STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

SELECT SPECIALTY HOSPITAL - ESCAMBIA, INC.,

Petitioner,

vs. Case No. 05-0319CON

AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.

RECOMMENDED ORDER

Pursuant to notice, a final hearing was held in this case on March 1-2, 2005, in Tallahassee, Florida, before T. Kent Wetherell, II, the designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Mark A. Emanuele, Esquire
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For Respondent: Kenneth W. Gieseking, Esquire
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STATEMENT OF THE ISSUE

The issue is whether the Agency for Health Care Administration should approve Petitioner’s application for a

Certificate of Need to establish a 54-bed freestanding long-term care hospital in Escambia County.

PRELIMINARY STATEMENT

Petitioner, Select Specialty Hospital-Escambia, Inc. (Select-Escambia), filed Certificate of Need (CON) applications in the second batching cycle of 2003 (CON 9701), the first batching cycle of 2004 (CON 9746), and the second batching cycle of 2004 (CON 9800), each of which proposed the establishment of a long-term care hospital (LTCH) in Escambia County. Respondent, Agency for Health Care Administration (Agency), denied each of the applications, and Select-Escambia timely petitioned the Agency for administrative hearings on the denials.

The Agency referred the petitions to the Division of Administrative Hearings (Division), where they were assigned DOAH Case Nos. 04-0455CON (CON 9701), 04-3148CON (CON 9746), and 05-0319CON (CON 9800). DOAH Case No. 04-0455CON was consolidated with DOAH Case No. 04-0462CON, which was SemperCare Hospital of Pensacola, Inc.'s (SemperCare-Pensacola) challenge to the Agency's denial of its co-batched CON application in the second batching cycle of 2003. DOAH Case No. 04-3148CON was consolidated with DOAH Case No. 04-3137CON, which was SemperCare-Pensacola's challenge to the Agency's denial of its co-batched CON application in the first batching cycle of 2004.

SemperCare-Pensacola voluntarily dismissed its challenges, and the Division's files in DOAH Case Nos. 04-0462CON and 04-3137CON were closed through Orders dated December 2, 2004. Thereafter, the three cases involving Select-Escambia's applications were consolidated through an Order dated February 3, 2005.

At the outset of the final hearing, Select-Escambia voluntarily dismissed its petitions challenging the Agency's denial of CON 9701 and CON 9746, and withdrew those applications. The hearing proceeded on CON 9800 only, and the Division's files in the cases involving the other applications -- DOAH Case No. 04-0455CON and 04-3148CON -- were closed through an Order dated March 3, 2005.

At the hearing, Select-Escambia presented the testimony of Gregory Sassman, who was accepted as an expert in LTCH development; Marsha Webb-Medlin, who was accepted as an expert in nursing, LTCH nursing, intensive care unit (ICU) nursing, and LTCH operations; and Sharon Gordon-Girvin, who was accepted as an expert in health care planning. Select-Escambia also presented the deposition testimony of Jeffrey Gregg (Exhibit P5) and Karen Rivera (Exhibit P6). Select-Escambia's Exhibits P1 through P6 were received into evidence. The Agency presented the testimony of Jeffrey Gregg, who was accepted as an expert in

health planning. The Agency's Exhibits A-1 through A-3 were received into evidence.

Official recognition was taken of pages 48916 and 49191 through 49214 of the Federal Register, as published on August 11, 2004[1]; the Recommended and Final Orders in Kindred Hospitals, LLC v. Agency for Health Care Administration, Case No. 01-2712CON (DOAH July 23, 2002; AHCA Nov. 1, 2002); Select Specialty Hospital-Sarasota, Inc. v. Agency for Health Care Admininstration, Case No. 03-2484CON (DOAH Mar. 15, 2004; AHCA May 20, 2004) (hereafter "Select-Sarasota"); Select Specialty Hospital-Marion, Inc. v. Agency for Health Care Administration, Case Nos. 03-2483CON and 03-2810CON (DOAH July 14, 2004; AHCA Sep. 15, 2004) (hereafter "Select-Marion"); and the State Agency Action Report (SAAR) for CON 9596 and CON 9597, through which the Agency approved the LTCH in Panama City.

The two-volume Transcript of the final hearing was filed on March 16, 2005. The parties initially requested and were given 20 days from that date to file their proposed recommended orders (PROs). However, the filing deadline for the PROs was subsequently extended to May 20, 2005, upon the parties' motions. The parties' PROs were timely filed and have been given due consideration.

FINDINGS OF FACT

A. Parties

1. Select-Escambia is a subsidiary of Select Medical Corporation (Select), which has been in the business of operating LTCHs since the 1980's.

2. Select currently operates 99 LTCHs in 27 states, including three in Florida.

3. Select's Florida LTCHs are located in Orlando, Miami, and Panama City. The Orlando and Panama City LTCHs were formerly operated by SemperCare, Inc. (SemperCare), which Select acquired in January 2005.

4. Three other Select LTCHs -- in Tallahassee, Orlando, and Alachua County -- have been approved by the Agency, but are not yet operational. The Tallahassee LTCH, which was also formerly a SemperCare facility, was originally projected to open in 2006, but that date is no longer certain.

5. The Agency is the state agency responsible for administering the CON program and for licensing LTCHs and other health care facilities.

B. Application Submittal and Review and Preliminary Agency Action

6. In the second batching cycle of 2004 for hospital beds and facilities, Select-Escambia filed with the Agency an

application for a CON to establish a 54-bed freestanding LTCH in Escambia County.

7. There were no co-batched applications comparatively reviewed by the Agency with Select-Escambia's application, CON 9800.

8. Select-Escambia's application was complete, and it satisfied the applicable submittal requirements in the statutes and the Agency's rules.

9. The Agency's review of Select-Escambia's application complied with the applicable statutory and rule requirements.

10. The Agency's review culminated in a SAAR issued on December 10, 2004. The SAAR recommended denial of CON 9800, primarily based upon Select-Escambia's failure to demonstrate to the Agency's satisfaction that there is a need for the proposed Escambia County LTCH.

11. The determination in the SAAR that Select-Escambia failed to adequately demonstrate need for its proposed LTCH was largely based upon a 2004 report by MedPAC, which is an organization that advises Congress on issues related to Medicare. The MedPAC report concluded that LTCH patients need to be better defined so as to ensure that the patients treated at LTCHs are of the highest severity and cannot be more cost-effectively treated in other care settings.

12. The Agency formally published notice of its intent to deny CON 9800 in the Florida Administrative Weekly, and Select-Escambia thereafter timely filed a petition challenging the Agency's denial of its application.

13. The Agency reaffirmed its opposition to Select-Escambia's application at the hearing through the testimony of Jeffrey Gregg, the bureau chief over the Agency's CON program.

C. LTCHs

(1) Generally

14. An LTCH is defined by statute and Agency rule as "a hospital licensed under chapter 395 which meets the requirements of 42 C.F.R. s. 412.23(e) and seeks exclusion from the Medicare prospective payment system for inpatient hospital services."

15. LTCHs provide extended medical and rehabilitative care to patients with multiple, chronic, and/or clinically complex acute medical conditions. They serve a patient population whose average length of stay (ALOS) exceeds 25 days.

16. There are two types of LTCHs: hospital-within-a-hospital (HIH) and freestanding. Both types are accepted in the industry, and both types are found in Florida and nationwide.

17. HIH LTCHs are located in the same building or on the same campus as a traditional acute care hospital, which is referred to as the "host hospital." HIH LTCHs contract with the

host hospital for ancillary services such as laboratory and radiology services.

18. HIH LTCHs get the vast majority of their admissions from the host hospital, whereas freestanding LTCHs tend to get their admissions from a number of different hospitals.

19. LTCHs fit into the continuum of care between traditional acute care hospitals and traditional post-acute care facilities such as nursing homes, skilled nursing facilities (SNFs), hospital-based skilled nursing units (SNUs), and comprehensive medical rehabilitation (CMR) facilities.

20. LTCHs are designed to serve patients that would otherwise have to be maintained in a traditional acute care hospital (often in the ICU) where the reimbursement rates may be insufficient to cover the costs associated with a lengthy stay, or be moved to a traditional post-acute care facility where the patient may not receive the level of care needed.

21. Patients with co-morbidities, complex medical conditions, or frailties due to age are typically appropriate LTCH patients, particularly if the patient would otherwise remain in the ICU of a traditional acute care hospital. For such patients, an LTCH is likely the most appropriate setting from both a financial and patient-care standpoint.

22. There is a distinct population of patients who, because of the complexity or severity of their medical

condition, are best served in an LTCH. However, there is an overlap between the population of patients that can be served in an LTCH and the population of patients that could also be well-served in the ICU of an acute care hospital or a traditional post acute care setting with ventilator capability. Indeed, as noted in the MedPAC report, "[i]n the absence of LTCHs, clinically similar patients are principally treated in acute hospitals or in freestanding SNFs that are equipped to handle patients requiring a high level of care."

23. Because of the overlap in patients, it is important for LTCHs to adopt detailed admission criteria to ensure that the LTCH (rather than a SNF, SNU, or CMR) is the most appropriate care setting for the patient.

24. InterQual, which is a private organization that establishes standards for quality of care for a variety of health care settings, has developed model admission criteria for LTCHs.

25. The Interqual criteria are designed to ensure that the LTCH is the most appropriate care setting for the patient, and they are referenced in the MedPAC report as an example of the type of admission criteria that LTCHs should adopt to ensure that they are not treating patients that should be treated in another setting.

26. Mr. Gregg and Karen Rivera, the supervisor of the CON program, acknowledged in their deposition testimony that an LTCH's use of the InterQual criteria would, at least to some degree, address the Agency's concern that LTCHs might be serving patients that should be served in a more traditional, less-intensive (and/or less-costly), post-acute care setting.

27. Select utilizes the InterQual criteria as part of its admission process at its existing LTCHs, and it intends to utilize those criteria at its proposed Escambia County LTCH. Specifically, Select's nurses screen patients prior to admission and, again, shortly after admission to ensure they are LTCH-appropriate patients. Additionally, Select's nurses and care teams periodically evaluate each patient to ensure that the LTCH is still the most appropriate care setting for the patient and to determine whether the patient is ready for discharge, either to a traditional post-acute care setting or to home.

28. Select also utilizes a third-party organization to review and assess the patient-outcomes achieved at each of its LTCHs. This is a quality assurance/improvement tool because it allows Select to compare and "benchmark" the performance of its LTCHs against each other and against other LTCHs nationwide and it helps to identify functions or services that need improvement.

29. LTCH services are most highly utilized by persons in the 65 and older (65+) age cohort because those persons are more likely to have complex and/or co-morbid medical conditions that require long-term acute care. In calendar year 2003, for example, approximately 77 percent of LTCH patients in Florida were in the 65+ age cohort and approximately 51 percent were in the 75 and older (75+) age cohort.

30. The typical LTCH patient is still in need of considerable acute care, but a traditional acute care hospital may no longer be the most appropriate or lowest cost setting for that care.

31. The vast majority of LTCH admissions are patients transferred directly from a traditional acute care hospital. It is not uncommon for an LTCH patient to be transferred on life support from a critical care unit or ICU after the patient has been diagnosed and stabilized.

32. Nursing homes, SNFs, SNUs, CMR facilities, and home health care are not appropriate for the typical LTCH patient because the patient's acuity level and medical/therapeutic needs are higher than those generally treated in those settings. Indeed, unlike traditional post-acute care settings, which typically do not admit patients who still require acute care, the core patient-group served by LTCHs are patients who require considerable acute care through daily physician visits and

intensive nursing care in excess of eight hours of direct patient care per day.

33. LTCH patients are often discharged to a traditional post-acute care facility such as a nursing home, SNF, CMR facility, or home health care. Thus, those facilities cannot be considered as "substitutes" for LTCHs, even though there is some overlap between the services provided to lower acuity LTCH patients and higher acuity patients in those traditional post-acute care facilities.

34. The family of a patient in an LTCH is generally encouraged to be more involved in the patient's care than it would be if the patient was in the ICU of a traditional acute care hospital. For example, the visiting hours at LTCHs are typically more liberal than the visiting hours of the ICU at a traditional acute care hospital.

35. Medicare reimbursements are the primary source of revenue for LTCHs because, on average, 75 to 85 percent of LTCH patients are covered by Medicare. In this case, Select-Escambia projected that approximately 77 percent of the patient days at its proposed Escambia County LTCH would be generated by Medicare patients.

36. In 2002, the federal government adopted a Medicare prospective payment system (PPS) specifically for LTCHs. That system recognizes the LTCH patient population as being distinct

from the patient populations treated by traditional acute care hospitals and post-acute care facilities such as nursing homes, SNFs, SNUs, and CMR facilities, even though there may be some overlap between the patient populations served by LTCHs and those other types of facilities.

37. Under the LTCH PPS, services are reimbursed by Medicare at a predetermined rate that is weighted based upon the patient's diagnosis and acuity, regardless of the cost of care. This reimbursement system is similar to, but uses Diagnosis Related Groups (DRGs) that are different than the DRGs used in the PPS for traditional acute care hospitals.

38. The Medicare reimbursement rates for services to long-stay patients in an LTCH are generally higher than the reimbursement rates for the same services to long-stay patients at a traditional acute care hospital. As a result, there is a financial incentive for hospitals to transfer their long-stay patients to an LTCH.

39. In August 2004, the federal regulations governing Medicare reimbursements for LTCHs were substantially amended. One significant change in the regulations is that the number of admissions that an HIH LTCH can receive from its host hospital and still qualify for reimbursement under the LTCH PPS is generally capped at 25 percent. The effect of that change is that new HIH LTCHs will not be viable in most instances.

(2) LTCHs in Florida

40. At the time CON 9800 was filed, there were 12 LTCHs operating in Florida with a total of 799 licensed beds. There were an additional four approved but not yet licensed LTCHs, including the three Select facilities referenced above.

41. There are no licensed or approved LTCHs in District 1, which consists of Escambia, Santa Rosa, Okaloosa, and Walton Counties.

42. There is at least one licensed or approved LTCH in each health planning district, except for Districts 1 and 9.[2]

43. The closest Florida LTCH to Escambia County is the former SemperCare (now Select) facility in Panama City, which is in District 2. That facility, which opened in early 2003, is a 30-bed HIH LTCH, and is approximately 100 miles and a two-hour drive from Pensacola.

44. There is or soon will be an LTCH in Mobile, Alabama, which is approximately 60 miles from Pensacola. There was no evidence presented regarding the type, size, utilization, or quality of care at that facility.

45. The existing Florida LTCHs are well-utilized. According to the SAAR, the overall occupancy rate for the Florida LTCH beds was approximately 68 percent in 2003, and several of the facilities had occupancy rates in excess of 80 percent.

46. The newer facilities -- Select's Miami LTCH, which opened in December 2002, and the former SemperCare (now Select) LTCH in Orlando, which opened in June 2003 -- had considerably lower occupancy rates, which as discussed in the Select-Marion Recommended Order (page 23), is to be expected. If the beds and patient days for those facilities are excluded from the calculation in the SAAR, the overall occupancy rate for the Florida LTCH beds in 2003 would have been slightly above 71 percent.

47. The existing Florida LTCHs receive a majority of their admissions from the county in which they are located, which is consistent with the comment in the MedPAC Report that proximity to an LTCH "quadruples the likelihood that a [patient] will use a long-term care hospital."

48. Florida LTCHs served patients in 174 of the 527 DRGs in calendar year 2003, but 50 of the DRGs accounted for 91 percent of the cases and 93 percent of the patient days. By far, the most commonly treated DRG is No. 475, which is "respiratory system diagnosis with ventilator support."

(3) Select-Escambia's Proposed LTCH

49. Select-Escambia's proposed LTCH will be a 54-bed freestanding facility in 54,090 square feet of new construction.

50. The precise location of the proposed LTCH is not yet known. However, Select-Escambia conditioned approval of its CON

application on the facility being located in Escambia County, and the application states that the facility will be located "proximate to the area acute care hospitals."

51. The service area for the proposed LTCH is Escambia County and a 40-mile radius around Pensacola. The service area extends into Alabama on the west and into Santa Rosa and Okaloosa Counties on the east. It excludes Walton County.

52. The service area is reasonable based upon the facts discussed in Part D(2)(a) below, particularly the concentration of the population and the acute care beds in Escambia County, the large elderly population in Escambia County, and the large in-migration to (and small out-migration from) Escambia County for acute care services.

53. The bed complement at the proposed LTCH will be 35 private rooms (five of which are ICU-level), 8 semi-private rooms, and three isolation rooms (one of which is ICU-level). The facility will also include a surgical suite, a gym for physical and occupational therapy, a pharmacy, and laboratory and x-ray facilities.

54. The total project cost is approximately $17.1 million. That cost will be funded by Select from its net cash flow from operations and through borrowings from Select's bank.

55. The services at the proposed LTCH will include the same "core" services found at other Select LTCHs. Those

services are the treatment of pulmonary and ventilator patients, neuro-trauma and stroke patients, medically complex patients, and wound care.

56. Select-Escambia has not negotiated patient transfer agreements with any of the area hospitals, but the CON application does include letters of support from Sacred Heart Hospital-Pensacola in Escambia County and North Okaloosa Medical Center in Okaloosa County. It is not unusual for patient transfer agreements not to have been negotiated at the CON-stage of the development of a new LTCH.

57. The proposed LTCH was projected to open approximately two years after approval of the CON, or in November 2006. That date has been delayed as a result of this proceeding, but the two-year construction period is reasonable.

58. The need projections in the application focus on the first two years of the facility's operation, 2007 and 2008, as do the utilization and financial projections.

59. Select-Escambia projects that its proposed LTCH will have 8,819 patient days in its first year of operation, and 14,054 patient days in its second year of operation. Those patient days equate to utilization rates of 45 percent in the first year and 71 percent in the second year. Those projections are reasonable and attainable.

60. Select-Escambia projects that its proposed LTCH will generate a net loss of approximately $2.18 million in the first year of operation, and a net profit of approximately $1.19 million. Those projections are reasonable and attainable based upon the utilization projected.

61. In addition to the letter of support from the two hospitals referenced above, the CON application includes letters of support from physicians, local politicians and businesses, the operator of rehabilitation clinics in Pensacola, and the medical director of several nursing homes in Pensacola.

62. The letters of support attest to the general unavailability of LTCH services in Escambia County and, as discussed below, several of the letters specifically state that the traditional post-acute care settings in the area are inadequate for patients in need of long-term acute care.

D. Statutory and Rule Criteria

63. The statutory criteria applicable to the review of Select-Escambia's application are in the 2004 version of Section 408.035, Florida Statutes.[3]

64. The Agency's rules do not contain any specific criteria relating to LTCHs.

65. The general criteria in Florida Administrative Code Rule 59C-1.008(2)(e)2. are applicable because the Agency does not publish a fixed need pool or a need methodology for LTCHs.

That rule requires the applicant to demonstrate that there is a need for its proposed facility or service.

(1) Stipulated Criteria

66. The parties' Joint Pre-hearing Stipulation includes the following stipulations relating to the statutory criteria[4]:

> With respect to compliance with Section 408.035(3), Florida Statutes, it is agreed that Select-Escambia has the ability to provide quality programs based on the description of their programs in their CON application and based on the operational facilities of the applicant and/or of the applicant's parent facilities which are JCAHO certified.
>
> With respect to compliance with Section 408.035(4), Florida Statutes, it is agreed that Select-Escambia has the ability to provide the necessary resources including health personnel, management personnel and funds for capital operating expenditures, for project accomplishment and operation.
>
> With respect to compliance with Section 408.035(6), Florida Statutes, it is agreed that the immediate financial feasibility of the Select-Escambia project is not in dispute. It is further agreed by all parties that the long term financial feasibility of Select-Escambia is not in dispute.
>
> The parties agree that, if the projected levels are realized (i.e., need) with respect to compliance there is no disputed issue with respect to compliance with Section 408.035(7), Florida Statutes, in that the project will foster competition that promotes quality and cost effectiveness.

> The parties agree there are no disputed issues with respect to compliance with Section 408.035(8), Florida Statutes, which relates to an applicant's proposed costs and methods of proposed construction for the type of project proposed.
>
> The parties agree there is no disputed issues with respect to compliance with 408.035(9), Florida Statutes, as it relates to Medicaid patients in that Select's Medicaid provision (conditions - Schedule C) exceeds the state average.
>
> Section 408.035(10), Florida Statutes, is not at issue with respect to a review of the CON application filed by Select-Escambia.

67. In light of those stipulations, the only statutory criteria still at issue are those relating to "need" -- Section 408.035(1),[5] (2), and (5), Florida Statutes -- and the charity care component of Section 408.035(9), Florida Statutes.

68. The issue of "need" was identified as the dispositive issue in this case. Mr. Gregg acknowledged in his testimony at the hearing and in his deposition that other than the issue of "need" there is no basis to deny Select-Escambia's application.

(2) Criteria Related to "Need"

69. The statutory criteria in Section 408.035(1), (2), and (5), Florida Statutes -- i.e., need for the proposed service; availability, quality of care, accessibility, and extent of utilization of the service in the district; and the extent to which the proposed service will enhance access in the district -

- encompass essentially the same factors that are enumerated in Florida Administrative Code Rule 59C-1.008(2)(e)2.

70. Mr. Gregg testified at the hearing that where there is no LTCH in a district (as is the case in District 1), the Agency presumes that there is some amount of need for LTCH services in the district. However, Select-Escambia has the burden to demonstrate the extent of that need.

(a) Demographic, Market, etc. Factors Showing Need

71. Each of the four counties in District 1 is relatively long and narrow. The counties extend from the Gulf of Mexico to the south and the Florida-Alabama line to the north.

72. Escambia County is the westernmost county in District 1, and Walton County is the easternmost county in the district. Santa Rosa County is immediately to the east of Escambia County, and Okaloosa County is between Santa Rosa and Walton Counties.

73. A 40-mile radius around Pensacola, which is the largest city in Escambia County, encompasses all of Santa Rosa County and almost all of Okaloosa County. Although much of Walton County is outside of that radius, it (and all of District 1) is within an hour and a half drive of Pensacola.

74. Walton County is bordered on the east by Washington and Bay Counties, which are in District 2. Panama City, which currently has an LTCH, is in southern Bay County.

75. District 1 had a population of 670,283 in July 2004, with approximately 45.6 percent of that population located in Escambia County.

76. Approximately 13.4 percent of the July 2004 population in District 1 was in the 65+ age cohort, and 5.98 percent of that population was in the 75+ age cohort. Those percentages were lower than the statewide averages of 17.8 percent in the 65+ age cohort and nine percent in the 75+ age cohort.

77. The population of District 1 and the percentages of the population in the 65+ and 75+ age cohorts are almost the same as the population and percentages in District 2, which has one operational (Panama City) and one approved (Tallahassee) LTCH.

78. The population of District 1 is projected to grow approximately 6.91 percent to 716,585 by July 2009, which is five-year planning horizon applicable to this case.

79. The five-year growth rate in District 1 is lower than the 7.93 percent rate that the state as a whole is projected to grow over the same period. However, the projected five-year growth rate in the 65+ and 75+ age cohorts, which most heavily utilize LTCH services, are higher than the statewide growth rates in those age cohorts.

80. Specifically, the 75+ age cohort in District 1 is projected to grow 13.85 percent by July 2009, which is a higher

percentage than any other health planning district in the state and nearly twice the statewide rate of 6.33 percent. The 65+ age cohort in District 1 is projected to grow 11.36 percent by July 2009, which is higher than the 9.94 percent statewide rate and higher than all but three of the other health planning districts.

81. Walton County is projected to grow at a higher rate, both as a whole and in the 65+ and 75+ age cohorts, over the applicable five-year planning horizon than any of the other counties in District 1. The higher growth rate is due in large part to the fact that Walton County is considerably smaller than the other District 1 counties.

82. From a raw population perspective, there will be considerably more growth in Escambia and Santa Rosa Counties than in Walton County over the applicable five-year planning horizon. The population of Walton County is expected to increase by only 7,400 persons over that period, while the population of Escambia and Santa Rosa Counties are expected to increase by almost 27,000 persons.

83. As of December 2003, there were approximately 1,800 acute care beds in District 1 at 11 hospitals. For calendar year 2003, the district-wide average occupancy of those beds was 52.4 percent.

84. The three largest hospitals in District 1 are located in Escambia County. Those hospitals -- Baptist Hospital, Sacred Heart Hospital-Pensacola, and West Florida Regional Medical Center -- are all similar in size and account for approximately 1,135 (or 62.6 percent) of the acute care beds in District 1.

85. Sacred Heart Hospital-Pensacola provided a letter of support for Select-Escambia's proposed LTCH, as did two hospitals in Okaloosa County (i.e., Sacred Heart Hospital of the Emerald Coast and North Okaloosa Medical Center).

86. The data presented in the CON application (at pages 000118 to 000121) shows that between 62.4 and 68.4 percent of the "long-stay patients" in District 1 were in the three Escambia County hospitals; that those hospitals had a relatively high (28.8 to 31.6 percent) in-migration rate of long-stay patients from outside of Escambia County; and that there is very little (1.3 to 3.6 percent) out-migration of Escambia County long-stay patients to other District 1 hospitals.

87. Only one District 1 resident was admitted to a Florida LTCH in calendar year 2003, which is a strong indication that LTCH services are not reasonably accessible to District 1 residents even with the establishment of the Panama City LTCH in early 2003.

88. The Panama City LTCH, which is approximately 100 miles from Pensacola, is too far away from Escambia County to be a

reasonable alternative for residents of that county. The same is true for the other counties in District 1, except for Walton County which is geographically closer to Panama City than it is to Pensacola.

89. The Panama City LTCH was not expected to serve District 1. According to the SAAR that recommended approval of that LTCH, the facility was projected to get 60 percent of its admissions from its host hospital, Bay Medical Center, and only two of the potential LTCH referrals were projected to come from a District 1 hospital. Those referrals were projected to come from Santa Rosa Medical Center in Santa Rose County, and none of the referrals to the Panama City LTCH were projected to come from Escambia County.

90. Those projections are consistent with the experience of the Panama City LTCH since it opened in early 2003. Only five or six patients from Escambia County have been referred to the Panama City LTCH, and none have chosen to be admitted to the facility.

91. There are no LTCHs or "like services" in District 1 because, as more fully discussed in Part C(1) above, the traditional post-acute care settings such as SNFs, CMRs, and hospital-based SNUs are not substitutes for LTCHs.

92. The data presented in the CON application shows that in calendar year 2003 there were 500 patients treated in

District 1 hospitals with LTCH-appropriate DRGs who were in the hospital for a collective 13,942 days beyond the geometric mean length of stay (GMLOS),[6] which corresponds to an average of 27.9 days beyond the GMLOS. It is reasonable to expect that that those patients would have been discharged to a post-acute care setting if they no longer needed acute care, and because there were available CMR, SNU, and SNF beds in the district,[7] it is reasonable to infer that the patients were still in need of long-term acute care and/or that the available post-acute care facilities did not offer the requisite level of intensive care.

93. This inference is corroborated by the letters of support from local physicians that were included in the CON application. For example, the October 7, 2003, letter to Mr. Gregg from Dr. Donna Jacobi states that:

> Our skilled nursing facilities and subacute units have had difficulty in managing complex, more unstable patients . . . . One facility was equipped and staffed for ventilator patients when it opened; now that ward is for routine SNF care. Our rehabilitation institute is not the place for these patients either – they may be too ill for three hours of therapy daily.
>
> Currently some of these patients remain in acute care much longer than necessary and are subjected to iatrogenic [sic] risks, depression, and possible further decline in functional status while becoming more medically stable. Others bounce back and forth between nursing home and hospital, and a few leave our area of the state to find care elsewhere – far from their family and

> friends who are very important to their recovery. A LTACH [sic] would provide the opportunity for them to remain here in a supportive environment.[8]

94. Letters of support such as Dr. Jacobi's and those quoted in Endnote 8, with detailed information about the inability to place patients in existing facilities, are the type that the Mr. Gregg identified in Select-Marion (page 60, endnote 5) as being the most useful to the Agency in "validating" the applicant's numeric need projections.

95. In sum, the demographic and market conditions described above, coupled with the letters of support from local physicians and two of the acute care hospitals in District 1, support the establishment of an LTCH in the district, and more specifically, in Escambia County.

(b) Quantification of the Need / Numeric Need

96. Select-Escambia presented two different methodologies in its application to quantify the need for LTCH beds in District 1. The methodologies are similar, but not identical to the methodology recently accepted by the Agency in Select-Marion.[9]

97. The methodologies presented in the application each define the potential patients for Select-Escambia's proposed LTCH as the "long-stay patients" in the existing District 1 acute care hospitals with "LTCH-appropriate DRGs." That

approach is reasonable from a health planning perspective because, as discussed in Part C(1) above, an LTCH is likely the most appropriate setting for such patients from a financial and patient-care standpoint.

98. The methodologies differ in their definition of what constitutes a "long-stay patient," but they both use the GMLOS as the starting point, which is reasonable from a health planning perspective.

99. Both methodologies define the "LTCH-appropriate DRGs" as the 50 DRGs that are most commonly treated in the existing Florida LTCHs. The focus on the "top 50" DRGs was reasonable from a health planning perspective because those DRGs account for more than 91 percent of the cases and 93 percent of the patient days at the existing Florida LTCHs.

(i) GMLOS+15 Methodology

100. The first methodology presented in the application -- "the GMLOS+15 methodology" -- identified all of the patients treated in the District 1 hospitals with LTCH-appropriate DRGs whose length of stay was at least 15 days longer than the GMLOS for the DRG. A similar definition of long-stay patients was accepted by the Agency in Select-Marion.

101. There were a total of 500 potential LTCH patients identified through Select-Escambia's GMLOS+15 methodology. According to the data included in the CON application (at page

000120), 30 of those patients were Walton County residents and 55 resided outside of District 1.

102. Select-Escambia calculated a total of 19,409 potential LTCH patient days that would be generated by the 500 identified long-stay patients, which equates to an average daily census (ADC) of 53.

103. According to Select-Escambia's health planner (Transcript, at 131), the 19,409 patient-days included all of the days in the patient’s hospital stay as potential LTCH patient days, and not just that portion of the stay that exceeded the GMLOS. The inclusion of all of the days in the patient’s hospital stay as potential LTCH patient days is not reasonable because the vast majority of LTCH patients are transferred from an acute care hospital at some point during the patient’s hospital stay, typically at or after the GMLOS.

104. The effect of including all of the days in the patient’s hospital stay as potential LTCH patient days rather than just the days after the GMLOS is an overstatement of the potential LTCH patient days and the ADC calculated under the GMLOS+15 methodology in Select-Escambia’s application.

105. If only the days beyond the GMLOS were included (as was done in Select-Marion), the result would be 13,941 potential LTCH patient days. If the 875 days attributable to Walton County residents and the 1,596 days attributable to non-District

1 residents were excluded (see Exhibit P2, at 000121), then the total would be 11,471 potential LTCH patient days.

106. The ADC of 53 calculated by Select-Marion under the GMLOS+15 methodology is not reliable because it was based upon the 19,409 patient days. Using the 13,941 or 11,471 patient days referenced above would result in an ADC of 38.2 or 31.4, respectively.

107. Based upon an 80 occupancy standard, those ADCs would translate into a projected need for 40 to 48 LTCH beds in District 1. If a 75 percent occupancy standard was used, the projected LTCH bed need would be 42 to 51 beds. The lower numbers in each of those ranges reflect the exclusion of the patient days attributable to Walton County residents and non-District 1 residents; the higher numbers in those ranges reflect the inclusion of those residents.

108. An 80 percent occupancy standard was accepted by the Agency in Select-Marion and was also used by Select in Select-Sarasota. As stated in the Recommended Order in Select-Marion (at page 37), the 80 percent occupancy standard "better reflects the lower bed turn-over by LTCH patients than does the 75 percent occupancy standard typically applied to traditional, 'short-term' acute care hospitals."

(ii) GMLOS+7 Methodology

109. The second methodology presented in the application -– "the GMLOS+7 methodology" -- uses a broader definition to identify the potential LTCH patients in District 1. It includes all of the patients with LTCH-appropriate DRGs who were treated in the District 1 hospitals and whose lengths of stay were at least seven days longer than the GMLOS.

110. The broader definition of long-stay patients in the GMLOS+7 methodology resulted in 1,498 potential LTCH patients (see Exhibit P2, at 000117 (Table 1-16(b)), 000120), as compared to the 500 potential LTCH patients identified through the GMLOS+15 methodology.

111. The Agency did not expressly take issue with the broader definition used in the GMLOS+7 methodology to identify the potential LTCH patients, and it cannot be said based upon the record evidence in this case that the definition is inherently unreasonable.

112. In calculating the potential LTCH patient days under the GMLOS+7 methodology, Select-Escambia only included the days that the patient stayed in the hospital beyond the GMLOS, which are referred to in the application as "excess days." See Transcript, at 132. A similar approach was used in the methodology accepted by the Agency in Select-Marion.

113. The following table, which is derived from the data in Table 1-16(a) in the CON application, summarizes the number of excess days generated by patients in the District 1 hospitals based upon the patient's county of residence:

Escambia County	11,434
Okaloosa County	5,634
Santa Rosa County	3,194
Subtotal: District 1 Residents except for Walton County	20,262
Walton County	1,410
Subtotal: All District 1 residents	21,672
Outside of District 1	2,340
Total	24,012

114. Select-Escambia then converted the excess days into "forecasted LTCH cases" by dividing the most conservative figure -- the 20,262 days, which excluded Walton County residents and non-District 1 residents -- by the 33.6 ALOS at Select's existing freestanding LTCHs. The result -- 603 cases -- was then inflated based upon the projected growth rate in District 1 to determine the number of forecasted LTCH cases in 2007 and 2008, which were projected to be the first two years of operation for Select-Escambia's proposed LTCH. The forecasted

cases were then converted into "forecasted LTCH days" by multiplying the number of cases by the same 33.6 ALOS.

115. The conversion of the excess days into forecasted LTCH cases and then back into forecasted LTCH days based upon a 33.6 ALOS is not reasonable because, according to the CON application,[10] the initial calculation of the excess days is intended to reflect the number of days that patients would likely spend in the LTCH rather than the short-term acute care hospitals in District 1 if an LTCH was available in the area. The ALOS experienced by Select at its other facilities is irrelevant to that issue.

116. The effect of the conversion step in Select-Escambia's GMLOS+7 methodology is an overstatment of the forecasted LTCH patient days, as can be seen through a comparison of the data in Tables 1-16(a) and 1-16(b) in the CON application.

117. Table 1-16(b) shows the number of cases associated with the excess days calculated in Table 1-16(a). The 1,498 total cases identified on Table 1-16(b) correlate to the 24,012 total excess days identified on Table 1-16(a). As a result, there is an average of only 16.03 excess days per case.

118. Stated another way, the long-stay patients identified through the GMLOS+7 methodology are staying in the hospital an average of 16.03 days longer than the GMLOS. It is those 16.03

days/case that make up the potential LTCH patient days, but the conversion described above appears to assume that those same patients would stay in Select-Escambia's proposed LTCH for 33.6 days. There is no logic or reason to that assumption, and as a result, the patient days, ADC, and bed need reflected in Table 1-17 of the application are not reliable.

119. The most reliable projection of bed need that can be calculated based upon the data presented in connection with the GMLOS+7 methodology is derived from the Table 1-16(a), to wit:

	Excess Days	ADC	Bed Need (at 80%)
Escambia only	11,434	31.3	40
District 1 excluding Walton and non-District 1	20,262	55.5	70
District 1 including Walton; excluding non-District 1	21,672	59.4	75

120. Accordingly, the GMLOS+7 methodology projects a need for 70 to 75 LTCH beds, depending upon whether Walton County residents are included in the calculation, with 40 of the beds attributable to the excess days generated by Escambia County residents alone.

(iii) Ultimate Findings Regarding Numeric Need

121. Using the most conservative figures produced by the respective need methodologies presented in the application,

there is a need for between 40 (see Finding of Fact 107) and 70 (see Findings of Fact 119 and 120) LTCH beds in District 1.

122. It is reasonable to expect that the "actual" bed need is towards the mid-point of that range -- 55 beds -- because Select-Escambia's proposed LTCH will likely get some of the potential LTCH admissions from Walton County, as well as some of the potential LTCH admissions from outside of District 1; because as many as seven percent of the facility's patient days will be attributable to patients whose diagnoses are not within the "top 50" DRGs used in the methodologies to identify the potential LTCH patients; and because the methodologies and the fiqures reflected in the preceeding paragraphs do not take into account the growth in admissions and patient days between 2003 (the period used in the methodologies) and 2007 (when Select-Escambia's proposed LTCH is projected to open) that is expected as the population of District 1 grows, particularly in the 65+ and 75+ age cohorts.

123. Accordingly, the preponderance of the evidence establishes that there is a numeric need for the 54 LTCH beds proposed by Select-Escambia.

(3) Other Disputed Criteria

124. Section 408.035(9), Florida Statutes, requires consideration of the "applicant's past and proposed provision of

health care services to Medicaid patients and the medically indigent."

125. The statutory reference to "the medically indigent" encompasses what are typically referred to as charity patients.

126. Select-Escambia conditioned the approval of its CON application on the provision of two percent of the patient days at its proposed LTCH to Medicaid patients and 0.8 percent of the patient days to charity patients.

127. It was stipulated that Select-Escambia's commitment to Medicaid patients exceeds the statewide average for LTCHs, which according to the SAAR is 1.24 percent of patient days.

128. Select-Escambia's commitment to charity patients is slightly lower than the statewide average for LTCHs, which is 0.94 percent of patient days.[11]

129. When viewed collectively, Select-Escambia's commitment to Medicaid and charity patients -- 2.8 percent of patient days -- exceeds the statewide average for LTCHs of 2.18 percent of patient days.

130. The commitments to Medicaid and charity patients in Select-Escambia's CON application were based upon Select's experience at its other LTCHs, and they are reasonable and attainable in District 1.

131. The fact that Select-Escambia's commitment to charity patients is slightly lower than the statewide average for LTCHs

is not significant under the circumstances of this case. Indeed, Mr. Gregg conceded at the hearing that it is not an independent basis to deny Select-Escambia's application, and that the Agency will accept Select-Escambia's proposed charity commitment of 0.8 percent of patient days if the CON is ultimately approved.

CONCLUSIONS OF LAW

132. The Division has jurisdiction over the parties to and subject matter of this proceeding pursuant to Sections 120.569, 120.57(1), and 408.039(5), Florida Statutes.

133. Select-Escambia has the burden to prove by a preponderance of the evidence that its CON application should be approved. See, e.g., Boca Raton Artificial Kidney Center, Inc. v. Dept. of Health & Rehabilitative Servs., 475 So. 2d 260, 263 (Fla. 1st DCA 1985); Select-Marion, supra, at 56; Select-Sarasota, supra, at 21.

134. Generally, the review of a CON application requires a balanced consideration of the applicable statutory and rule criteria in which the appropriate weight to be given to each criterion is not fixed, but rather varies based upon the facts of the case. See, e.g., Morton F. Plant Hospital Ass'n, Inc. v. Dept. of Health & Rehabilitative Servs., 491 So. 2d 586, 589 (Fla. 1st DCA 1986) (quoting North Ridge General Hospital, Inc.

v. NME Hospitals, Inc., 478 So. 2d 1138, 1139 (Fla. 1st DCA 1985)); Select-Marion, supra.

135. In this case, however, the parties' stipulations have made the issue of "need" the dispositive criterion. If Select-Escambia establishes need for its proposed LTCH -- numerically and based upon the criteria in Florida Administrative Code Rule 59C-1.008(2)(e)2. -- then the balancing of the remaining statutory and rule criteria tilt in favor of granting the application, but if it does not establish need then the balance tilts in favor of denying the application. Accord Select-Sarasota, supra, at 21-22.

136. Because the Agency does not publish a fixed need pool for LTCHs or a formula or methodology for projecting need for LTCH beds, the determination of need for new LTCH beds is governed by Florida Administrative Code Rule 59C-1.008(2)(e)2. That rule provides:

> (e) . . . . If an agency need methodology does not exist for the proposed project:
>
> * * *
>
> 2. . . . the applicant will be responsible for demonstrating need through a needs assessment methodology which must include, at a minimum, consideration of the following topics, except when they are inconsistent with the applicable statutory and rule criteria:

a. Population demographics and dynamics;

b. Availability, utilization and quality of like services in the district, subdistrict or both;

c. Medical treatment trends; and

d. Market conditions.

137. The criteria in that rule encompass essentially the same issues as are contained in the statutory criteria that have not been stipulated to by the parties. See § 408.035(1), (2), (5), Fla. Stat. Thus, to the extent that Select-Escambia establishes "need" based upon the rule criteria, it has also done so under the statutory criteria.

138. Select-Escambia met its burden to establish "need" for its proposed LTCH in accordance with the statutory and rule criteria. Specifically, as more fully discussed in Part D(2) of the Findings of Fact, the preponderance of the evidence establishes that the population of District 1 and Escambia County are growing, particularly in the 65+ and 75+ age cohorts that most heavily utilize LTCH services; that the existing LTCH in Panama City does not serve Escambia County and, because of its distance, it is not a reasonable alternative for District 1 residents in need of LTCH services except for those residents in Walton County; that there is support for Select-Escambia's proposed LTCH from physicians and hospitals in District 1; that the traditional post-acute care settings in District 1 do not

provide reasonable alternatives to the proposed LTCH because they are not currently being utilized by long-stay patients with LTCH-appropriate DRGs and, according to the letters of support, the post-acute care facilities cannot accommodate ventilator patients, which make up a large percentage of the LTCH patient population; that Select-Escambia's proposed LTCH will utilize admission criteria designed to ensure that its facility is only used by patients for whom other care settings are not medically appropriate; and that, even excluding Walton County residents, a numeric need has been shown for the 54 LTCH beds that Select-Escambia has proposed.

139. Therefore, in light of the parties' stipulations regarding the other review criteria, Select-Escambia's CON application should be approved.

RECOMMENDATION

Based upon the foregoing findings of fact and conclusions of law, it is

RECOMMENDED that the Agency issue a final order approving Select-Escambia's application, CON 9800.

DONE AND ENTERED this 17th day of June, 2005, in Tallahassee, Leon County, Florida.

S

T. KENT WETHERELL, II
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Filed with the Clerk of the
Division of Administrative Hearings
this 17th day of June, 2005.

ENDNOTES

1/ Official recognition of the Federal Register pages was taken through an Order issued in DOAH Case No. 04-0455CON on August 19, 2004, which was prior to the consolidation of that case with this case. The parties agreed at the hearing that those materials should be part of the record of this case, even though the file in DOAH Case No. 04-0455CON was subsequently closed. See Transcript, at 6-7.

2/ A Recommended Order was recently issued recommending approval of two LTCHs with a total of 130 beds in District 9. See Select Specialty-Hospital-Palm Beach, Inc. v. Agency for Health Care Admin., Case Nos. 03-2486CON and 03-2854CON (DOAH Apr. 18, 2005).

3/ Unless otherwise indicated, all statutory references in this Recommended Order are to the 2004 version of the Florida Statutes.

4/ The Joint Pre-hearing Stipulation cited the 2003 version of Section 408.035, Florida Statutes, but the parties agreed at the hearing that the 2004 version of the statute applies to CON 9800. See Transcript, at 9-10. Accordingly, the citations to

the 2003 version of the statute in the stipulations quoted from the Joint Pre-hearing Stipulation have been replaced with the corresponding citations to the 2004 version of the statute. Brackets are omitted for ease of reading.

5/ The Joint Pre-hearing Stipulation indicated that the criteria in Section 408.035(1), Florida Statutes (2003), were not applicable because there are no local health plan preferences related to LTCHs. The reference to the local health plan preferences in that subsection was deleted by Chapter 2004-383, Laws of Florida, and the subsection now more generally requires consideration of "[t]he need for the health care facilities and health services being proposed." See § 408.035(1), Fla. Stat.

6/ The GMLOS is a statistically-adjusted value calculated by the federal government for each DRG that takes into account certain types of cases that could skew an arithmetic ALOS. In essence, the GMLOS is the length of time that the "typical" patient would be expected to spend in the hospital for a particular illness/injury.

7/ Table 1-10 of the CON application indicates that the 2003-2003 occupancy rates in District 1 were 61.76 percent for CMR beds, 58.49 percent for hospital-based SNU beds, and 91.84 percent for SNF beds. See Exhibit P2 at 000078. Similarly, the SAAR identifies occupancy rates of 63.63 percent for CMR beds, 47.65 percent for hospital-based SNU beds, and 83.64 percent for SNF beds for calendar year 2003. See Exhibit A-2, at 7.

8/ See Exhibit P2, at 000020. Other letters are in accord. See, e.g., October 1, 2003, letter to Mr. Gregg from Dr. F. James Fleischhauer (Exhibit P2, at 000009 and 000021), which was "reaffirmed" through his letter dated March 23, 2004 (id. at 000008), and which identifies 24 patients treated by his group "who would likely be candidates for admission into an LTACH [sic] if one were conveniently located in Pensacola" and who were otherwise required to remain in the short-term acute care setting since they were too ill to be discharged to a SNF or other traditional post-acute care setting; September 18, 2003, letter to Mr. Gregg from Pensacola Lung Group (id. at 000007 and 000022), which was "reaffirmed" through a letter dated March 23, 2004 (id. at 000006), and which states that "ventilator supported patient[s] must be sent out of the area for current long-term care"; October 7, 2003, letter to Mr. Gregg from Dr. Barbara H. Wade (id. at 000025 and 000027), which identifies six patients treated by her group "who would likely be candidates

for admission into LTACH [sic] if one were conveniently located in Pensacola"; October 8, 2003, letter to Mr. Gregg from Tina Craft and Sue Kearney, the managers of case management and social services, respectively, at Sacred Heart Hospital (id. at 000026), which states that "[s]killed nursing facilities in our community are not able to meet the needs of our patients who require ventilator support."

9/ The methodology used by Kindred Hospitals East, LLC (Kindred) and accepted by the Agency in Select-Marion was more conservative than either of the methodologies presented in Select-Escambia's application. Kindred's methodology defined long-stay patients as those with lengths of stay at least 17 days longer than the GMLOS, and in calculating the potential LTCH days generated by those patients, Kindred excluded the days before the GMLOS as well as the first seven days after the GMLOS. See Select-Marion, supra, at 34. The purpose of excluding the first seven days after the GMLOS was to "take[] into account the fact that hospitals typically do not consider the transfer of patients to an LTCH until after the GMLOS and that it typically takes several days for the transfer to be coordinated once the patient has been identified as a potential LTCH patient." Id. Neither of the methodologies presented in Select-Escambia's application take into account the delay-in-transfer issue discussed in Select-Marion, but the Agency did not argue in the SAAR, at the final hearing, or in its PRO that the methodologies are deficient for that reason.

10/ See Exhibit P2, at 000097 (stating that the calculation of the excess days "identifies the days acute care hospitals incurred [] for treating long-stay patients" and the calculation "provide[es] an estimate of the potential long-term care hospital patient days").

11/ In making this finding, the undersigned did not overlook the data in the CON application that purports to show that charity patients represented only 0.02 percent of patient days in the Florida LTCHs in calendar year 2003. See Exhibit P2, at 000288. However, Select-Escambia's health planner testified at the hearing that the statewide average for charity patients was "under one percent, it might be .9 or .94 or something like that" (Transcript, at 125), which is consistent with the percentage identified in the SAAR. See Exhibit A-2, at 20-21.

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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.