Florida Administrative Code.

55. In deciding that admissions are counted at the location of the patient at the time of admission, it necessarily follows that AHCA is not required to construe the Rule as requiring a correlation between the admission and death of a patient. The parties agree that under some circumstances, a patient may generate more than one admission in the same or subsequent reporting period, i.e., an admission to and discharge from one hospice provider followed by an admission to another hospice provider in the same SA. Therefore, there can never be a direct correlation between the admissions and deaths of patients.

56. Additionally, Rule 59C-1.0355(4)(a), Florida Administrative Code, specifically requires resident deaths to be calculated using data, which is available from the Department of

Health's Office of Vital Statistics at least three months prior to publication. This data is collected based on information contained in death certificates that indicate the deceased person's permanent residence no matter where the death occurred. Because admissions are counted in the SA where the patient is located at the time of admission regardless of the patient's usual residence and resident deaths are counted in the SA of permanent residence regardless of where the death occurred, a correlation between admissions and deaths is not possible, much less required.

57. The second issue that LifePath resolved is that the patient is admitted when the admissions process outlined above is complete. It is not necessary for the hospice to develop a plan of care or provide additional services. The patient does not have to elect Medicare benefits to be admitted. Therefore, BBH correctly and accurately reported admissions of all patients who had completed the admissions process. This is true even though some of the patients never elected Medicare benefits and never received additional services under a plan of care.

58. LifePath did not resolve a remaining question at issue here. The issue is whether a hospice may "double count" the admissions of the same patient who is admitted, discharged, and readmitted, or who transfers or relocates, to the same or

different hospice, in the same or different SA, in the same or subsequent reporting period.

59. BBH particularly objects to the scenario in which hospices that serve more than one SA, such as Covenant, are allowed to count the admission of a patient in one of its SAs and to count the same patient as a second admission when the patient transfers to the provider's other SA without a break in service. BBH makes this objection, claiming that Covenant has an unfair competitive advantage, despite the fact that Covenant counted no such double admissions for the time period at issue here. Moreover, there is no persuasive evidence that allowing any multiple SA provider to count transfers of its patients from one of its SAs to another of its SAs as two separate admissions, has adversely impacted the fixed need pool determination in this case.

60. BBH asserts that LifePath implicitly rejected the propriety of double-counting of admissions of the same patient admitted in one SA and subsequently transferred to its program in a different SA. LifePath, Inc., was licensed to serve hospice patients in SA 6A and SA 6B, while Hernando-Pasco Hospice, Inc., was licensed in SA 3D and SA 5A. AHCA initially determined that there was a need for one additional hospice in SA 6A. However, based on revised report forms submitted by LifePath, Inc., AHCA recalculated numeric need formula

determining that there was zero need for a new hospice in SA 6A. Hernando-Pasco Hospice, Inc., challenged the revised fixed need pool projection.

61. In LifePath, the revised report forms submitted by LifePath, Inc., subtracted 36 admissions from its count of patients served in SA 6B and added them to its count of patients served in SA 6A. LifePath, Inc., made this change because the 36 patients were physically located in hospitals in SA 6A when they were admitted before returning to their homes in SA 6B for continued hospice services.

62. LifePath, Inc.'s, revised reports also subtracted four admissions from its count of patients served in SA 6A and added them to its count of patients served in SA 6B. LifePath, Inc., made this change because the four patients were physically located in hospitals in SA 6B when they were admitted before returning to their homes in SA 6A for continued hospice services.

63. LifePath, Inc., did not count the patients as having been admitted in both of its SAs. AHCA accepted LifePath, Inc.'s, revised reports with full knowledge of the circumstances.

64. In his Findings of Fact, the Administrative Law Judge in LifePath stated as follows:

27. . . . LifePath's ability to admit in one service area and provide treatment later in a different services area makes this case somewhat unusual. There are few hospices in Florida that provide service in more than one service area. For that reason, the issues presented in this case have not surfaced in the past. The more common situation for when a patient is admitted in a hospital in one service area and provided hospice services there and then returns to a permanent residence in another service area would call for the patient to be admitted to two different hospices at two different times. In such a case, for the sake of consistency, the Agency "would want to see . . . an admission to the program in [the service area in which the hospital was located]" (Tr.934) and then a second admission to the hospice in the service area in which the patient had a permanent residence when the patient moved back home or to a location in the second service area. This expectation of the Agency, however, is not required by the rule. It is one that apparently has emerged in the context of this case.

* * *

34. The Agency interprets "service area of residence" not to mean the service area where the patient has a "permanent residence," but the service area which is the patient's "location at the time of admission."

35. There are good reasons in support of the AHCA's interpretation. Hospitalized hospice patients come from a population that has been mobile. Some have permanent residences in foreign countries, other states (so-called "snowbirds") or in other counties in the state or different health planning service areas than the one in which they are hospitalized. Some hospice patients may have no permanent residence at all, as in the case of the homeless. To

> report as admissions only those who reside permanently in a service area in Florida by that service area and to not report the patient as an admission when admitted in the service area in which the patient is hospitalized or located at the time of admission would omit many admissions. As Mr. Gregg testified on behalf of the Agency, the numeric need formula produces the "most accurate projection of need by having the best data and the most complete data; therefore you would want every possible admission to be reported." (Tr. 958).

65. In this case, AHCA is not taking an inconsistent position from the one it took in LifePath. The question of counting multiple admissions of the same patient was not addressed in that case. Instead, AHCA's interpretation of the Rule here is consistent with its position in LifePath, i.e., every possible admission should be counted.

66. Here, as in LifePath, AHCA accepted the revised report forms with full knowledge that unduplicated but multiple admissions were being reported for some of the patients. In doing so, AHCA relied on its interpretation of the terms "new patients admitted" and "service area of residence" in the Rule as meaning that every admission or readmission of the same patient should be counted in any of the following situations: (a) a patient may temporarily decide that he or she no longer desires hospice services resulting in an admission, a discharge, and second admission to the same or another hospice in the same or another SA; (b) a patient may decide to relocate and receive

services in another SA with the same or another hospice resulting in separate admissions in both SAs; and (c) a patient may elect to transfer from one hospice to another hospice in the same SA resulting in a separate admission for each hospice.

67. AHCA's interpretation of the Rule is appropriate and reasonable. It results in the most accurate projection of hospice need ensuring that every possible admission is reported by "service area of residence."

68. AHCA's interpretation of the Rule is not contrary to the plain language of the Rule. An agency's interpretation of its own rules is entitled to great weight and will not be disregarded unless clearly erroneous, Orange Park Kennel Club, Inc. v. State, Department of Business Regulation, 644 So. 2d 574 (Fla. 1st DCA 1994), even if not the sole interpretation, the most logical, or even the most desirable. State, Board of Optometry v. Florida Society of Ophthalmology, 538 So. 2d 878, 885 (Fla. 1st DCA 1988).

69. AHCA's approach to counting admissions is consistent with the definition of HP, which is "the number of patients admitted to hospice programs serving an area during the most recent 12-month period." Rule 59C-1.0355(4)(a), Florida Administrative Code. If the definition of HP does not square with the Rule's reporting requirement, it is a matter of internal rule consistency that AHCA should address. As a matter

of attempting to construe the terms of its rule to achieve consistency in an manner that most effectuates the purposes of the Rule, AHCA's interpretation is not clearly erroneous.

70. Perhaps BBH's numerous arguments about what constitutes an admission and what is not an admission of the same patient should be incorporated into an agency rule but that is a decision for AHCA on another day. This is not a rule-making proceeding. It is a proceeding challenging the validity of agency action: revision of a fixed need pool.

71. Whatever merit BBH's many arguments have with regard to what AHCA's policy should be on the subject of admissions, and particularly the multiple admissions of the same patient, there is nothing in law that compels a result different from the one last reached by AHCA and maintained throughout this proceeding.

72. BBH has failed to carry its burden of proof to overturn AHCA's revised fixed need pool determination showing a net need for an additional hospice program in SA 2B, as published on August 17, 2001.

RECOMMENDATION

Based on the foregoing Findings of Facts and Conclusions of Law, it is

RECOMMENDED:

That AHCA enter a final order determining the fixed need pool for SA 2B for the January 2003 planning horizon to be one.

DONE AND ENTERED this 7th day of November, 2002, in Tallahassee, Leon County, Florida.

SUZANNE F. HOOD
Administrative Law Judge
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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the final order in this case.