STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

SA-PG SUN CITY, LLC, d/b/a
PALM GARDEN OF SUN CITY et al.,

Petitioners,

vs.

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Respondent.
_____/

DOAH CASE NOS. 06-3824
thru
06-3837
ENGAGEMENT NO. NH05-140J
RENDITION NO.: AHCA-09- 093 -FOF-MDA

FINAL ORDER

This case was referred to the Division of Administrative Hearings (DOAH) where the assigned Administrative Law Judge (ALJ), Lawrence P. Stevenson, conducted a formal administrative hearing. At issue in this proceeding is whether the Agency for Health Care Administration ("AHCA") properly disallowed Petitioners' expense for liability insurance and accrued contingent liability costs contained in AHCA's audit of Petitioners' Medicaid cost reports. The Recommended Order dated October 24, 2008 is attached to this final order and incorporated herein by reference, except where noted infra.

RULINGS ON EXCEPTIONS

Respondent filed exceptions to the recommended order, and Petitioners filed a response to Respondent's exceptions.

In its First Exception, Respondent took exception to the conclusion of law in Paragraph 100 of the Recommended Order, arguing that CMS Pub 15-1 was adopted by the Agency to determine the type of expenditures that are allowable costs. While Respondent's argument may be true, it does not contradict the conclusion of law in Paragraph 100 of the Recommended

Order. The Agency finds that it could not substitute a conclusion of law that was as or more reasonable than that of the ALJ. Therefore, Respondent's first exception is denied.

In its second exception, Respondent took exception to the conclusions of law in Paragraph 103 of the Recommended Order, arguing that there was no record evidence indicating Petitioners disclosed the inclusion of unsupported money as third party insurance until well into the audit, long after it was included in the cost report. Respondent further argued that Petitioners explained the unsupported money as "self insurance", and never provided support to the Agency for the disallowed amount. The conclusions of law in Paragraph 103 of the Recommended Order were based on the findings of fact in the Recommended Order, which, in turn, were based on competent, substantial evidence. See, e.g., Paragraphs 14 and 34 of the Recommended Order; Transcript, Volume I, Pages 73, 81, 110-112 and 116; and Transcript, Volume III, Pages 377-378. "The agency is not authorized to weigh the evidence presented, judge credibility of witnesses, or otherwise interpret the evidence to fit its desired ultimate conclusion." See Heifetz v. Department of Bus. & Prof'l Regulation, 475 So.2d 1277, 1281 (Fla. 1985). Therefore, Respondent's second exception is denied.

In its third exception, Respondent took exception to the conclusions of law in Paragraph 104 of the Recommended Order, arguing that the Agency's inquiry was not limited to whether there was insurance coverage, but whether Petitioners included amount met any of the allowable ways of protecting against malpractice and comprehensive general liability, as required by §2162 of CMS Pub 15-1. The conclusions of law in Paragraph 104 of the Recommended Order were based on the findings of fact in Paragraphs 75 and 76 of the Recommended Order, to which Respondent did not take exception. These findings of fact, were, in turn, based on competent, substantial evidence. See Transcript, Volume III, Pages 285-293. The Agency cannot re-weigh

the evidence to reach conclusions of law that are different than those of the ALJ. See Heifetz. Therefore, Respondent's third exception is denied.

In its fourth exception, Respondent took exception to the conclusions of law in Paragraph 110 of the Recommended Order, arguing that the provisions of CMS Pub 15-1 cited to by the Respondent are applicable to the facts of this matter. The Agency finds that the conclusions of law in Paragraph 110 of the Recommended Order involves a policy consideration for which the Agency has special responsibility, namely the interpretation of the State Plan that the Agency is required to administer. As such, "policy considerations left to the discretion of the Agency may take precedence over findings of fact by an administrative law judge." Gross v. Department of Health, 819 So.2d 997, 1002 (Fla. 5th DCA 2002). Thus, the Agency finds that it has substantive jurisdiction over the conclusions of law in Paragraph 110 of the Recommended Order, and that it could substitute a conclusion of law as or more reasonable than that of the ALJ. Therefore, the Respondent's fourth exception is granted, and Paragraph 110 of the Recommended Order is changed to state:

> 110. In response, Petitioners return to Subsection 409.908(2)(b), Florida Statutes, and the Plan, both of which reference applicable state and federal laws, rules and regulations. The Manual provisions cited by AHCA in disallowing the contingent expenses are applicable.

In its fifth exception, Respondent took exception to the conclusions of law in Paragraph 112 of the Recommended Order, arguing that Petitioners' costs would have been allowable up to the coverage limits for the policies purchased and that, if the minimal coverage of the mature care policies were exceeded, the Petitioners would have been allowed to seek reimbursement for the actual amount of claims accrued during the year. While Respondent's arguments are true, they do not prove that the ALJ's conclusions of law were incorrect. Additionally, the ALJ's

conclusions of law in Paragraph 112 of the Recommended Order were based on findings of fact that were, in turn, based on record evidence (See Paragraphs 8 and 44 of the Recommended Order; Transcript, Volume I, Pages 54 and 100-101; and Transcript, Volume II, Pages 155-156). The Agency cannot re-weigh the evidence to reach conclusions of law that are different than those of the ALJ. See Heifetz. Therefore, Respondent's fifth exception is denied.

In its sixth exception, Respondent took exception to the conclusions of law in Paragraph 115 of the Recommended Order, arguing that the Petitioners did not show that they could not comply with the requirements of the rules, and, in fact, did have commercial insurance coverage for general and professional liability. The conclusions of law in Paragraph 115 of the Recommended Order were based on the findings of fact in Paragraphs 64-66 of the Recommended Order, which, in turn, were based on competent, substantial evidence. See Transcript, Volume II, Pages 205-208. The Agency is prohibited from re-weighing the evidence in order to reach conclusions of law that differ from those of the ALJ. See Heifetz. Therefore, Respondent's sixth exception is denied.

In its seventh exception, Respondent took exception to the conclusions of law in Paragraph 116 of the Recommended Order, arguing that, contrary to the ALJ's conclusions, Petitioners' situation was contemplated by the rules used in this program. The Agency finds that the conclusions of law in Paragraph 116 of the Recommended Order involve policy considerations for which the Agency has special responsibility, namely the interpretation of the State Plan that the Agency is required to administer. The Petitioners chose not to purchase more commercial liability insurance than the policies they purchased. Additionally, Section 2162.6 of CMS Pub 15-1 would have allowed them to recoup expenditures accrued in excess of the insurance coverage in the year those expenditures occurred (See Transcript, Volume III, Page

354) if they had provided documentation of those expenditures. Thus, the Agency finds that it has substantive jurisdiction over the conclusions of law in Paragraph 116 of the Recommended Order and that it could substitute conclusions of law that are as or more reasonable than those of the ALJ. Therefore, Respondent's seventh exception is granted, and Paragraph 116 of the Recommended Order is changed to state:

> 116. However, Petitioners could have purchased commercial insurance even if the premium paid was in excess of the amount of the coverage, and could have recouped expenditures accrued in excess of the insurance coverage in the year those expenditures occurred under Section 2162.6 of CMS Pub 15-1 by providing the Agency with documentation of those expenditures.

In its eighth exception, Respondent took exception to the conclusions of law in Paragraph 117 of the Recommended Order, arguing that the Petitioners could have purchased additional commercial insurance, and that the evidence showed that Petitioners selected a coverage option not allowed under the rules and were seeking reimbursement for amounts that were never spent. Petitioners argued that the conclusions of law in Paragraph 117 of the Recommended Order were supported by the findings of fact in Paragraphs 64-68 and 86-87 of the Recommended Order. While those findings of fact may indicate that Petitioners could not set up some other form of insurance other than purchasing commercial insurance, they do not prove that it was impossible for Petitioners to obtain general and professional liability insurance or that it would have been impossible for Petitioners to recoup their general and professional liability losses. The Agency finds that it has substantive jurisdiction over the conclusions of law in Paragraph 117 of the Recommended Order and that it could substitute conclusions of law that are as or more reasonable than those of the ALJ. Therefore, Respondent's eighth exception is granted and Paragraph 117 of the Recommended Order is hereby stricken in its entirety.

In its ninth exception, Respondent took exception to the conclusions of law in Paragraph 118 of the Recommended Order, arguing that the ALJ's conclusions were contrary to the record evidence, which established that Petitioners had commercial insurance coverage through the mature care policies of $25,000 per facility. The Agency finds that it has substantive jurisdiction over the conclusions of law in Paragraph 118 of the Recommended Order and that it could substitute conclusions of law that are as or more reasonable than those of the ALJ. Therefore, Respondent's ninth exception is granted and Paragraph 118 of the Recommended Order is changed to state:

> 118. While Petitioners could not have been self-insured or established a captive insurance program, the evidence at hearing established that Petitioners could have and did purchase commercial insurance.

In its tenth exception, Respondent took exception to the conclusions of law in Paragraph 120 of the Recommended Order, arguing that the Agency adopted the rules, including the plan, based on its statutory requirement for prospective reimbursement. Additionally, Respondent argued that there was no evidence presented to show that Petitioners incurred expenses for general and professional liability insurance in excess of the amounts paid for the $25,000 mature care policies purchased by Petitioners. However, the ALJ's conclusions of law in Paragraph 120 of the Recommended Order are merely a restatement of Petitioners' case at hearing. Therefore, Respondent's tenth exception is denied.

In its eleventh exception, Respondent took exception to the conclusions of law in Paragraph 121 of the Recommended Order, arguing that general and professional liability insurance is a short term liability, but the amounts included in Petitioners cost report that were referred to as "contingent liabilities" may not be short term and may not ever be expenses. In that case, Petitioner would be covered by CMS Pub 15-1 §2305.A, which deals with the

liquidation of liabilities. However, the ALJ's conclusions of law in Paragraph 121 of the Recommended Order were based on the findings of fact in Paragraphs 75-76 of the Recommended Order, which, in turn, were based on competent, substantial evidence (See Transcript, Volume III, Pages 284-293). The Agency cannot re-weigh the evidence in order to reach conclusions of law that differ from those of the ALJ. See Heifetz. Therefore, Respondent's eleventh exception is denied.

In its twelfth exception, Respondent took exception to the conclusions of law in Paragraph 122 of the Recommended Order, arguing that CMS Pub 15-1 covers when Petitioners' accrued costs would be allowable. The conclusions of law in Paragraph 122 of the Recommended Order involve policy considerations for which the Agency has special responsibility, namely the administration of the Medicaid state plan. The ALJ is incorrect in asserting that CMS Pub 15-1 is apparently silent as to the liquidation of non-current liabilities. CMS Pub 15-1 §2305.A specifically covers this type of liability. Thus, the Agency finds that it has substantive jurisdiction over the conclusions of law in Paragraph 122 of the Recommended Order and that it could substitute conclusions of law that are as or more reasonable than those of the ALJ. Therefore, Respondent's twelfth exception is granted and Paragraph 122 of the Recommended Order is stricken in its entirety.

In its thirteenth exception, Respondent took exception to the conclusions of law in Paragraph 125 of the Recommended Order, arguing that case law shows that Petitioners' contingency costs would not have been paid by Medicare. Respondent also argued that, pursuant to their Medicaid provider agreement, Petitioners have to follow Medicaid policy regardless of what Medicare policy is. The conclusions of law in Paragraph 125 of the Recommended Order involve policy considerations for which the Agency has special responsibility. The cases of Los

Medanos Community Hospital v. Blue Cross and Blue Shield Assoc./Blue Cross of California, HCFA Admr. Dec. (Aug. 2, 1992); and Mt. Diablo Medical Center v. Blue Cross and Blue Shield Assoc., PRRB Dec., No. 90-1202 (July 1, 1996), demonstrate that Medicare would also not have allowed Petitioners' to report the unliquidated liabilities as an expense. Additionally, what Medicare may or may not allow is not germane to the situation. Petitioners agreed to abide by Medicaid policies when they voluntarily entered into Medicaid provider agreements with the Agency. Medicaid policy does not classify the Petitioners' accrued contingency costs as an allowable expense. Thus, the Agency finds that it has substantive jurisdiction over the conclusions of law in Paragraph 125 of the Recommended Order and that it could substitute conclusions of law that are as or more reasonable than those of the ALJ. Therefore, Respondent's thirteenth exception is granted and Paragraph 125 of the Recommended Order is changed to state:

> 125. Petitioners argue that the underscored language provides further support for their argument that the Manual provisions should not be applied to their situation. AHCA employs those provisions to disallow Petitioners' accrued contingency costs for the audit period. However, even under the Medicare system, Petitioners could not have anticipated payment in subsequent reporting periods.

In its fourteenth exception, Respondent took exception to the conclusions of law in Paragraph 126 of the Recommended Order, arguing that the position expressed in the conclusions of law was contrary to clearly expressed opinions from the Federal Department of Health and Human Services. The conclusions of law in Paragraph 126 of the Recommended Order are merely a restatement of Petitioners' argument at hearing and were supported by record testimony (See, e.g., Transcript, Volume I, Pages 51-52 and 138-139). The Agency is prohibited

from re-weighing the evidence in order to reach conclusions of law that differ from those of the ALJ. See Heifetz. Therefore, Respondent's fourteenth exception is denied.

In its fifteenth exception, Respondent took exception to the conclusions of law in Paragraph 127 of the Recommended Order, arguing that, contrary to the ALJ conclusions, the state plan and Rule 59G-1.010 determine the allowance of costs in the cost report for Medicaid cost reimbursement. Respondent argued that Petitioners simply failed to meet any of the rule requirements. The conclusions of law in Paragraph 127 of the Recommended Order involve policy considerations for which the Agency has special responsibility. The Agency agrees with Respondent's arguments and feels that the ALJ erred in concluding that Petitioners could not have complied with the provisions of CMS Pub 15-1. Thus, the Agency finds that it has substantive jurisdiction over the conclusions of law in Paragraph 127 of the Recommended Order and that it could substitute conclusions of law that are as or more reasonable than those of the ALJ. Therefore, Respondent's fifteenth exception is granted and Paragraph 127 of the Recommended Order is changed to state:

> 127. However, there is no distinction between the opinions cited by AHCA and the instant case. In both matters, the parties could have complied with the provisions of the Manual but failed to do so.

In its sixteenth exception, Respondent took exception to the conclusions of law in Paragraph 128 of the Recommended Order, arguing that it is clear that Petitioners' costs for general and professional liability insurance in excess of the $25,000 value of the mature care policies should not be allowed. The Agency agrees with Respondent's argument and finds that it has substantive jurisdiction over the conclusions of law in Paragraph 128 of the Recommended Order and that it could substitute conclusions of law that are as or more reasonable than those of

the ALJ. Therefore, Respondent's sixteenth exception is granted and Paragraph 128 of the Recommended Order is changed to state:

> 128. Based on all the evidence and argument presented in this proceeding, Petitioners' position is incorrect as to the accrued contingent liability costs. Petitioners could have complied with the provisions of the Manual during the audit period. The evidence shows that insurance was available during the audit period because Petitioners purchased such insurance.

In its seventeenth exception, Respondent took exception to the conclusions of law in Paragraphs 129-131 of the Recommended Order, arguing that the Agency's windfall argument was correct and demonstrates the fundamental reason for the Medicaid rules. The Agency finds that it has substantive jurisdiction over the conclusions of law in Paragraph 129-131 of the Recommended Order and that it could substitute conclusions of law that are as or more reasonable than those of the ALJ.

In reaching its conclusion of law, the ALJ overlooks the voluntary nature of Petitioners' participation in Medicaid. The Petitioners voluntarily entered into a contract with the Agency to provide services to Medicaid recipients and thereby agreed to abide by the laws and rules applicable to the Medicaid program. Thus Petitioner has agreed to abide by Rule 59G-6.010, Florida Administrative Code, the state plan (incorporated in Rule 59G-6.010), and CMS Pub. 15-1 (incorporated in the state plan).

The Agency is responsible for administering the Medicaid program and must account to Florida's citizens and the Federal government for each dollar spent. The Agency cannot pay a provider for a claimed expense unless there is supporting documentation. Here, the record evidence establishes the only documented general and professional liability insurance expense that Petitioners had during the audit period was $25,000 per facility for the purchase of mature

care policies. The state plan clearly provides that the Petitioners cannot claim any general and personal liability insurance expense in excess of this amount.

Further, Petitioner's decision to purchase a bankrupt company with inadequate records appears to have been voluntary. A voluntary business decision does not provide a legal basis for a nursing home to unilaterally circumvent Agency rules. If Petitioners had doubts about the law as it applied to their situation, they had means of resolving those doubts. First, they could have requested a declaratory statement from the Agency pursuant to section 120.565, Florida Statutes. Second, they could have requested a variance or waiver from Rule 59G-6.010 (setting forth allowable insurance costs) pursuant to section 120.542, Florida Statutes. There is no evidence or finding that Petitioner attempted to use these means of obtaining Agency guidance prior to these proceedings, and such a variance cannot be granted after the fact or through these proceedings.

Therefore, Respondent's seventeenth exception is granted and Paragraphs 129-131 of the Recommended Order are stricken in their entirety.

In its eighteenth exception, Respondent took exception to the ALJ's Recommendation. However, the Recommendation is not a finding of fact or conclusion of law to which a party can take exception. Therefore, Respondent's eighteenth exception is denied. However, in light of the rulings on Respondent's first seventeen exceptions supra, the Agency declines to adopt the ALJ's Recommendation as written.

FINDINGS OF FACT

The Agency hereby adopts the findings of fact set forth in the Recommended Order.

CONCLUSIONS OF LAW

The Agency adopts the conclusions of law set forth in the Recommended Order, except where noted supra.

ORDER

Based upon the foregoing, the Agency's disallowances in its October 3, 2005 cost report audit are hereby upheld. Petitioners shall govern themselves accordingly.

DONE and **ORDERED** this 26th day of February, 2009, in Tallahassee, Florida.

HOLLY BENSON, SECRETARY
AGENCY FOR HEALTH CARE ADMINISTRATION

NOTICE OF RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO A JUDICIAL REVIEW WHICH SHALL BE INSTITUTED BY FILING ONE COPY OF A NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A SECOND COPY ALONG WITH THE FILING FEE AS PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF RENDITION OF THE ORDER TO BE REVIEWED.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been furnished by U.S. Mail, or by the method indicated, to the persons named below on this 4th day of March, 2009.

RICHARD J. SHOOP, Agency Clerk
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