STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

KINDRED HOSPITALS EAST, LLC,	)	
	)	
Petitioner,	)	
	)	
vs.	)	
	)	Case No. 05-2745CON
AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
	)	
Respondent,	)	
	)	
	)	

RECOMMENDED ORDER

This case was heard by David M. Maloney, Administrative Law Judge of the Division of Administrative Hearings on September 13 and 14, 2005, in Tallahassee, Florida.

APPEARANCES

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STATEMENT OF THE ISSUE

Kindred Hospitals East, LLC (Kindred) filed CON Application 9831 with the Agency for Health Care (AHCA or the "Agency"). The application seeks the establishment of a 60-bed Long Term

Care Hospital (an "LTCH") in Volusia County, AHCA Health Care Planning District 4. The Agency preliminarily denied the application. Kindred has challenged the denial.

The issue in this case is whether the application should be approved.

PRELIMINARY STATEMENT

On July 28, 2005, the Agency filed a notice with the Division of Administrative Hearings (DOAH). The notice advised DOAH that AHCA had received a request for a formal hearing from Kindred. The Agency further requested that DOAH assign the matter to an administrative law judge to conduct all proceedings required by law.

Attached to the notice is Kindred's petition. It requests appropriate administrative relief including submission of a recommended order to AHCA recommending approval of CON Application No. 9831.

On July 29, 2005, the undersigned was designated as the administrative law judge to conduct the proceeding and an Initial Order was sent to the parties.

A Notice of Hearing was issued on August 11, 2005. It set final hearing for a three-day period from August 31 through September 2, 2005. The case was continued and ultimately proceeded to final hearing on September 13 and 14, 2005.

As the applicant and the party with the burden of proof, Kindred proceeded first. It presented the live testimony of two witnesses: James John Novak, Senior Vice President of Kindred Healthcare, Inc.'s hospital division, accepted as an expert in the fields of health care administration and LTCH administration; and Clarence "Bud" Wurdock, Director of Market Planning for Kindred Healthcare, Inc., accepted as an expert in the field of health care planning. Eight exhibits were marked for identification as Kindred Nos. 1 through 4 and 7 through 10, either during the final hearing or as late-filed exhibits (Kindred Nos. 3 and 4, both transcripts of depositions were filed on September 30, 2005.) All were admitted into evidence.

Among the eight exhibits were three depositions: the first of Sean Muldoon, M.D., Chief Medical Officer of Kindred Healthcare Inc.'s hospital division; the second of Timothy Simpson, Chief Executive Officer of Kindred Hospital-North Florida in Clay County, Florida; and, the third of Julie Peters, Managed Care and Marketing Specialist for Kindred Hospital-North Florida.

Dr. Muldoon was tendered as a expert in pulmonary disease, internal medicine, preventive medicine, and critical care medicine. During his deposition, the Agency announced that it had no objection to Dr. Muldoon's acceptance as an expert in the fields tendered. He is so accepted.

Likewise, Mr. Simpson was tendered during his deposition as an expert in LTCH administration without objection from AHCA. He is hereby accepted as an expert in the field as tendered.

The process with respect to Ms. Peters' expertise was not as smooth. She was tendered as an expert in the fields of LTCH management, LTCH marketing, and LTCH public relations. From the deposition transcript, it appears that AHCA counsel did not expect the tender with regard to "LTCH marketing and LTCH public relations." See Kindred Ex. 3, p. 9: "MR. ELLIOT: . . . I heard marketing and public relations. I mean, what, more specifically, is the area that covers, as applied to this case?" Counsel, therefore, conducted a brief voir dire that concluded with the following question:

> Q And what would be your ultimate . . . opinion . . .on that issue, . . . marketing and public relations?

Kindred Ex. 3, p. 10. The question was followed by a colloquy that ended with an objection from counsel for AHCA:

> MR. ELLIOT: I'm going to just state an objection on the record to her qualification as an expert in that area. I understand what her qualifications are, but I'd just like the objection on the record and just let the administrative law judge consider that issue and rule on it. And then, of course, you all can go forward from here.

Id., pgs. 10-12. The last-quoted statement is interpreted to mean that AHCA maintained its objection to the tender of

Ms. Peters in the fields of LTCH marketing and LTCH public relations. The objection is overruled and Ms. Peters is accepted as an expert in the fields in which she was tendered.

The Agency presented the testimony of Karen Rivera, a Health Services and Facilities Consultant Supervisor in AHCA's CON Office in the Bureau of Health Facility Regulation. Ms. Rivera is the primary person in the Agency who supervises reviews of CON applications. She was accepted as an expert in both health care planning and CON review.

The Agency submitted to the administrative law judge a notebook of documents that listed in its index as "AHCA Exhibits," sixteen exhibits, under tabs 1 through 16. The index lists the deposition of Karen Rivera as No. 16, but the transcript of the deposition is not contained in the notebook, presumably because the Agency opted to present Ms. Rivera's testimony live. Of the remaining 15 exhibits, No. 11 was not offered. AHCA No. 8 was offered, admitted but then withdrawn. The rest of AHCA's exhibits, Nos. 1 through 7, 9, 10 and 12 through 15 were admitted into evidence and considered for purposes of this Recommended Order.

The parties entered into a detailed Prehearing Stipulation. An Amended Prehearing Stipulation ("Amended Stipulation") was subsequently presented. The Amended Stipulation corrected clerical errors and, as had the earlier stipulation, resolved a

substantial number of issues regarding the application of statutory and rule criteria regarding Kindred's application. In the wake of the Amended Stipulation, the issues remaining concern, generally, the need for Kindred's proposed facility, the accessibility of existing LTCH facilities, and whether competition would be promoted by Kindred's proposed facility.

The two-volume transcript of the final hearing was filed September 26, 2005. At the conclusion of the final hearing, the parties agreed to file proposed recommended orders by Friday, October 21, 2005. Three unopposed motions filed by AHCA to extend the time for the filing of proposed orders were granted. Proposed orders were timely filed on November 21, 2005.

This Recommended Order follows.

FINDINGS OF FACT

The Parties

1. Kindred, the operator of 22 LTCHs, is a wholly-owned subsidiary of Kindred Healthcare, Inc. Through its subsidiaries, Kindred Healthcare, Inc., operates 75 LTCHs nationwide, seven of which are in Florida. Of the seven Florida facilities, Kindred operates six. If CON Application 9831 is approved and the proposed facility becomes operational, therefore, Kindred will become the operator of 23 LTCHs, seven of which are in Florida.

2. The Agency is the state agency responsible for administration of the Certificate of Need program. See § 408.031, Fla. Stat., et seq.

Kindred North Florida and District 4

3. Kindred currently operates a 40-bed freestanding LTCH in Clay County ("Kindred North Florida"). Although in Clay County, Kindred North Florida is considered by Kindred to be in the area of Jacksonville or Duval County, a center of population greater than Clay County's.

4. Kindred proposes to build and operate the project subject to CON Application 9831 in Volusia County, approximately 80 miles south of Kindred North Florida. Volusia County is one of seven counties that comprise District 4, a health service planning district established by the Health Facility and Services Development Act. In addition to Volusia, Clay, and Duval Counties, the other counties that make up District 4 are Baker, Nassau, St. Johns, and Flagler.

Stipulated Facts

5. The parties have stipulated to the following facts:

a. Kindred's CON application complies with statutory and rule application content, submission, filing fee and review process requirements; and the Agency's review complied with review process requirements.

b. Kindred has the ability to provide a quality LTCH program.

c. Kindred has the necessary resources, including health personnel, management personnel, and funds for capital and operating expenditures, for project accomplishment and operation.

d. Kindred's project is likely to be financially feasible.

e. Kindred's proposed costs and methods of construction are reasonable.

f. There are no disputes regarding Kindred's proposed provision of services to Medicaid patients and the medically indigent.

g. The statutory criterion relating to nursing home beds is not applicable.

h. Kindred complied with the letter of intent requirements found in AHCA rules.

i. AHCA did not at the time of review, and currently does not, calculate a fixed need pool for LTCH beds.

Amended Stipulation, at pp. 4-6.

LTCH Services

6. The length of stay in the typical acute care hospital (a "short-term hospital") for most patients is three to five days. Some hospital patients, however, are in need of acute care services on a long-term basis ("LTCH services"), that is, much longer than the average lengths of stay for most patients. Patients in need of LTCH services often have lengths of stay in the hospital that exceed the typical three-to-five day stay in a short-term hospital by 20 to 22 days or more.

7. Some patients who exceed the usual short-term lengths of stay by similar lengths are not appropriate for LTCH services. Their stays are regarded more as custodial in nature. Those in need of LTCH services, whose stays are not custodial, however, are generally better served in an LTCH than in a short-term hospital.

8. Patients appropriate for LTCH services represent a small but discrete sub-set of all inpatients. They are differentiated from other hospital patients in that, by definition, they have multiple co-morbidities that require concurrent treatment. Patients appropriate for LTCH services tend to be elderly, frail, and medically complex and are usually regarded as catastrophically ill.

9. Some LTCH patients, however, are not elderly. These younger LTCH patients are often victims of trauma. Whatever the age of LTCH patients, they are typically medically unstable for their entire hospital stay. Because of their status as medically unstable, complex and seriously ill, they require extensive nursing care and daily physician oversight. Very often their care involves some sort of technologically advanced support such as a ventilator.

Case Mix and Patient Acuity

10. A "case mix index" for a hospital is a measure of its average resource consumption. Resource consumption can be

viewed as a surrogate measure of complexity and severity of illness. The case mix index of Kindred hospitals is high compared to the entire LTCH industry and, as would be expected, is higher than the average case mix index for short-term hospitals.

11. A way to further refine the variation of patients' acuity within a diagnostic related group (DRG) is through the APRDRG system. Not routinely used in hospitals, it is a tool of health services research. The system assigns not only a DRG but a severity of illness as well on a scale of one (minor severity) to four (extreme severity.) Applying the system to Kindred's database as well as to federal data confirms that the distribution of severe and extremely severe cases is skewed toward LTCH patients. This confirmation is consistent with empirical observation that patients in LTCHs are sicker on average than those in general hospitals.

12. A third measure of patient acuity routinely used in Kindred hospitals is an APACHE score. It was described by Dr. Muldoon in his deposition testimony in the following way:

> [A]n APACHE score . . . is a combination of physiologic derangement and concurrent illnesses. While not universally applied to the LTAC [sic] population, it is a routine measurement in Kindred Hospitals.
>
> Using that indicator, we find that the average Kindred patient has an APACHE III score of about 45, whereas the average

> critical care patient in all of short-term acute care has a score about two-and-a-half points higher. This further supports the observation that LTACs [sic] in the Kindred portfolio treat a severely ill population only a few points, on the APACHE measure, below that of critical care units across the country.

(Kindred Ex. 2, p. 15).

13. The comparisons of acuity levels between LTCHs in general and short-term hospitals or Kindred LTCHs and short-term hospitals, while they show that the Kindred LTCH population is at a higher acuity level than patients in short-term hospitals, do not prove that Kindred LTCH patients are all appropriate for LTCH services. The Agency does not by rule define the level of acuity for admission of a patient to an LTCH. Nor has it done so by order. Information on acuity level of patients in short-term hospitals is not available through the AHCA's health statistics data base.

14. That acuity levels are higher for Kindred's LTCHs than short-term hospitals does not necessarily mean that all patients admitted to Kindred hospitals are appropriate LTCH patients. One of the bases Kindred advances for why LTCH beds are not available in the district, despite low occupancy rates of Specialty Hospital of Jacksonville (Specialty or "Specialty Jacksonville") for the last several years (see paragraph 36, below), is that Specialty lowers utilization of its beds by

restricting admission to patients of higher acuity than threshold LTCH acuity. The assertion does not prove that LTCH beds are unavailable in District 4. Rather, it begs a series of questions: does Specialty refuse patients with LTCH-appropriate acuity levels, does Kindred admit some patients whose acuity level would allow them to be served appropriately in an alternative post-acute care setting, or is the answer a combination of both?

Districts Without LTCHs: Restricted Choice

15. In those health care planning districts that do not have LTCHs, hospital patients in need of long-term acute care typically have little choice but to stay in the short-term hospital. The short-term hospital is usually dissatisfied with such an arrangement and short-term hospital staff, oriented toward stabilizing and treating the patient on a short-term basis, may lose interest in the patient after the patient exceeds the average length of stay associated with the patient's diagnosis. The patient can opt to transfer to an LTCH a long distance from home or to be treated in a setting that is less than appropriate for their level of acuity such as a skilled nursing unit of a nursing home. Neither option presents much appeal to the patient in need of LTCH services or the patient's family.

16. Transfer to a distant LTCH is difficult and inconvenient for the patient's family. Consequently, such a transfer creates a hardship for the patient in need of family visits. Such a transfer also presents the possibility of one of two less-than-optimal results: the family loses contact with the loved one or family members have to relocate to the area of the LTCH. Re-location frequently entails significant hardship.

17. Opting for a nursing home in the family's locality is not adequate for a patient in need of LTCH services. With the intensive nursing and daily physician oversight LTCH services entail, a skilled nursing unit in a nursing home is not an adequate setting. Its medical services, quite simply, are not of adequate intensity to the true potential LTCH patient. This difference is but one of several between LTCHs and other providers.

Differences between LTCHs and Other Providers

18. Short-term hospitals and LTCHs do not have the same purpose. The gap is widening between the two. Over the last 20 years, short-term hospitals have evolved into setting that stabilize patients, diagnose, and develop treatment plans. Most admissions to the medical ward of a short-term hospital are through the emergency room where patients are so acute and so unstable that emergency care is required.

19. In their role as diagnostic centers, short-term hospitals provide imaging and laboratory services and then develop a treatment plan based on the diagnostic work-up performed. Short-term hospitals have moved away from the function of carrying out a treatment plan. This is borne out by lengths of stay in short-term hospitals growing shorter over the last 20 years. Lengths of stay now average three to five days. As a result, short-term hospitals have limited capability to provide a prolonged treatment plan for patients with multiple co-morbidities. In contrast, LTCHs do not hold themselves out to be diagnostic or stabilization centers. LTCH have developed expertise in caring for the small subset of patients that require a prolonged treatment plan. A multi-disciplinary physician-based care plan is provided in LTCHs that is not provided in short-term hospitals or other post-acute settings.

20. If there is no LTCH readily available to provide a hospital-level discharge, then the short-term hospital must either keep the patient or discharge the patient to a setting that is less than appropriate for the patients needs. If the hospital keeps the patient, it is often not staffed to give the patient the amount of therapeutic rehabilitation required. The patient is not stable enough to transfer to a comprehensive medical rehabilitation facility. The patient that qualifies for an LTCH has a very different set of needs from many patients in

the intensive care unit and/or medical-surgical (med-surg) beds in a short-term hospital.

21. A very low percentage of all med-surg patients are appropriate for LTCH services. Placing these patients in an LTCH preserves the resources of short-term hospitals and encourages their financial health, which are outcomes driven by Medicare Prospective Payment System (PPS) that provides incentives to discharge patients from short-term hospitals as quickly as possible.

22. Skilled nursing facilities (SNFs) and LTCHs are different both in intent and execution. Stable patients who require minimum medical intervention, whose primary needs are nursing and who are unlikely to become unstable, are appropriate for SNFs. Conversely, LTCHs are appropriate when daily medical intervention is required. Access to diagnostics, laboratory, radiology and pharmacy services make LTCHs better able to respond to changes in conditions and care plans than SNFs.

23. Comprehensive medical rehabilitation hospitals (CMRs) and LTCHs are distinctly different. Geared for patients with primarily neurologic or musculoskeletal orthopedic issues, the CMR care model is based on physical rather than internal medicine that requires a minimum of three hours per day of physical therapy. Internists, therefore, are required to oversee LTCHs rather than other types of medical doctors. While

rehabilitation is a concurrent component of an LTCH, patients appropriate for an LTCH bed, because of their medical conditions, cannot tolerate the three hours per day of therapy per patient conducted at a CMR. A CMR may be an appropriate facility after a stay in an LTCH when the patient has improved to the point where typical CMR therapy can be tolerated.

24. Home health care is no substitute for LTCH care needed by patients appropriate for admission to an LTCH. By definition, LTCH patients meet criteria for inpatient hospitalization. Home health care is designed for patients who are stable and have limited medical needs that can be administered by nurses or families that visit or are in the patient's home. In sharp contrast, LTCH patients require many hours a day of nursing, respiratory, and other therapies under the direct care of a physician.

25. On the basis of regulation alone, short-term hospitals can provide LTCH-type care. Generally, however, they do not. Because of Medicare's PPS, short-term hospitals have evolved into centers of stabilization and diagnosis, where care plans are initiated but not carried out fully. With such an orientation, short-term hospital staff often cannot sustain the focus and interest in a patient whose length of stay greatly exceeds the average length of stay for patients with the same diagnosis. Case studies bear out that when patients who are not

progressing in a short-term hospital are transferred to LTCHs, where a multi-disciplinary approach replaces the diagnostic focus, the patients improve in both medical and physical well-being.

26. In short, in the health care continuum, LTCH care constitutes a component dedicated to catastrophically ill and medically complex patients in need of acute care services that exceed by a considerable amount the average length of stay of those patients in a short-term hospital. Typically medically unstable for the entire time of stay in the short-term hospital, these patients require extensive nursing care with daily physician oversight usually accompanied by some type of technologically advanced support.

Federal Government Recognition of LTCHs

27. The federal government recognizes the distinct place occupied by LTCHs in the continuum of care based on the high level of LTCH patient acuity. The PPS of the federal government treats LTCH care as a discrete form of care. LTCH care therefore has its own system of DRGs and case mix reimbursement that provides Medicare payments at rates different from what PPS provides for other traditional post-acute care providers.

Medicare and the PPS System

28. The federal definition of a "long term care hospital" is a hospital whose average length of stay for Medicare patients

is greater than 25 days. The 25-day length of stay requirement only applies to Medicare patients, not to non-Medicare, such as commercial patients; some of Kindred's LTCHs have a substantial number of commercial pay patients where the average length of stay is not 25 days. The federal government clearly identifies LTCHs as hospitals, separate from SNFs, CMR hospitals, and short-term hospitals. The very earliest LTCHs were primarily chronic care hospitals, but over the past 20 years the LTCH has evolved into a place where people are cared for who require an extended stay in a hospital, not a SNF or CMR facility, and who will benefit from extra therapeutic care, nursing, and equipment that is more orientated toward therapy than the stabilization and diagnosis of acute conditions provided by short-term hospitals.

29. The basic concept of the Medicare PPS is the classification of patients into DRGs based on the services they need and the expenditures the hospital will make to care for the patient. The federal government analyzes these patients by group and identifies what the average cost is for each kind of patient. The classification of the patient by DRG determines the amount the Medicare program will pay the hospital for caring for that patient. As an example, if a patient comes to a short-term hospital and, based on diagnosis and intensity, is classified in DRG 13, there is a certain payment rate attached

to that DRG, and that payment rate will be different from a DRG 14 or 15. The weights determine whether a hospital is paid more or less than the average for a certain type of patient.

30. PPS was designed for Medicare patients, but payers other than Medicare including Medicaid, commercial insurance, and managed care, now also reimburse hospital providers and SNF providers as some function of the PPS. Each sector of the health care industry has a some what different payment system.

31. DRGs were first developed for short-term hospitals, and there are hundreds of DRGs used to determine reimbursement. Not designed to measure acuity and tied to the amount of Medicare reimbursement, DRGs relate to resource utilization.

32. The difference between reimbursement for an LTCH and a short-term hospital has to do with the average rate, which is a figure that varies somewhat from market to market based on labor costs, and the weight which is attached to each of the DRGs. The rate times the weight determines the reimbursement.

33. When a patient is in a short-term hospital much longer than a few days past the average length of stay that the federal government has established for that DRG, financial loss for the hospital mounts. The federal government recognized that problem. It has developed a system using an "outlier" reimbursement, an add-on to the normal DRG payment for a patient who stays for an unusually long time. But, the outlier payment

is calculated to recover only 80 percent of what the federal government estimates to be the hospital's true costs.

34. In response to the PPS system, short-term hospitals have to manage their patients very closely. If a patient falls into the outlier category and is going to be hospitalized substantially longer than the average, short-term hospitals can lose a significant amount of money, so short-term hospitals are constantly searching for discharge options for their patients. Every day of utilization that a short-term hospital can save benefits the short-term hospital financially; as a result, hospitals invest significant effort into developing case management, utilization review, and clinical management departments.

35. Effective October 1, 2002, the Centers for Medicare and Medicaid Services (CMS) implemented categories of payment designed specifically for LTCHs, the "LTC-DRG." The LTC-DRG is a sign of the recognition by CMS and the federal government of the differences between short-term hospitals and LTCHs when it comes to patient population, costs of care, resources consumed by the patients and health care delivery.

Existing LTCHs in District 4

36. There are currently two licensed LTCHs operating in District 4: Kindred's Green Cove Springs facility ("Kindred North Florida") in Clay County and Specialty's Jacksonville

facility in Duval County. Kindred North Florida is approximately 80 miles (and a 1.5 hour drive) from Daytona Beach where Kindred intends to locate its proposed Volusia County facility. Specialty Jacksonville is within 85 miles of Kindred's proposed facility.

37. The LTCH occupancy and utilization rates for District 4 is below 70 percent.

38. Kindred North Florida is a 40-bed LTCH. Specialty Jacksonville is a 107-bed LTCH.

39. Specialty Jacksonville has an occupancy rate that has been consistently below 60 percent. The most recently available data shows an occupancy rate for Specialty of 56 percent. In recent years, it has been even lower.

40. Kindred North Florida has been operating near or above optimal occupancy. Specialty has not.

41. Beds are available within the district.

CON Application Process

42. Kindred submitted CON Application 9831 in the first CON Application Review Cycle of 2005. Kindred was the only applicant for an LTCH CON in District 4 for the batching cycle.

43. The Agency evaluated the application and reported the evaluation in a State Agency Action Report (SAAR) issued on June 1, 2005. The SAAR recommended denial of Kindred's application.

44. A basis for the denial of Kindred's application is summed up in the "Need" section of the SAAR:

> The applicant intends to focus on the provision of complex LTCH services (many requiring ventilator/pulmonary services) and contends patients remain in less appropriate settings in District 4. It maintains that Volusia County is an appropriate service area for this project due to the travel distance to a current LTCH. Although support letters state that many patients would have benefited from LTCH services, the disposition of these patients is not known and access problems to LTCH services was not shown. The applicant did not demonstrate that area residents are unable to access needed care or that care currently being provided is inappropriate.
>
> The applicant's need analysis did not solely consider high acuity patients that are LTCH appropriate that could not be more appropriately treated in lower cost long-term care facilities such as nursing homes and rehabilitation hospitals. As stated earlier, CMS announced that it plans to make changes in its reimbursement to LTCHs this fall with other updates planned for October 1, 2005.
>
> The applicant stated opposition when another LTCH proposed to establish a hospital in this area indicating that its Clay County facility would be adversely impacted and that the establishment of a third LTCH in District 4 would be a duplication of services.

AHCA Ex. 1, p. 28.

45. On June 1, 2005, AHCA adopted the SAAR's recommendation that Kindred's application be denied.

46. Kindred timely challenged the denial of its application and its petition was referred to DOAH for formal administrative proceedings.

Post-stipulation Issues

47. The parties have resolved a number of potential issues by way of the Amended Stipulation. The remaining issues relate to need, access and competition.

LTCH Need Methodology and AHCA's Concerns

48. The Agency has not adopted a need methodology for LTCH services. Consequently, it does not publish fixed need pools for LTCHs.

49. In response to a rise in LTCH application over the last several years, the Agency has consistently voiced concerns about identification of the patients that appropriately comprise the LTCH patient population. Because of a lack of specific data from applicants with regard to the composition of LTCH patient populations, AHCA is not convinced that there is not an overlap between the LTCH patient populations and the population of patients served in other healthcare settings. In the absence of data identifying the LTCH patient population, AHCA has reached the conclusion that there are other options available to those patients targeted by the LTCH applicant, depending on such matters as physician preference.

50. In denying Kindred's application, AHCA relied in part on reports issued to Congress annually by the Medicare Payment Advisory Committee (MedPAC), that discuss the placement of Medicare patients in appropriate post-acute settings. The June 2004 MedPAC report (MedPAC Report) states the following about LTCHs:

> Using qualitative and quantitative methods, we find that LTCHs' role is to provide post-acute care to a small number of medically complex patients. We also find that the supply of LTCHs is a strong predictor of their use and that acute hospitals and skilled nursing facilities are the principal alternatives to LTCHs. We find that, in general, LTCH patients cost Medicare more than similar patients using alternative settings but that if LTCH care is targeted to patients of the highest severity, the cost is comparable.

AHCA Ex. 9, p. 121 (emphasis supplied.) The MedPAC Report, therefore, concludes that LTCHs should "be defined by facility and patient criteria that ensure that patients admitted to these facilities are medically complex and have a good chance of improvement." Id.

51. There is some gross administrative data to support the hypothesis that SNFs are a substitute for LTCHs; the data is limited, however, for drawing such a conclusion definitively. This is because of the wide variation of patient conditions that may be represented by a single DRG. Dr. Muldoon explained this

in his deposition with the example of DRG-475, which groups patients who were on life support for 96 hours:

> [P]atients . . . under DRG-475 . . . may be discharged in conditions that vary greatly, ranging from an alert, talking patient, no longer on life support, to a patient who is not on life support making no progress. There is no[] administrative data that describes patients at the time of their discharge and therefore the MedPAC analysis was just unable, from a pure data point of view, to determine why some of those patients went to a higher versus lower level of care.

Kindred Ex. 2, pgs. 24-25. While the conclusion that there is overlap is suspect, so is the conclusion that there is no significant overlap. The data is insufficient to conclude that there are only an insignificant number of LTCH patients who are not appropriate for treatment in another post-acute care setting. The data is insufficient to make one judgment or another.

52. The SAAR also concludes, based on a letter from the MedPAC Chairman, that LTCH patients cost Medicare more on average than patients in other settings. This conclusion was also critically analyzed by Dr. Muldoon:

> [The comment] is based on an analysis that is unable to differentiate patients within a DRG based on their severity at the time of discharge. The limitation on the DRG is that it is designed to describe the patient's need at the time of admission rather than discharge. So there is no way

> to tell whether someone is in good shape or poor shape at the time of discharge.
>
> So lumping them together and then observing how much they cost, depending on their site of care, is a very rough cut.

Kindred Ex. 2, pgs. 27-28. In contrast, for patients at the extreme of severity and complexity there is a trend for lower cost of care for patients whose care included long-term acute care. Again, however, that the very sickest patients may be treated at a cost in an LTCH comparable to the cost in the short-term hospital does not demonstrate that there are patients who would be admitted to an LTCH at an acuity level not appropriate for an LTCH. This latter category of patients, if it exists, would be treated less expensively in a short-term hospital or a non-LTCH post-acute care setting.

Need Demonstration: the Applicant's Responsibility

53. The Agency analyzes LTCH applications on a district basis[1] but it does not provide a specific formula or methodology by rule for determining need for LTCH beds as it does with some other types of beds and health care services. Consequently, AHCA does not publish a fixed need pool for LTCH beds. Nor did AHCA provide Kindred with any policy upon which to determine need for LTCH beds. Florida Administrative Code Rule 59C-1.008(2)(e) (the "Rule"), therefore, applies to Kindred's application:

> . . . If an agency need methodology does not exist for the proposed project:
>
> 1. The Agency will provide to the applicant, if one exists, any policy upon which to determine need for the proposed beds or service. The applicant is not precluded from using other methodologies to compare and contrast with the agency policy.
>
> 2. If not agency policy exist, 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.

Application of the Rule

a. Population Demographics and Dynamics

54. In assessing an area's population and demographics for the purpose of evaluating LTCH need, special attention is paid to the elderly population. The bulk of LTCH patients are patients over the age of 65 and on Medicare. Elderly patients in need of LTCH services do not heal as quickly as younger patients, are more difficult to wean from a ventilator, and do not improve through rehabilitation as quickly so that they can be discharged from the hospital setting.

55. There are more than 100,000 "seniors," those 65 and over, in Volusia County. Seniors account for more than 20

percent of the county's population; the national average is between 12 and 13 percent.

56. Volusia County was projected to have a senior population of 485,000 out of a total county population of 1.8 million as of January 1, 2005. According to AHCA population data, over the next five years Volusia's elderly population is expected to grow by another 10 percent.

57. Volusia also accounts for a disproportionate share of all of the seniors in District 4. Its senior population is almost 40 percent of the senior population in the district.

b. Availability, Utilization and Quality of Like Services

58. In evaluating the availability, utilization and quality of like services under the rule, Kindred points out that there are a significant number of short-term hospitals in Volusia County and a relatively large senior population but no LTCH in the county.

59. The LTCHs to which Volusia County residents have access are either in Orlando or the two other LTCHs in District 4: Kindred North Florida and Specialty Jacksonville. Access for Volusia County residents or patients in short-term hospitals in Volusia County was described at hearing by Clarence Joseph Wurdock, Director of Market Planning at Kindred Health Care:

> Both of these distances [to Orlando and the Jacksonville area] are very substantial. Orlando is more than an hour away, drive

> time, and then the Jacksonville hospitals [Kindred North Florida and Specialty] are 70 to 80 miles away.
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> * * *
>
> So as far as access goes, it's not that Volusia County does not have access. The question is whether it's reasonable access for the majority of people who would benefit from the services that we offer. And given the distances involved, it would be very hard to argue that the typical potential long-term hospital patient of Volusia County really has access. Yes, we do get patients at our hospital in Green Cove Springs [Kindred North Florida], a few of them do go to Jacksonville Specialty and some of them go to Orlando, but generally, our understanding is that these patients tend to be the most acute, the patients who really need this type of care so much that they're willing -- they or their families are willing to go great distances for their care.
>
> On the other hand, the majority of long-term hospital potential patients, patient who would benefit from our services, who are still spending a fair amount of time in the short-term hospitals, those patients are at that point where they're not willing, they or their families are not willing to go that far, so consequently they're remaining in the short-term hospital. So there's an access problem.

Tr. 70-71 (emphasis supplied).

60. Of the two "Jacksonville area" LTCHs, Kindred North Florida has been operating around 90 percent occupancy; Specialty, licensed for 107 beds, according to most recently

available data at 56 percent and for some time at various levels all below 60 percent.

61. As Kindred concedes, reasonableness of access is a judgment call. See Kindred's Proposed Recommended Order, p. 20. Contrary to Kindred's present claim of "no reasonable access," Kindred North Florida indicated two years before the hearing that Volusia County patients had access in the District to LTCH services. See paragraphs 69 and 70, below. Relevant data has not changed in the two years between Kindred North Florida's statement and the final hearing in this case.

62. A map in Kindred's CON application identifies the location of five short-term hospitals in Volusia County. The two largest (Halifax Medical Center and Florida Hospital-Ormond) are within two to five miles of Kindred's proposed location. Kindred's CON application contained letters of support from the CEOs of Halifax Community Health Systems and Florida Hospital Deland. Both hospital CEOs strongly support Kindred's application as a source of continued inpatient care for their medically complex patients. There were a number of letters of support in the application from Volusia physicians who have referred patients to Kindred North Florida in the past, and are familiar with Kindred's services and abilities.

c. Medical Trends

63. As to medical trends, as found earlier, LTCHs are recognized as a legitimate part of the health care continuum by the federal government. Medicare's PPS provides reimbursement for LTCHs under their own discrete set of DRGs so that reimbursement rates are different for LTCHs from short-term hospitals. LTCHs supplement acute care following the short-term hospital stay and they are complementary to SNFs and other post-acute care providers. The trend is for LTCHs to be increasingly used to meet the needs of patients in other settings who for a variety of reasons are better served in LTCHs.

d. Market Conditions

64. Market conditions do not favor the application.

65. The occupancy rate overall in the District indicates that beds are available. Of the two "Jacksonville area" LTCHs, Specialty has had an occupancy rate below 60 percent. According to "data over the past few years . . . [it has] been operating at that level for some period of time."[2] (Tr. 73).

66. It is reasonable to assume that Volusia County patients in need of LTCH services and their families, no matter how inconvenient or what hardship may be entailed, will seek admission to the existing LTCHs in the District or to Orange County facilities if LTCH services are truly needed and valued.

67. Other changes in the market that have occurred in the last several years also diminish Kindred's case. Besides approval to Kindred-North Florida to add another 20 beds at its facility in Clay County, additional beds can now be added by existing LTCH facilities at will. These include both the Kindred-North Florida facility and the Specialty facility.

68. Kindred's claim of favorable market conditions is undercut, moreover, by recent objections to two other District 4 LTCH applications on the basis that there was no need in District 4, and the implication, if not direct statement, that there is no access problems for Volusia County residents in need of LTCH services.

69. In a letter on Kindred Healthcare letterhead, dated April 12, 2004, Mr. Wurdock wrote:

> On behalf of Kindred Hospital North Florida, this letter is submitted in opposition to the Certificate of Need application (action number 9752) filed by Select Specialty Hospital - Duval, Inc. to establish a long-term acute care hospital of up to 40 beds at Shands-Jacksonville Medical Center. Kindred Hospital North Florida has consistently provided high quality long-term acute care in District 4 for many years. Approval of an application for an additional long term hospital in District 4 will have a significantly adverse impact on the future of Kindred Hospital North Florida and will result in a wasteful duplication of services in District 4.
>
> In January of 2004, the Agency for Health Care Administration (AHCA) granted Kindred

> Hospital North Florida a Certificate of Need to add 20 beds, increasing our total offering to 80 beds and enhancing our capacity to serve the residents of District 4. Including this bed increase, the long-term acute care occupancy of District 4 is approximately 59 percent. Utilizing existing providers is the most cost-effective option for the district, thus eliminating any duplication of services and minimizing additional start-up costs. The occupancies of existing providers in the district clearly indicate there is not a need for an additional long-term acute care hospital in District 4.

AHCA Ex. 4, page 1 (emphasis supplied).

70. Less than six months earlier, Mr. Simpson in a letter dated October 31, 2003, on Kindred Hospital North Florida letterhead, objected to a Volusia County LTCH CON application:

> On behalf of Kindred Hospital North Florida, I submit this letter in opposition to the Certificate of Need application (action number 9706) filed by SemperCare of Volusia, Inc. to establish a long-term acute care hospital of up to 50 beds at Florida Hospital Oceanside. Kindred Hospital North Florida has been providing high-quality long-term acute care in District 4, including many patients in Volusia Count, for the past nine years. Approval of an application for an additional hospital in District 4 will have a significant adverse impact on the future of Kindred Hospital North Florida and will result in a wasteful duplication of services in District 4.
>
> In December 2002, the Agency for Health Care Administration (AHCA) granted Kindred Hospital North Florida with preliminary approval to add 20 beds, increasing our total offering to 80 beds and enhancing our capacity to serve the residents of District

> 4. Including this bed increase, the long-term acute care occupancy of District 4 would be approximately 59 percent (Kindred Hospital North Florida: 68 percent and Specialty Hospital Jacksonville: 52 percent - *Florida Hospital Bed Service Utilization by District,* July 2003). Utilizing the existing providers is the most cost effective option for the district, thus eliminating any duplication of services and minimizing additional start-up costs that are ultimately passed on to the consumer. The occupancies of existing providers in the district clearly indicate there is not a need for an additional long-term acute care hospital in District 4.
>
> Kindred Hospital North Florida has a strong working relationship with hospitals in Volusia County. In 2002, approximately 26 percent of our patients were referred from hospitals in Volusia County.

AHCA Ex. 5 (emphasis supplied). The evidence, as a whole, in this proceeding supports the claims made by Kindred North Florida in the two letters. Data has not changed significantly, moreover, since the letters were written.

71. By way of explanation of its earlier position, Kindred pointed out that at the time of the submission of the letter opposing the establishment of a Volusia County LTCH, neither it nor Kindred North Florida had conducted a detailed need analysis for Volusia County. A need analysis conducted subsequent to the statement of opposition to a Volusia County LTCH is presented in the CON application in this proceeding. It includes Kindred's need methodology.

Kindred's Need Methodology

72. The need methodology employed by Kindred is a variation of commonly used and accepted methodologies[3] in the LTCH industry for determining need in a proposed service area. In this case the proposed service area is Volusia County.

73. The methodology provides a multi-step process. It begins with the examination of AHCA discharge data for short-term hospitals. Kindred began the process in this case, therefore, with identification of short term hospital patients in Volusia County and limited this population to Florida citizens. The methodology incorporates two assumptions: one, that patients will require five days to transfer from the short term hospital after the geometric mean of the length of stay (GMLOS) for the patient's DRG and that the patient will be in the LTCH for at least 10 days. The result of the assumptions in Kindred's calculation in this case is that the potential pool of Volusia County LTCH patients "had to have exceeded their [GMLOS] by more than two weeks." Tr. 88. Application of the assumptions to AHCA's database, therefore, arrived at a population "that could reasonably be expected to be long-term hospital admissions." Tr. 88. For that population, a population that exceeded the GMLOS by more than two weeks, the Kindred summed up the number of days the population spent in the hospital in excess of the GMLOS plus five days as required by

the methodology. This sum equaled potential LTCH days. This grand total of days was divided by the number of days in a year, 365, as called for by the methodology. The calculation for the twelve month period ending in March of 2004 yielded an average daily census of 40.8. The methodology further considered Volusia County patients receiving services at Kindred North Florida. When they were added into the calculation, the average daily census of potential LTCH patients from Volusia County increased to 47.2. The methodology includes the impact of future population growth at an 8.2 percent rate. This yielded an additional average daily census of 3.9 so that the potential average daily census increased to 51.1. As a final step, the methodology assumes operation of a new LTCH at an 85 percent occupancy rate. Application of this assumption yielded a bed need in Volusia County of 60 beds.

74. The methodology assumes that 100 percent of the eligible pool of potential LTCH patients are going to be referred to an LTCH. Kindred concedes that the actual referral rate is likely to be less than 100 percent and certainly so in the beginning. Kindred's application, therefore, provides a ramp up period. Kindred believes furthermore that the less than 100 percent referral rate is offset by patients that do not come from acute care hospitals.

75. Application of the methodology in this case is flawed. It is also not applicable legally to this CON case.

76. The methodology is flawed in this case first because it does not account for beds available elsewhere in the District. Kindred postulated that Specialty's sub-60 percent occupancy rates are due to Specialty's decision to limit utilization of the number of beds far below the licensed capacity for beds. This assertion by Kindred is rejected as unsupported by adequate proof. See endnote 2, below.

77. The methodology, moreover, determines need generated solely by and within Volusia County, one county in District 4, a multi-county district. Consistent with the CON Law, AHCA approaches LTCH need on a district-wide basis. Methodologies for LTCH bed need on a county basis in a multi-county district have been held by AHCA to be invalid to legally establish need for CON purposes. See Select Specialty Hospital-Marion, Inc. vs Agency for Health Care Administration, Case No. 04-0444CON (DOAH October 31, 2005, AHCA December 21, 2005).

Competition

78. Kindred concedes that "[h]aving an LTCH in Volusia County would not foster competition in the traditional sense." Kindred's Proposed Recommended Order, p. 33.

79. The Agency did not intend to give considerations of competition much weight in this proceeding.

CONCLUSIONS OF LAW

80. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding. §§ 120.569, 120.57(1), and 408.039(5), Fla. Stat.

81. Kindred has the burden to prove by a preponderance of the evidence that its CON application should be approved. See Boca Raton Artificial Kidney Center, Inc. v. Department of Health and Rehabilitative Services, 475 So. 2d 260 (Fla. 1st DCA 1985).

82. In light of the parties' stipulation and the neutral role of criteria related to competition, a balancing of statutory and rule criteria turns on need and access to LTCH services. The balance does not favor Kindred's application.

83. The determination of need in this case is governed by the Rule since AHCA does not have an LTCH need methodology. The Rule requires the applicant to demonstrate need through a "needs assessment methodology." Fla. Admin. Code R. 59C-1.008(2)(e).

84. The methodology used by Kindred does not account for unused LTCH beds in the district. There is inadequate proof, moreover, for Kindred's assumption that Volusia County patients do not have access to the unused District 4 LTCH beds. Furthermore, the methodology yields bed need as if Volusia County were the health planning district. The methodology fails to determine need on a district-wide basis as required by law.

Select Specialty Hospital-Marion, Inc. vs. Agency for Health Care Administration, Case No. 04-0444CON (DOAH October 31, 2005, AHCA December 31, 2005).

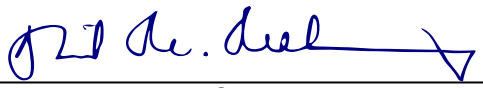
85. In short, Kindred's methodology yielded bed need in Volusia County, rather than on a district-wide basis as required by law. Kindred failed to prove that Volusia County patients do not have access to unutilized beds elsewhere in District 4. The failure to take into account available beds in the district also makes the methodology inapplicable in this case.

86. Kindred has not met its burden of proof in this case.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is recommended that the Agency for Health Care Administration deny CON application No. 9831 filed by Kindred Hospitals East, LLC.

DONE AND ENTERED this 20th day of January, 2006, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 20th day of January, 2006.

ENDNOTES

1/ The Rule refers to evaluation on either a District or sub-district basis. "'Subdistricts' mean a subdivision of a district designated by the local health council as established under Rules 59C-2.100 and 59C-2.200, F.A.C." Fla. Admin. Code R. 59C-1.002(38). Kindred did not counter the Agency's approach with proof that Volusia County is a validly designated subdistrict. The Agency's evaluation on a District basis follows the Rule.

2/ Kindred attempted to explain away the low occupancy rate of Specialty with this assertion made by Mr. Wurdock in his testimony: ". . . based on information from the market our understanding now is that Jacksonville Specialty does have a lot of paper beds that exist[.] [I]in reality, they have chosen not to use those beds." (Tr. 73). This testimony was objected to on the basis that it was hearsay. No attempt was made to have the hearsay ruled admissible over objection in civil actions. See § 120.57(1)(c), Fla. Stat. The testimony of Mr. Wurdock supplemented deposition testimony by Timothy L. Simpson, CEO of Kindred-North Florida. Mr. Simpson was asked why Specialty "operates at the 50 to 56 percent level . . ." Kindred Ex. 4, p. 21. Mr. Simpson's testimony also appears to be hearsay but no objection was raised to it. It was more specific than Mr. Wurdock's: "My understanding is that they limit the types of patients they take. They do not take the acuity that we do here at North Florida. They limit their ventilator census . . . [a]nd they also are 98 percent Medicare patients." Kindred Ex. 4, pgs. 21-22. Taken together, the testimony of Mr. Wurdock at hearing as a supplement to Mr. Simpson's deposition testimony and the deposition testimony itself is not adequate to support a finding of fact that beds are not available in the district. Other evidence with regard to acuity levels of Kindred North Florida patients and inferences to be gathered thereby with regard to the higher acuity levels of the Specialty patient population as a whole likewise are not adequate to draw the conclusion that beds are not available at Specialty. The questions remain: does Specialty restrict access to patients with acuity lower than the level of its population who are nonetheless appropriate LTCH patients? Or does Kindred North

Florida admit patients who are at acuity levels that could be treated appropriately in other post-acute care settings?

3/ See Select Specialty Hospital-Marion, Inc. v. AHCA, Case No. 03-2483CON (DOAH April 20, 2004, AHCA September 17, 2004); Select Specialty Hospital-Escambia Inc. v. AHCA, Case No. 05-0319CON (DOAH June 17, 2005, AHCA July 14, 2005.)

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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.