STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

MADISON POINTE REHABILITATION AND HEALTH CENTER, Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent.	)	Case No. 08-1691
EXCEL REHABILITATION AND HEALTH CENTER, Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent.	)	Case No. 08-1692
COURTYARDS OF ORLANDO REHABILITATION AND HEALTH CENTER, Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent.	)	Case No. 08-1694

BAYSIDE REHABILITATION AND HEALTH CENTER, Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent.	)	Case No. 08-1695
SHORE ACRES REHABILITATION AND HEALTH CENTER, Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent.	)	Case No. 08-1697
PALMETTO REHABILITATION AND HEALTH CENTER, Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent.	)	Case No. 08-1698

ADVANCED REHABILITATION AND HEALTH CENTER, Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent.	)	Case No. 08-1699
WOODBRIDGE REHABILITATION AND HEALTH CENTER, Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent.	)	Case No. 08-1700
NORTH LAKE REHABILITATION AND HEALTH CENTER, Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent.	)	Case No. 08-3155

RECOMMENDED ORDER

Pursuant to notice, a final hearing was conducted in this case on November 19, 2008, in Tallahassee, Florida, before Administrative Law Judge R. Bruce McKibben of the Division of Administrative Hearings.

APPEARANCES

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STATEMENT OF THE ISSUES

The issues in this case are whether Respondent applied the proper reimbursement principles to Petitioners' initial Medicaid rate setting, and whether elements of detrimental reliance exist so as to require Respondent to establish a particular initial rate for Petitioners' facilities.

PRELIMINARY STATEMENT

In September 2007, each of the Petitioners filed an application with the Agency for Health Care Administration ("AHCA" or "the Agency") seeking a Change of Licensed Operator for a long-term health care facility. Each of the Petitioners also filed an application to be part of the Medicaid program in order to receive Medicaid reimbursement for services provided to its eligible residents. During the licensure application process, each Petitioner submitted, as part of its application, a Proof of Financial Ability ("PFA") document intending to prove its ability to operate the subject facility. AHCA reviewed and

approved the PFA for each Petitioner, i.e., deeming each applicant financially sound.

Each of the Petitioners' applications for inclusion in the Medicaid program for reimbursement purposes was also approved. Those applications resulted in the issuance of a Medicaid provider number for each facility.

Subsequent to receiving its license to operate and its Medicaid provider number, each Petitioner received from AHCA a notice of the interim Medicaid rate assigned to the facility for reimbursement purposes. The interim Medicaid rates were, in each Petitioner's case, less than the Medicaid rate projected in the PFA filed as part of the licensure application. Petitioners believe the Medicaid rate set by AHCA was incorrect and contrary to provisions of the Florida Title XIX Long-Term Care Reimbursement Plan (the "Plan").

Petitioners also believe that AHCA had represented that a higher interim Medicaid rate would be issued, that each Petitioner relied upon that representation to its detriment, and that AHCA should be estopped from subsequently assigning a different interim Medicaid rate.

Petitioners timely filed Amended Requests for Administrative Hearings with AHCA, which were then forwarded to the Division of Administrative Hearings ("DOAH") on April 7, 2008, consolidated, and assigned to the undersigned. At the

final hearing, Petitioners called two witnesses: Stanley W. "Sandy" Swindling, shareholder with Moore Stephens Lovelace, P.A., a healthcare accounting firm; and Laura Wilson, shareholder with Moore Stephens Lovelace, P.A. Petitioners offered one independent exhibit which was accepted into evidence; Petitioners also adopted each of Respondent's 31 pre-marked exhibits as joint exhibits, all of which were accepted into evidence. Respondent presented the testimony of four witnesses: Ryan Fitch, regulatory analyst supervisor for AHCA's Financial Analysis Unit, Bureau of Health Facility Regulation; J. Ross Nobles, Medicaid cost reimbursement planning administrator at AHCA's Medicaid Program Analysis Office; Wesley Hagler, regulatory analyst supervisor for AHCA's Medicaid Program Analysis Office; and Tzvi Bogomilsky, representative of Petitioners' long-term care facilities. Respondent's 31 pre-marked exhibits were adopted by Petitioners as joint exhibits and admitted into evidence.

The undersigned granted an unopposed Motion for Official Recognition on September 12, 2008, as to the following: 42 U.S.C. Sections 1396a(13), (28) and (30); 1396(a); 1396d(c) and (f); 1396r(a); 42 C.F.R. Sections 447.250 through 447.280 and 431.108; Chapter 2007-72, Laws of Florida; Sections 409.901, 409.902, and 409.908 and Subsection 409.905(8), Florida Statutes (2007); Florida Administrative Code Rules 59G-4.200 and 6.010;

Florida Medicaid Nursing Facility Services, Coverage and Limitations Handbook; Florida Title XIX Long-Term Care Reimbursement Plan, Version XXXII; and the Provider Reimbursement Manual, CMS Publication 15-1.

The parties advised the undersigned that a transcript of the final hearing would be ordered. Parties were given ten days from the date the transcript was filed at DOAH to submit proposed recommended orders. The Transcript was filed at DOAH on December 5, 2008. Subsequently, the parties filed a joint motion seeking additional time to file their proposed recommended orders and requesting that the 40-page limit for proposed recommended orders be waived. An Order was entered giving the parties until January 16, 2009, to file their proposed recommended orders; the page limit for the orders was extended to not more than 50 pages. Each party timely submitted a proposed recommended order, and they were given due consideration in the preparation of this Recommended Order.

FINDINGS OF FACT

1. There are nine Petitioners in this case. Each of them is a long-term health care facility (nursing home) operated under independent and separate legal entities, but, generally, under the umbrella of a single owner, Tzvi "Steve" Bogomilsky. The issues in this case are essentially the same for all nine Petitioners, but the specific monetary impact on each Petitioner

may differ. For purposes of addressing the issues at final hearing, only one of the Petitioners, Madison Pointe Rehabilitation and Health Center (Madison Pointe), was discussed, but the pertinent facts are relevant to each of the other Petitioners as well.

2. Each of the Petitioners has standing in this case. The Amended Petition for Formal Administrative Hearing filed by each Petitioner was timely and satisfied minimum requirements.

3. In September 2008, Bogomilsky caused to be filed with AHCA a Change of Licensed Operator ("CHOP") application for Madison Pointe.[1] The purpose of that application was to allow a new entity owned by Bogomilsky to become the authorized licensee of that facility. Part and parcel of the CHOP application was a Form 1332, PFA. The PFA sets forth projected revenues, expenses, costs and charges anticipated for the facility in its first year of operation by the new operator. The PFA also contained projected (or budgeted) balance sheets and a projected Medicaid cost report for the facility.

4. AHCA is the state agency responsible for licensing nursing homes in this state. AHCA also is responsible for managing the federal Medicaid program within this state. Further, AHCA monitors nursing homes within the state for compliance with state and federal regulations, both operating and financial in nature.

5. The AHCA Division of Health Quality Assurance, Bureau of Long-Term Care Services, Long-Term Care Unit ("Long-Term Care Unit") is responsible for reviewing and approving CHOP applications and issuance of an operating license to the new licensee. The AHCA Division of Health Quality Assurance, Bureau of Health Facility Regulation, Financial Analysis Unit ("Financial Analysis Unit") is responsible for reviewing the PFA contained in the CHOP application and determining an applicant's financial ability to operate a facility in accordance with the applicable statutes and rules. Neither the Long-Term Care Unit nor the Financial Analysis Unit is a part of the Florida Medicaid Program.

6. Madison Pointe also chose to submit a Medicaid provider application to the Medicaid program fiscal agent to enroll as a Medicaid provider and to be eligible for Medicaid reimbursement. (Participation by nursing homes in the Medicaid program is voluntary.) The Medicaid provider application was reviewed by the Medicaid Program Analysis Office (MPA) which, pursuant to its normal practices, reviewed the application and set an interim per diem rate for reimbursement. Interim rate-setting is dependent upon legislative direction provided in the General Appropriations Act and also in the Title XIX Long-Term Care Reimbursement Plan (the Plan). The Plan is created by the federal Centers for Medicare and Medicaid Services (CMS). CMS

(formerly known as the Health Care Financing Administration) is a federal agency within the Department of Health and Human Services. CMS is responsible for administering the Medicare and Medicaid programs, utilizing state agencies for assistance when appropriate.

7. In its PFA filed with the Financial Analysis Unit, Madison Pointe proposed an interim Medicaid rate of $203.50 per patient day (ppd) as part of its budgeted revenues. The projected interim rate was based on Madison Pointe's expected occupancy rate, projected expenses, and allowable costs. The projected rate was higher than the previous owner's actual rate in large part based on Madison Pointe's anticipation of pending legislative action concerning Medicaid reimbursement issues. That is, Madison Pointe projected higher spending and allowable costs based on expected increases proposed in the upcoming legislative session.

Legislative Changes to the Medicaid Reimbursement System

8. During the 2007 Florida Legislative Session, the Legislature addressed the status of Medicaid reimbursement for long-term care facilities. During that session, the Legislature enacted the 2007 Appropriations Act, Chapter 2007-72, Laws of Florida.

9. The industry proposed, and the Legislature seemed to accept, that it was necessary to rebase nursing homes in the

Medicaid program. Rebasing is a method employed by the Agency periodically to calibrate the target rate system and adjust Medicaid rates (pursuant to the amount of funds allowed by the Legislature) to reflect more realistic allowable expenditures by providers. Rebasing had previously occurred in 1992 and 2002. The rebasing would result in a "step-up" in the Medicaid rate for providers.

10. In response to a stated need for rebasing, the 2007 Legislature earmarked funds to address Medicaid reimbursement. The Legislature passed Senate Bill 2800, which included provisions for modifying the Plan as follows:

- To establish a target rate class ceiling floor equal to 90 percent of the cost-based class ceiling.
- To establish an individual provider-specific target floor equal to 75 percent of the cost-based class ceiling.
- To modify the inflation multiplier to equal 2.0 times inflation for the individual provider-specific target. (The inflation multiplier for the target rate class ceiling shall remain at 1.4 times inflation.)
- To modify the calculation of the change of ownership target to equal the previous provider's operating and indirect patient care cost per diem (excluding incentives), plus 50 percent of the difference between the previous providers' per diem (excluding incentives) and the effect class ceiling and use an inflation multiplier of 2.0 times inflation.

11. The Plan was modified in accordance with this legislation with an effective date of July 1, 2007. Four relevant sentences from the modified Plan are relevant to this proceeding, to wit:

> [1] For a new provider with no cost history resulting from a change of ownership or operator, where the previous provider participated in the Medicaid program, the interim operating and patient care per diems shall be the lesser of: the class reimbursement ceiling based on Section V of this Plan, the budgeted per diems approved by AHCA based on Section III of this Plan, or the previous providers' operating and patient care cost per diem (excluding incentives), plus 50% of the difference between the previous providers' per diem (excluding incentives) and the class ceiling.
>
> [2] The above new provider ceilings, based on the district average per diem or the previous providers' per diem, shall apply to all new providers with a Medicaid certification effective on or after July 1, 1991.
>
> [3] The new provider reimbursement limitation above, based on the district average per diem or the previous providers' per diem, which affects providers already in the Medicaid program, shall not apply to these same providers beginning with the rate semester in which the target reimbursement provision in Section V.B.16. of this plan does not apply.
>
> [4] This new provider reimbursement limitation shall apply to new providers entering the Medicaid program, even if the new provider enters the program during a rate semester in which Section V.B.16 of this plan does not apply.

[The above cited sentences will be referred to herein as Plan Sentence 1, Plan Sentence 2, etc.]

Madison Pointe's Projected Medicaid Rate

12. Relying on the proposed legislation, including the proposed rebasing and step-up in rate, Madison Pointe projected an interim Medicaid rate of $203.50 ppd for its initial year of operation. Madison Pointe's new projected rate assumed a rebasing by the Legislature to eliminate existing targets, thereby, allowing more reimbursable costs. Although no legislation had been passed at that time, Madison Pointe's consultants made calculations and projections as to how the rebasing would likely affect Petitioners. Those projections were the basis for the $203.50 ppd interim rate. The projected rate with limitations applied (i.e., if Madison Pointe did not anticipate rebasing or believe the Plan revisions applied) would have been $194.26.

13. The PFA portion of Madison Pointe's CHOP application was submitted to AHCA containing the $203.50 ppd interim rate.

14. The Financial Analysis Unit, as stated, is responsible for, inter alia, reviewing PFAs submitted as part of a CHOP application. In the present case, Ryan Fitch was the person within the Financial Analysis Unit assigned responsibility for reviewing Madison Pointe's PFA. Fitch testified that the purpose of his review was to determine whether the applicant had

projected sufficient monetary resources to successfully operate the facility. This would include a contingency fund (equal to one month's anticipated expenses) available to the applicant and reasonable projections of cost and expenses versus anticipated revenues.[2]

15. Upon his initial review of the Madison Pointe PFA, Fitch determined that the projected Medicaid interim rate was considerably higher than the previous operator's actual rate. This raised a red flag and prompted Fitch to question the propriety of the proposed rate. In his omissions letter to the applicant, Fitch wrote (as the fourth bullet point of the letter), "The projected Medicaid rate appears to be high relative to the current per diem rate and the rate realized in 2006 cost reports (which includes ancillaries and is net of contractual adjustments). Please explain or revise the projections."

16. In response to the omissions letter, Laura Wilson, a health care accountant working for Madison Pointe, sent Fitch an email on June 27, 2008. The subject line of the email says, "FW: Omissions Letter for 11 CHOW applications."[3] Then the email addressed several items from the omissions letter, including a response to the fourth bullet point which says:

> Item #4 - Effective July 1, 2007, it is anticipated that AHCA will be rebasing Medicaid rates (the money made available

> through elimination of some of Medicaid's participation in covering Medicare Part A bad debts). Based on discussions with AHCA and the two Associations (FHCA & FAHSA), there is absolute confidence that this rebasing will occur. The rebasing is expected to increase the Medicaid rates at all of the facilities based on the current operator's spending levels. As there is no definitive methodology yet developed, the rebased rates in the projections have been calculated based on the historical methodologies that were used in the 2 most recent rebasings (1992 and 2002). The rates also include the reestablishment of the 50% step-up that is also anticipated to begin again. The rebasing will serve to increase reimbursement and cover costs which were previously limited by ceilings. As noted in Note 6 of the financials, if something occurs which prevents the rebasing, Management will be reducing expenditures to align them with the available reimbursement.

17. It is clear Madison Pointe's projected Medicaid rate was based upon proposed legislative actions which would result in changes to the Plan. It is also clear that should those changes not occur, Madison Pointe was going to be able to address the shortfall by way of reduced expenditures. Each of those facts was relevant to the financial viability of Madison Pointe's proposed operations.

18. Madison Pointe's financial condition was approved by Fitch based upon his review of the PFA and the responses to his questions. Madison Pointe became the new licensed operator of the facility. That is, the Long-Term Care Unit deemed the

application to have met all requirements, including financial ability to operate, and issued a license to the applicant.

19. Subsequently, MPA provided to Madison Pointe its interim Medicaid rate. MPA advised Madison Pointe that its rate would be $194.55 ppd, some $8.95 ppd less than Madison Pointe had projected in its PFA (but slightly more than Madison Pointe would have projected with the 50 percent limitation from Plan Sentence 1 in effect, i.e., $194.26). The PFA projected 25,135 annual Medicaid patient days, which multiplied by $8.95, would equate to a reduction in revenues of approximately $225,000 for the first year of operation.[4]

20. MPA assigned Madison Pointe's interim Medicaid rate by applying the provisions of the Plan as it existed as of the date Madison Pointe's new operating license was issued, i.e., September 1, 2007. Specifically, MPA limited Madison Pointe's per diem to 50 percent of the difference between the previous provider's per diem and the applicable ceilings, as dictated by the changes to the Plan. (See Plan Sentence 1 set forth above.)

21. Madison Pointe's projected Medicaid rate in the PFA had not taken any such limitations into account because of Madison Pointe's interpretation of the Plan provisions. Specifically, that Plan Sentence 3 applies to Madison Pointe and, therefore, exempts Madison Pointe from the new provider limitation set forth in Plan Sentences 1 and 2. However,

Madison Pointe was not "already in the Medicaid program" as of July 1, 2007, as called for in Plan Sentence 3. Rather, Madison Pointe's commencement date in the Medicaid program was September 1, 2007.

22. Plan Sentence 1 is applicable to a "new provider with no cost history resulting from a change of ownership or operator, where the previous operator participated in the Medicaid program." Madison Pointe falls within that definition. Thus, Madison Pointe's interim operating and patient care per diems would be the lesser of: (1) The class reimbursement ceiling based on Section V of the Plan; (2) The budgeted per diems approved by AHCA based on Section III of the Plan; or (3) The previous provider's operating and patient care cost per diem (excluding incentives), plus 50 percent of the difference between the previous provider's per diem and the class ceiling.

23. Based upon the language of Plan Sentence 1, MPA approved an interim operating and patient care per diem of $194.55 for Madison Pointe.

24. Plan Sentence 2 is applicable to Madison Pointe, because it applies to all new providers with a Medicaid certification effective after July 1, 1991. Madison Pointe's certification was effective September 1, 2007.

25. Plan Sentence 3 is the primary point of contention between the parties. AHCA correctly contends that Plan

Sentence 3 is not applicable to Petitioner, because it addresses rebasing that occurred on July 1, 2007, i.e., prior to Madison Pointe coming into the Medicaid system. The language of Plan Sentence 3 is clear and unambiguous that it applies to "providers already in the Medicaid program."

26. Plan Sentence 4 is applicable to Madison Pointe, which entered the system during a rate semester, in which no other provider had a new provider limitation because of the rebasing. Again, the language is unambiguous that "[t]his new provider reimbursement limitation shall apply to new providers entering the Medicaid program. . . ." Madison Pointe is a new provider entering the program.

Detrimental Reliance and Estoppel

27. Madison Pointe submitted its CHOP application to the Long-Term Care Unit of AHCA for approval. That office has the clear responsibility for reviewing and approving (or denying) CHOP applications for nursing homes.

28. The Long-Term Care Unit requires, as part of the CHOP application, submission of the PFA which sets forth certain financial information used to determine whether the applicant has the financial resources to operate the nursing home for which it is applying. The Long-Term Care Unit has another office within AHCA, the Financial Analysis Unit, to review the PFA.

29. The Financial Analysis Unit is found within the Bureau of Health Facility Regulation. That Bureau is responsible for certificates of need and other issues, but has no authority concerning the issuance, or not, of a nursing home license. Nor does the Financial Analysis Unit have any authority to set an interim Medicaid rate. Rather, the Financial Analysis Unit employs certain individuals who have the skills and training necessary to review financial documents and determine an applicant's financial ability to operate.

30. A nursing home licensee must obtain Medicaid certification if it wishes to participate in the program. Madison Pointe applied for Medicaid certification, filing its application with a Medicaid intermediary which works for CMS. The issuance of a Medicaid certification is separate and distinct from the issuance of a license to operate.

31. When Madison Pointe submitted its PFA for review, it was aware that an office other than the Long-Term Care Unit would be reviewing the PFA. Madison Pointe believed the two offices within AHCA would communicate with one another, however. But even if the offices communicated with one another, there is no evidence that the Financial Analysis Unit has authority to approve or disapprove a CHOP application. That unit's sole purpose is to review the PFA and make a finding regarding financial ability to operate.

32. Likewise, MPA--which determines the interim Medicaid rate for a newly licensed operator--operates independently of the Long-Term Care Unit or the Financial Analysis Unit. While contained within the umbrella of AHCA, each office has separate and distinct duties and responsibilities.

33. There is no competent evidence that an applicant for a nursing home license can rely upon its budgeted interim rate--as proposed by the applicant and approved as reasonable by MPA--as the ultimate interim rate set by the Medicaid Program Analysis Office. At no point in time did Fitch tell Madison Pointe that a rate of $203.50 ppd would be assigned. Rather, he said that the rate seemed high; Madison Pointe responded that it could "eliminate expenditures to align them with the available reimbursement."

34. The interim rate proposed by the applicant is an estimate made upon its own determination of possible facts and anticipated operating experience. The interim rate assigned by MPA is calculated based on the applicant's projections as affected by provisions in the Plan.

35. Furthermore, it is clear that Madison Pointe was on notice that its proposed interim rate seemed excessive. In response to that notice, Madison Pointe did not reduce the projected rate, but agreed that spending would be curtailed if a lower interim rate was assigned. There was, in short, no

reliance by Madison Pointe on Fitch's approval of the PFA as a de facto approval of the proposed interim rate.

36. MPA never made a representation to Madison Pointe as to the interim rate it would receive until after the license was approved. There was, therefore, no subsequent representation made to Madison Pointe that was contrary to a previous statement.

37. The Financial Analysis Unit's approval of the PFA was done with a clear and unequivocal concern about the propriety of the rate as stated. The approval was finalized only after a representation by Madison Pointe that it would reduce expenditures if a lower rate was imposed. Thus, Madison Pointe did not change its position based on any representation made by AHCA.

CONCLUSIONS OF LAW

38. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding pursuant to Section 120.569 and Subsection 120.57(1), Florida Statutes (2008). Unless otherwise stated herein, all references to Florida Statutes shall be to the 2007 version.

39. The burden of proof in this case is on Petitioners, as they are the parties asserting the affirmative of the issue. Department of Banking and Finance, Division of Securities and Investor Protection v. Osbourne Stern & Co., 670 So. 2d 932, 934

(Fla. 1996); see also Young v. Department of Community Affairs, 625 So. 2d 831 (Fla. 1993). Further, the parties in this case have stipulated that Petitioners bear the burden of proof.

40. Chapter 408, Part II (Sections 408.801 through 408.832), Florida Statutes, the "Health Care Licensing Procedures Act," applies to all providers required to be licensed by AHCA, including "nursing homes, as provided under part II of chapter 400."

41. AHCA is the agency which regulates nursing homes in this state. §§ 400.021(2) and 408.803(1), Fla. Stat. It is unlawful to operate a nursing home without applying to AHCA for a nursing home license. §§ 400.062 and 408.804(1), Fla. Stat. This also applies when a nursing home has a new owner or operator as a result of a change of ownership. §§ 408.806 and 408.807, Fla. Stat.

42. Section 408.806, Florida Statutes, sets forth the nursing home license application process, including a 60-day deadline for AHCA to receive a nursing home licensure application from an applicant in a change of ownership. §§ 408.806(2)(b) and 408.807(2), Fla. Stat. See also Subsections 408.807(1), Florida Statutes, requiring the transferor to notify the Agency in writing at least 60 days in advance of a nursing home change of ownership. Petitioners timely and properly filed their CHOP applications.

43. Florida Administrative Code Rule 59A-4.103 sets forth the administrative rule requirements for an initial, renewal, or change of ownership license to operate a nursing home facility and incorporates by reference into rule nursing home licensure forms. Petitioners complied with these rule requirements.

44. Pursuant to Subsection 408.810(8), Florida Statutes, an applicant for a nursing home license based on a change of ownership must furnish "satisfactory proof of the applicant's financial ability to operate." That statutory subsection also requires the Agency to establish standards and documentation requirements in determining the financial ability of nursing home applicants to operate.

45. AHCA, therefore, has by rule mandated that an applicant for change of ownership must provide a projected balance sheet, projected statement of monthly revenues and expenses (including projected occupancy), projected statement of monthly cash flows, a summary of significant projection assumptions, transaction costs, sources of funds and a projected Medicaid cost report for the first year of operation. Petitioners submitted all required information for the applications at issue.

46. Petitioners also submitted applications to enter the Medicaid program. The Medicaid program is the federal-state medical assistance program authorized by Title XIX of the

Federal Social Security Act, pursuant to which the State of Florida provides medical goods and services to eligible indigent recipients. 42 U.S.C. § 1396a, et. seq.; 42 C.F.R. Parts 400 and 430 through 447; and § 409.901(14), Fla. Stat. AHCA is the single state agency that administers the Medicaid program. §§ 409.901(2), (14), and (15); and 409.902, Fla. Stat.

47. The statutory authority for the Florida Medicaid Program is found in Sections 409.901 through 409.920, Florida Statutes. Florida Administrative Code Chapter 59G contains the applicable administrative rules regulating the Florida Medicaid Program.

48. AHCA may make payments for covered Medicaid goods and services only to an individual or entity with a Medicaid provider agreement in effect with AHCA. § 409.907, Fla. Stat. Each of the Petitioners obtained the requisite Medicaid provider agreement.

49. Because the Agency reimburses licensed Medicaid nursing homes by a prospective payment methodology, each Petitioner had to submit a proposed or projected Medicaid rate based on its overall financial projections. The proposed rates were included in Petitioners' PFA submissions to AHCA. The rates were higher than AHCA would have anticipated for Petitioners.

50. Pursuant to Subsection 409.908(2)(b), Florida Statutes, "[s]ubject to any limitations or directions provided for in the General Appropriations Act, the agency shall establish and implement a Florida Title XIX Long-Term Care Reimbursement Plan (Medicaid) for nursing home care. . . ." Using the terms and provisions of that Plan, AHCA projected Medicaid rates for Petitioners that included limitations. AHCA's projections were based on its interpretation of the Plan.

51. It has been a maxim of Florida law that an agency's interpretation of its own statutes, rules, and policies is given great deference. "[A] reviewing court must defer to an agency's interpretation of an operable statute as long as that interpretation is consistent with legislative intent and is supported by substantial, competent evidence." Floridian Community Bank, Inc. v. Office of Financial Regulation, Division of Financial Institutions, 989 So. 2d 1231, 1233 (Fla. 4th DCA 2008). "An agency's interpretation of the statute that it is charged with enforcing is entitled to great deference." Verizon Florida, Inc. v. Jacobs, 810 So. 2d 906, 908 (Fla. 2002). See also Creative Choice XXV, Ltd. v. Florida Housing Finance Corp., 991 So. 2d 899, 901 (Fla. 1st DCA 2008); and Floridian Community Bank, 989 So. 2d at 1233.

52. See also Brown v. Florida Commission on Ethics, 969 So. 2d 553, 557 (Fla. 1st DCA 2007), which holds in pertinent part:

> A more specific principle in the case law requires the appellate courts to show greater deference to an administrative agency if the agency has interpreted a statute within its jurisdiction. In such a case, the interpretation may have been based on a history that is best known by the agency or special expertise the agency has in applying the statute. To account for these factors, the courts have held that an agency decision construing a statute within its substantive jurisdiction should not be reversed unless it is clearly erroneous (citations omitted).

53. "Furthermore, it is a well-established maxim that an agency's interpretation of its own rules and regulations is entitled to considerable deference." Colonnade Medical Center v. AHCA, 847 So. 2d 540, 542 (Fla. 4th DCA 2003).

54. AHCA has provided competent and substantial evidence in this matter to support its interpretation of the Plan and its rules incorporating the plan. That interpretation is given great deference. There is no basis in law or in the record to reject the Agency's interpretation as applied to the facts of this case.

55. Further, Petitioners have not established any competent support for the proposition that approval of a PFA for licensure purposes (which includes a projected Medicaid per diem

rate) establishes a final Medicaid reimbursement rate for Medicaid purposes. Although there is some overlap, determination of financial ability for purposes of a CHOP application is not tantamount to establishing a Medicaid rate under the terms and provisions of the Plan.

56. The elements of equitable estoppel are: (1) A representation as to a material fact that is contrary to a later asserted position; (2) Reliance on that representation; and (3) A change in position detrimental to the party claiming estoppel, caused by the representation and reliance thereon. Council Brothers, Inc. v. City of Tallahassee, 634 So. 2d 264 (Fla. 1st DCA 1994). Equitable estoppel will apply against a governmental entity only in rare instances and under exceptional circumstances. Id.

57. It is clear that in the instant case, Petitioners submitted a PFA as part of their CHOP applications which included a projected Medicaid reimbursement rate. However, the projected rate was not acceptable to the Financial Analysis Unit as stated. It was only when Petitioners agreed that the projected rate was indeed higher than expected and that they would reduce expenditures if the final rate was lower, did AHCA approve the PFA. There was, therefore, no "representation" on the part of AHCA that the projected rate was acceptable.

58. When, thereafter, MPA calculated a rate that was lower than Petitioners had projected, the assignment of that rate was not contrary to any prior representation by MPA. In fact, the lower rate assigned by MPA confirmed the concerns of the Financial Analysis Unit stated in its omissions letter to Petitioners.

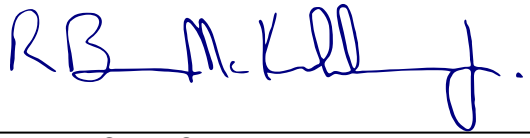
59. There being no change in position by AHCA, there is no basis for Petitioners' claim of detrimental reliance.

RECOMMENDATION

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

RECOMMENDED that a final order be entered by Respondent, Agency for Health Care Administration, approving the Medicaid interim per diem rates established by AHCA and dismissing each of the Amended Petitions for Formal Administrative Hearing.

DONE AND ENTERED this 23rd day of February, 2009, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 23rd day of February, 2009.

ENDNOTES

[1/] As set forth above, an application was filed for each of the nine facilities, but only Madison Pointe's application will be discussed.

[2/] Where, as in the current case, there are a group of related facilities reviewed at one time, Fitch will ascertain whether the group as a whole is financially viable rather than just any one of the facilities. For purposes of this case, Madison Pointe's financial ability is addressed individually as representative of the group.

[3/] "CHOW" is an acronym for Change of Ownership and is used to describe both changes of owners and changes of operators. It is synonymous to CHOP.

[4/] The actual loss per year for each of the Petitioners facilities would obviously be different, but each expected a significant negative impact.

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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.