STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION, Petitioner, vs. LIFE CARE CENTERS OF AMERICA, INC., d/b/a LIFE CARE CENTER OF PORT ST. LUCIE, Respondent.	)	Case No. 09-1772
AGENCY FOR HEALTH CARE ADMINISTRATION, Petitioner, vs. LIFE CARE CENTERS OF AMERICA, INC., d/b/a LIFE CARE CENTER OF WINTER HAVEN, Respondent.	)	Case No. 09-1773
AGENCY FOR HEALTH CARE ADMINISTRATION, Petitioner, vs. LIFE CARE CENTERS OF AMERICA, INC., d/b/a LIFE CARE CENTER OF OCALA, Respondent.	)	Case No. 09-1775

AGENCY FOR HEALTH CARE ADMINISTRATION, Petitioner, vs. LIFE CARE CENTERS OF AMERICA, INC., d/b/a LIFE CARE CENTER OF ORLANDO, Respondent.	)	Case No. 09-1776
AGENCY FOR HEALTH CARE ADMINISTRATION, Petitioner, vs. LIFE CARE CENTERS OF AMERICA, INC., d/b/a LIFE CARE CENTER OF CITRUS COUNTY, Respondent.	)	Case No. 09-2146

RECOMMENDED ORDER

Pursuant to notice, this cause was heard by Charles A. Stampelos, the assigned Administrative Law Judge of the Division of Administrative Hearings, on December 14 through 18, 2009, in Tallahassee, Florida.

APPEARANCES

For Petitioner: Richard Joseph Saliba, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Building 3
Tallahassee, Florida 32308

James H. Harris, Esquire
Agency for Health Care Administration
Sebring Building, Suite 330D
525 Mirror Lake Drive, North
St. Petersburg, Florida 33701

For Respondents: John E. Terrel, Esquire
John F. Gilroy, III, Esquire
John F. Gilroy, III, P. A.
1695 Metropolitan Circle, Suite 2
Tallahassee, Florida 32308

STATEMENT OF THE ISSUES

Whether Petitioner, the Agency for Health Care Administration (AHCA or Agency), proved that Respondents, Life Care Centers of America, Inc., d/b/a Life Care Center of Port St. Lucie, and other Life Care facilities in Winter Haven, Ocala, Orlando, and Citrus County, were not in compliance with the Medicaid-patient-days condition stated on the face of the Certificates of Need (CON) for each facility for calendar year 2006, and, if not in compliance, whether the Agency may impose administrative fines in the amount sought in the first amended administrative complaints.

PRELIMINARY STATEMENT

On or about April 28, 2008, the Agency filed six administrative complaints against the five Respondents. (A sixth nursing home facility (nursing home), Life Care Centers of America, Inc., d/b/a Life Care Center of Jacksonville, was an initial Respondent, but the matter was resolved.) The Agency sought to impose fines against each nursing home for allegedly

not complying with the Medicaid-patient-day condition set forth in each CON.

The Agency attached to the administrative complaints, the formal reports submitted (in February 2008) to AHCA by counsel for each Respondent, which provided, in part, information regarding each nursing home's compliance or noncompliance with the CON condition for calendar year 2006.

In each formal report except one, Respondents' counsel concluded that each facility appeared to strictly not meet the CON Medicaid-patient-days condition, but suggested that additional documentation and discussion was provided to AHCA to support a finding by AHCA that the facility was in substantial compliance. (It was suggested that Life Care Center of Ocala was in full compliance with the Medicaid-patient-days condition.) AHCA does not dispute any of the facts and figures set forth in the formal reports.

On or about May 19, 2008, Respondents timely filed petitions followed by amended petitions (filed on or about March 23, 2009) requesting that the cases be referred to the Division of Administrative Hearings (DOAH or the Division). (Respondents requested the Agency to hold the original petitions rather than refer them to DOAH.)

On April 7, 2009, the cases were referred to DOAH, with one case being referred on April 22, 2009. An administrative law

judge was assigned, the cases consolidated, and a final hearing was scheduled for July 27 through 31, 2009, and subsequently re-scheduled several times.

On or about July 20, 2009, Respondents were granted leave to file, and filed, their second amended petitions.

On October 2, 2009, Respondents were granted leave to file third amended petitions challenging the administrative complaints issued by the Agency.

On October 27, 2009, the Agency was granted leave to file amended administrative complaints to increase the amount of fines sought, collectively, from $95,363 to $381,037, based solely on Subsection 408.040(1)(e), Florida Statutes (2006).[1] On October 28, 2009, the Agency filed first amended administrative complaints to correct a scrivener's error. At the same time, the Agency's motion to strike several allegations in the Respondents' third amended petitions was granted, in part, as to paragraph 10; the first sentence in paragraph 13 ending with ". . . good cause should be denied"; and paragraphs 16b and 16c consistent with, in part, the Order of August 11, 2009, and in recognition of the caveat mentioned in the last paragraph of that Order. See Order, October 27, 2009, at 3. These paragraphs pertain to allegations regarding previously filed requests of the Agency to modify (for "good cause") Respondents' CON Medicaid-patient-days conditions for calendar year 2006.

These requests were denied by the Agency and the challenges to the Agency actions are consolidated for final hearing under Case Nos. 09-6207CON through 09-6212CON. The Agency's motion to strike Respondents' allegation pertaining to the Agency's alleged use of statements as unadopted rules, see Subsections 120.52(20) and 120.57(1)(e)1., Florida Statutes (2009), was denied. See Order, October 27, 2009, at 3.

The consolidated cases proceeded under the Agency's first amended administrative complaints and Respondents' third amended petitions for formal hearing, as limited by order.

Respondents filed a motion for official recognition that was granted by an Order dated November 13, 2009. Respondents also filed a second motion for official recognition on December 4, 2009, that was granted orally during the final hearing.

On November 13, 2009, the Agency filed a notice stating that the Agency filed a Notice of Development of Rulemaking in the November 3, 2009, edition of the Florida Administrative Weekly. The Agency proposed to amend Florida Administrative Code Rule 59C-1.021(3)(a) by adding the following sentence: "The degree of noncompliance means the result of the mathematical calculation of the difference between the conditioned level of compliance and the reported level of compliance."

On December 16, 2009, during the final hearing, the Agency filed a motion requesting an order granting an automatic stay. The Agency withdrew the motion. See T 231-34; 493-94. On December 23, 2009, an Order was entered confirming that the Agency's motion for stay was withdrawn and that the published Notice of Development of Rulemaking did not qualify for an automatic stay.

On October 2, 2009, the parties filed a joint Pre-Hearing Stipulation (JPHS). At the time, the final hearing was scheduled to commence on October 5, 2009. After the parties were granted leave to file amended pleadings (third amended petitions and first amended administrative complaints), on December 10, 2009, the Agency filed its pre-hearing statement followed on the same date by Respondents' supplement to the October 2, 2009, JPHS.

The final hearing was conducted on December 14 through 18, 2009.

At the final hearing, the Agency presented the testimony of the following witnesses: James McLemore, unit supervisor for the AHCA CON office and accepted as an expert in CON evaluation and compliance; Jeffrey N. Gregg, supervisor of AHCA's Bureau of Facilities and accepted as an expert in Florida health care policy and regulation, CON planning and regulation; and Wendy

Smith, program administrator in AHCA's Medicaid services and accepted as an expert in Medicaid reimbursement policy.

Agency Exhibits (PE) 1 through 10, 11 (as supplemented), 13, 15, 16, 18 through 22, 24 through 28, 30 through 33, 38, and 39 were admitted into evidence. Agency Exhibit 14 was admitted into evidence as a joint exhibit, and Agency Exhibit 41 is a page from Citrus County's third amended petition relating to allegations of unadopted rule statements.

Respondents presented the testimony of the following witnesses: Cathy M. Murray, chief operating officer for Life Care; James Steven Ziegler, chief financial officer for Life Care; Michael Zomchek, divisional vice-president and accepted as an expert in nursing home administration and nursing; Janet E. Sorel, regional vice-president of the Citrus region and accepted as an expert in nursing home administration and nursing; Jeffrey Thomas, regional vice-president of the Palmetto region and accepted as an expert in nursing home administration; James S. Weigard, president of Polaris Properties, Inc., and accepted as an expert in health planning and financial feasibility; Cheslyn Green, AHCA health services and facility consultant; and Ryan Fitch, AHCA supervisor of the financial analysis unit.

Respondents' Exhibits (RE) 1, 3 through 7, 9 through 12, 12b, 13 through 15, 17 through 25, 26 (pages 1 through 6 and 9 through 12), 27, 28, 30 (pages 1 through 15), 31 through 34, 37,

38, 40 through 42, 44 through 48, 54, and 55 were admitted into evidence. Ruling was reserved regarding Respondents' Exhibit 52 (JAPC letter), T 514. Respondents' Exhibit 52 is admitted into evidence.

On January 13, 2010, an eight-volume Transcript (T) was filed. On February 19, 2010, the parties filed proposed recommended orders and memoranda of law. All post-hearing submissions have been considered.

FINDINGS OF FACT

I. The Parties

1. The Agency for Health Care Administration is the state agency responsible for licensing and regulating nursing home facilities such as Respondents under Chapter 400, Part II, Florida Statutes, and issuing CONs under Chapter 408, Florida Statutes.

2. Respondents are community/skilled nursing home facilities that have CONs issued pursuant to Chapter 408, Florida Statutes. Each facility is located in the geographical area indicated by its name, e.g., Life Care Center of Port St. Lucie is located in Port St. Lucie, Florida, and in an AHCA health service planning district (District) and subdistrict.

3. Life Care Center of Port St. Lucie, a 123-bed facility, is located in District 9, Subdistrict 5; Life Care Centers of America, Inc., d/b/a Life Care Center of Winter Haven, a 177-bed

facility, is located in District 6, Subdistrict 5; Life Care Centers of America, Inc., d/b/a Life Care Center of Ocala, a 120-bed facility, is located in District 3, Subdistrict 4; Life Care Centers of America, Inc., d/b/a Life Care Center of Orlando, a 120-bed facility, is located in District 7, Subdistrict 2; and Life Care Centers of America, Inc., d/b/a Life Care Center of Citrus County, a 120-bed facility, is located in District 3, Subdistrict 5. § 408.032(5), Fla. Stat.; Fla. Admin. Code R. 59C-2.200.

II. The CONs; Medicaid Conditions; Dual Eligibility

4. The starting point of this story begins with the CONs that are effective for calendar year 2006 for each Respondent and the Medicaid-patient-days condition stated on each CON.[2] The Agency conditioned the issuance of the CONs based upon statements of intent expressed by Respondents in the CON applications. § 408.040(1)(a), Fla. Stat.

5. The primary purpose of requiring the CON Medicaid-patient-days condition is to ensure access for Medicaid-eligible or funded residents. T 499-500.[3]

6. When the CONs were issued, either through a transfer or as an initial CON, Respondents committed to provide a certain level of Medicaid patient days. The required Medicaid percentage of patient days for each Respondent is set forth in the table under Finding of Fact 36.

7. Agency Exhibits 1 through 11 and 13 show how Life Care Centers of America, Inc., characterized the agreed to number/percentage of Medicaid patient days in various CON application documents; verbalization of same; and the manner in which its facilities would account on Schedule 7 or 10, e.g., of the CON application, for projected revenue by payor source, including, but not limited to, Medicaid. See Fla. Admin. Code R. 59C-1.008(1)(f) (adoption of Agency forms); T 161. (Payor and payer are used throughout this record and in context have the same meaning.)

8. Agency Exhibit 4 contains excerpts from a 120-bed new freestanding nursing home in Marion County, Florida, submitted in 1995 on behalf of Life Care Centers of America, Inc. T 49. The conditions page states that the applicant agreed to provide "66% of patient days to Medicaid clients." The following page states in part: "Condition C2: A minimum percentage of proposed project for Medicaid eligible patients at stabilized occupancy." Under "Measurement and Conformance," it is stated: "Actual payor mix experience following project licensure and fill-up; annual reporting requirements." Id. at 3; T 49-50. (Another excerpt states: "Condition C2: Percentage of patient days for Medicaid beneficiaries." PE 13 at 4.) Schedule 10 provides projected operating revenue for year two ending December 31, 1996. Medicaid patient days are stated (26,981) as

well as a percentage (66.0%) of patient days. Id. at 5. (In other excerpts, similar material appears in Schedule 7.) The Schedule 10 Notes and Assumptions pages devote a paragraph to Medicaid. Id. at 7. See T 165-67.

9. None of the excerpts from Agency Exhibits 1 through 11 and 13 expressly refer to providing services to "dual eligible" patients. The schedules do not have a specific line item for entry of this information, although Schedule 7 has a category "Other Revenue," PE 1 at 4, which the Agency suggests could have been used to identify that revenue source. T 163.

10. The Agency considers Agency Exhibits 1 through 11 and 13 as proof that Respondents understood and agreed to provide a minimum percentage of patient days to residents whose care was paid for by Medicaid, a payor source. Thus, according to the Agency, only patient days that are provided to patients when Medicaid is the sole source of reimbursement are counted when determining compliance with the Medicaid condition. (According to the Agency, the statement "'Medicaid patient days' is defined, for purposes of CON condition compliance, as the 'patient days reimbursed by Medicaid,'" see PE 41 at paragraph 15.b., and is derived from Respondents' Schedule 7 indicating what the Respondents "expect their payers to be, and that is in rule." T 931.)

11. Agency Exhibits 21, 22, and 24 through 26 are the CONs at issue in this proceeding and, with some minor variations, state: A minimum of [ ] percent of the [ ] bed facility's total annual patient days shall be provided to Medicaid patients.

12. Medicare is a program of health insurance and benefits authorized and administered under Title XX of the Social Security Act. Medicaid is a program of health insurance and benefits authorized and administered under Title XIX of the Social Security Act.

13. "Nursing facilities may obtain reimbursement for services provided to recipients privately or through long term care insurance. There are also specific situations when Medicare will be the payer. Medicaid is always the payer of last resort." RE 46 at 2-2.

14. A person who is eligible for care under Medicare is not necessarily Medicaid-eligible. The person must meet eligibility factors to qualify. However, a person may be qualified as Medicare and Medicaid-eligible.

15. A Medicaid-eligible patient may stay at a nursing home one day or more. Not infrequently, such a patient is more or less permanent resident.

16. Generally, if a nursing home patient achieves the status of a Medicaid patient on day one of the stay, the

patient's status as a Medicaid patient continues throughout the stay at the nursing home, unless the patient loses that status either through an ineligibility determination or for some other reason. See T 393.[4]

17. Stated otherwise, Medicaid-eligible nursing home patients do not lose their status as Medicaid-eligible patients when the nursing home is reimbursed in whole or in part by Medicare.

18. According to the Florida Medicaid Nursing Facility Services Coverage and Limitations Handbook (Handbook), published by the Agency, a "recipient" "is used to describe an individual who is eligible for Medicaid." RE 46 at ii.

19. "If Medicare Part A covers the recipient, Medicare will reimburse the facility for the entire cost of the care provided for the first twenty (20) days the resident is in the facility following an acute care hospitalization. During the period of time between the twenty-first and one-hundredth days, the resident will incur a charge for coinsurance." RE 46 at 2-2. "Medicaid will cover the amount of the coinsurance if the recipient is eligible for Medicaid" under certain circumstances. Id.

20. "When a recipient is Medicare and Medicaid-eligible and is in the Medicare coinsurance period (21 through 100 days of Medicare coverage), Medicaid pays the Medicare coinsurance

amount for the recipient. The amount paid by Medicaid is the lesser of the Medicare rate or the Medicaid per diem rate minus the patient responsibility. Medicaid does not pay for a Medicare HMO recipient during the coinsurance period." RE 46 at 3-2. See also id. at "Qualified Medicare Beneficiary."

21. If the Medicaid patient either enters the nursing home after a three-day or longer hospitalization stay or is a resident of the nursing home and then is hospitalized for this length of time, the resident's care will be reimbursed by Medicare (assuming he or she is enrolled in the program) for up to 20 days upon returning to the nursing home. Medicare may continue to reimburse, typically 80%, (subject to Medicaid's payment of any coinsurance, typically 20%) the nursing home for the patient's care thereafter up to a maximum of 80 additional days, depending on the patient's continuing qualification to receive services paid by Medicare. See generally T 549-54, 663-65, 835-36.

22. In 2006, Medicare was the primary payer and Medicaid covered co-pays and deductibles only. Medicaid could have potentially paid for co-insurance or cross-over. Cross-over means if the patient has Medicare, then Medicaid would be potentially the secondary payer of the cross-over or co-insurance. Generally days 21 through 100 are the cross-over days. See generally T 387-93, 551, 663-65.

23. Subsection 408.040(1)(b), Florida Statutes, states:

> (b) The agency may consider, in addition to the other criteria specified in s. 408.035, a statement of intent by the applicant that a specified percentage of the annual patient days at the facility will be utilized by patients eligible for care under Title XIX of the Social Security Act. Any certificate of need issued to a nursing home in reliance upon an applicant's statements that a specified percentage of annual patient days will be utilized by residents eligible for care under Title XIX of the Social Security Act must include a statement that such certification is a condition of issuance of the certificate of need. The certificate-of-need program shall notify the Medicaid program office and the Department of Elderly Affairs when it imposes conditions as authorized in this paragraph in an area in which a community diversion pilot project is implemented.

(emphasis added).

24. Subsection 408.040(1)(d), Florida Statutes, states:

> (d) If a nursing home is located in a county in which a long-term care community diversion pilot project has been implemented under s. 403.705 or in a county in which an integrated, fixed-payment delivery system [program] for Medicaid recipients who are 60 years of age or older [or dually eligible for Medicare and Medicaid] has been implemented under s. 409.912(5), the nursing home may request a reduction in the percentage of annual patient days used by residents who are eligible for care under Title XIX of the Social Security Act, which is a condition of the nursing home's certificate of need. The agency shall automatically grant the nursing home's request if the reduction is not more than 15 percent of the nursing home's annual Medicaid-patient-days condition. A nursing

> home may submit only one request every 2 years for an automatic reduction. A requesting nursing home must notify the agency in writing at least 60 days in advance of its intent to reduce its annual Medicaid-patient-days condition by not more than 15 percent. The agency must acknowledge the request in writing and must change its records to reflect the revised certificate-of-need condition. This paragraph expires June 30, 2011.

(emphasis added). The language in brackets was inserted in 2007. "[P]rogram" was inserted for "system" and the remaining language in brackets was new. Ch. 2007-82, § 2 at 1051, Laws of Fla. The amendments to Subsection 408.040(1)(d) were made at the same time that amendments were made to Section 408.912, adding, in part, "program" and deleting "system," and adding "or dually eligible for Medicare and Medicaid" to Subsection 408.912(5). Id., § 1 at 1048.

25. The Agency interprets "utilized by patients eligible for care under Title XIX of the Social Security Act" to mean residents whose care is paid for solely by Medicaid. If the nursing home is reimbursed in whole or in part by Medicare for services to a resident Medicaid patient, e.g., during the one to 100-day period referred to above, the Agency does not count any days of treatment as a Medicaid patient day for the purpose of satisfying the Medicaid-patient-days condition.

26. Conversely, Respondents count all residents who are eligible for Medicaid, regardless of who pays for the resident's care.[5]

27. The Agency conditions the approval of a CON based on the applicant's commitment to provide services to the medically indigent, here Medicaid patients. There is no indication that the patients referred to as "dual eligible" by Respondents were not, in fact, Medicaid patients during calendar year 2006, notwithstanding the nature of the facilities reimbursement.

28. Respondents supplied the Agency with data counting traditional Medicaid days, hospice Medicaid days, and the days for "dual eligible" residents, separately stated.

29. The Agency does not take issue with Respondents' reported number of "dual eligible," Medicaid-eligible patient days, only that they should not be counted toward meeting the CON condition.

30. Based upon the persuasive evidence, it is determined that the Agency's interpretation to exclude the reported "dual eligible" Medicaid patient days from consideration for meeting the CON condition is not reasonable.

III. The Annual Compliance Reports; Reporting of Patient Data to the Agency

31. Respondents are required to provide annual compliance reports to the Agency that contain required information,

including but not limited to "[i]f applicable, the reason or reasons, with supporting data, why the [CON] holder was unable to meet the conditions set forth on the face of the [CON]." Fla. Admin. Code R. 59C-1.013(4)(a)7.

32. All nursing homes report occupancy data to the local health councils (LHC), with some data reported to the Agency. See PE 14. The LHCs supply the Agency with data concerning the total occupancy of each facility in patient days as well as the number of days reimbursed by Medicaid. Id.

33. This data is compiled into the Florida Nursing Home Utilization by District and Subdistrict Guide (NH Guide). PE 14 (calendar year 2006).

34. If data received from the LHC indicates that a facility is not in compliance with the CON Medicaid-patient-days condition, the Agency will send a letter to the facility requesting additional information. The Agency sent each Respondent a letter requesting additional information for calendar year 2006. See, e.g., RE 1.

35. Consistent with this reporting requirement, on February 25, 2008, counsel filed a formal report for each Respondent. Four of the Respondents, except Life Care Center of Ocala, submitted a detailed booklet setting forth the reason why it was unable to meet the CON Medicaid-patient-days condition. In each formal report except one (Ocala), Respondents' counsel

concluded that each facility appeared to strictly not meet the CON Medicaid-patient-days condition, but additional documentation and discussion was provided to the Agency to support a finding by the Agency that the facility was in substantial compliance with these conditions. (With respect to Life Care Center of Ocala, it was suggested that this facility was in full compliance with the Medicaid-patient-days condition.)

36. Except as otherwise stated herein,[6] the parties agree (see, e.g., T 155, PHS at 20) with the following data:

	A	B	$\frac{B}{A}$	C	$\frac{B + C}{A}$	
Life Care	Total Patient Days	Medicaid Patient Days	%	"Dual Eligible"	%	CON Minimum Cond.
Port St. Lucie	42,162	16,978	40.27%	1,429	43.66%	47.00%
Winter Haven	60,817	29,580	48.64%	5,914	58.36%	60.60%
Ocala	40,888	10,725	26.23%	5,387	39.41%	33.00%
Orlando	40,468	9,093	22.47%	2,781	29.34%	31.19%
Citrus Cty	40,846	14,559	35.64%	3,064	43.14%	45.64%

37. Without consideration of "dual eligible" patient days, five facilities are allegedly non-compliant as follows: Port St. Lucie -- 6.73 %; Winter Haven -- 11.96%; Ocala -- 6.77%; Orlando -- 8.72%; and Citrus County -- 10.00%. RE 41; JPHS at 5-6; Agency's Pre-Hearing Statement at 7.

38. If "dual eligible" patient days are considered, four out of five facilities remain allegedly non-compliant, but to a lesser degree: Port St. Lucie -- 3.34%; Winter Haven -- 2.24%; Orlando -- 1.85%; and Citrus County -- 2.50%. Ocala is compliant by 6.41%. See RE 3, 41; T 817; Agency's Pre-Hearing Statement at 8.

IV. The Administrative Complaints

39. This proceeding initially involved consideration of six (now five) separate administrative complaints alleging that each Respondent did not comply with the Medicaid-patient-days condition set forth in each CON for calendar year 2006.

40. Each administrative complaint is based on the information contained in and the Agency's analysis of the formal reports submitted on behalf of each Respondent.[7]

41. The Agency does not dispute the facts and figures set forth in the formal reports, although it disagrees with Respondents' contention of compliance with the Medicaid-patient-days condition and whether "dual-eligible" patients may be considered for compliance purposes.

42. Each administrative complaint states, in part, that "[t]his is an action to impose administrative fines in the amount of . . . against Respondent, pursuant to Section 408.040, Florida Statutes, and Florida Administrative Code Rules 59C-1.013 and 59C-1.021." The Agency has the statutory authority to

impose fines up to $1,000 per day for noncompliance, taking into account as mitigation the degree of noncompliance.[8]

43. Prior to filing its first amended administrative complaints on October 28, 2009, when a CON holder was determined to be in noncompliance, the Agency made an individualized determination as to whether and how much to fine the CON holder. RE 44 at 3; T 115-16.

44. The Agency created a chart that is completed as an analytical tool. Next, the Agency considered the individual situation of the CON holder, "including but not limited to" a number of factors, such as the "degree of noncompliance, absolutely and in comparison to others within the sub-district"; whether the "[f]acility is not at 85% occupancy"; whether the "[f]acility has not been operational for at least 18 months or first reached 85% occupancy during the reporting year"; whether the "[f]acility can demonstrate operational losses through financial statements and or audit"; whether the "[f]acility has a sister facility (facility owned by the same entity) in the same sub-district that either has no Medicaid condition or has met its Medicaid condition and has additional Medicaid Total Annual Patient-Days to donate to its sister facility"; "[p]rovision of patient care to Hospice Medicaid patients"; "[p]rovision of care to Charity/Indigent patients (days or cash)"; whether the "[f]acility is within 1% or less of its

condition"; whether "[p]rovision of Medicaid for facility exceeds that of the sub-district"; and "[a]ny other factors that a CON holder may present that could impact against fines are considered." RE 44.

45. These are a common list of factors that have been considered (not in isolation) by Agency management, if brought to their attention by the facility in assessing whether a fine should be imposed. RE 44; T 206-213, 215-216, 221, 279-80, 352-56, 373, 483, 927-30, 947-49. See also Fla. Admin. Code R. 59C-1.013(4)(a)7; Findings of Fact 73 through 83. "All things [were] considered prior to determining the fine, including [the Agency] gave [nursing homes] the 75 percent [for diversion programs] off." T 365. On a rare occasion, the Agency did not fine a noncompliant nursing home because the nursing home was closed during a portion of the year. T 267-68.[9]

46. With the filing of the third amended administrative complaints, none of these factors is considered in determining the fine. T 931, 949.

47. The Agency proposed to fine each Respondent as follows: Port St. Lucie -- $13,085; Winter Haven -- $18,022; Ocala -- $18,724; Orlando -- $25,540; and Citrus County -- $19,992.

48. The Agency explained how these fines were calculated, including the mitigation factors considered regarding the degree

of noncompliance. RE 26; T 225-30. Respondents' Exhibit 26 consists of the forms (Excel spreadsheets) used by the Agency to determine noncompliance matters in calendar year 2006. The Agency started applying the Excel spreadsheets in approximately 2004 or 2005 in condition compliance cases. T 223, 250-51.

49. For example, for Port St. Lucie, the maximum fine under the statutory framework is $365,000 ($1,000 per day times 365 days). The "applicable fine" was calculated to be $52,341, which is the maximum fine times the percent difference or $365,000 times 14.34%. Then the applicable fine was reduced by 75% to $13,085 ($52,341 times 25%), which is the fine sought in the administrative complaint. RE 26 at 5; see also T 252, 292-97. The 25% factor was applied in each case to reflect consideration of pilot diversion programs in each county where the Respondents are located. T 268, 295. Each Respondent was treated the same. See RE 26.[10]

50. Since approximately 2006 and 2007 and prior to the filing of the Agency's third amended administrative complaints in October of 2009, the Agency routinely applied the 25% diversion factor (a 75% deduction). T 294, 338-39.

51. With the filing of the third amended administrative complaints, prior to calculating the fine, the Agency still considers the circumstances of each nursing home and the reasons why they were unable to meet the Medicaid-patient-days

condition. "But in terms of the degree [the nursing home is] out of compliance, [the Agency is] using the statute based on the days that [the nursing home is] out of compliance and" the penalty is based on that calculation. T 366-68, 374. See also T 349-50, 357, 363-65.

V. The Third Amended Petitions for Formal Administrative Hearing and the First Amended Administrative Complaints

52. On October 2, 2009, Respondents filed a motion and revised motion to amend their second amended petitions and also filed their third amended petitions challenging the administrative complaints filed by the Agency. (The revised motion was granted over the Agency's objection.)

53. Respondents dispute that they failed to meet the respective Medicaid-patient-days conditions; dispute that the Agency appropriately considered the degree of alleged noncompliance; dispute how the Agency determined the number of residents eligible pursuant to Title XIX of the Social Security Act and Section 408.040, Florida Statutes, claiming that "dual eligible" residents should be counted for purposes of compliance; and further claim that the Agency is improperly relying on six alleged statements as unadopted rules. See PE 41.

54. On October 14, 2009, the Agency filed a motion requesting leave to amend its administrative complaints. (The

motion was granted over Respondents' objection.) In its motion, the Agency voiced its disagreement with Respondents' challenge to the alleged statements as unadopted rules and stated: "While the Agency disagrees that the alleged statements are rules, the Agency has determined that in the present proceeding, it will explicitly not rely on the alleged statements, but will explicitly only rely on the Agency's statutory authority conferred by" Subsection 408.040(1)(e), Florida Statutes, and that "the Agency has amended the administrative complaints as to each respondent based on the admissions by each respondent and based upon the authority and language of" Subsection 408.040(1)(e). The Agency incorporated by reference the exhibits (including, but not limited to, the formal reports submitted by Respondents) attached to the original administrative complaints.[11]

55. On October 28, 2009, the Agency filed first amended administrative complaints against each Respondent. Most notably, the Agency deleted reference to Florida Administrative Code Rules 59C-1.013 and 59C-1.021, cited in the administrative complaints, and proceeded, consistent with the Agency motion requesting leave to amend, to rely solely on Subsection 408.040(1)(e), as authority to impose the fines requested.

56. The proposed fines are based solely on the Agency's determination that each Respondent is not in compliance with the

applicable Medicaid-patient-days condition and based on its view that the degree of noncompliance means the result of the mathematical calculation of the difference between the conditioned level of compliance and the reported level of compliance. No consideration was given to any other factors such as the prior proposed reduction in fines (in the original administrative complaints) in light of the pilot diversion programs (the 25% factor).

57. Stated otherwise, the Agency applied the new proposed rule, see Finding of Fact 63, as the sole criterion for determining as mitigation the degree of noncompliance. T 219, 492. The Agency will no longer consider the mitigating factors considered by the Agency in the past. This led the Agency to proceed to rule development. T 494-95.

58. The Agency explained how it calculated the amended fines. Agency Exhibits 27 and 28 and 30 through 32 are the calculation sheets used by the Agency to determine the fines for the first amended administrative complaints. T 151, 274-79.

59. Based on each Respondents' formal report of compliance (without regard to "dual eligible" Medicaid patient days), except for "dual eligible" Medicaid patient days reported by a Respondent, the Agency considered all traditional Medicaid patient days, including Medicaid hospice days[12] and charity days.

T 152, 201-03. The Agency imposed a fine of $1,000 per day for each day in which Respondents were not in compliance. T 150-57, 272-79.

60. The degree of noncompliance per month in calendar year 2006 was taken into consideration by calculating the percentage of noncompliance. For January 2006, Port St. Lucie was required to provide 1,688 Medicaid patient days (47% times 3,592) and actually provided 1,506 traditional Medicaid patient days, which was then divided by the required number of Medicaid patient days (1,506/1,688) to equal 89.22% of the 31 days in January that were met or 27.66 days or 3.34 unmet days. The resulting fine for January was $3,342 or $1,000 per day times 3.34. These calculations were performed for each month with the actual fine requested in the first amended administrative complaint at $52,024, T 152-153, PE 27, which is the fine for the number of days out of compliance. T 279, 494. (Mr. McLemore thought the Agency would not fine a nursing home out of compliance for two days. T 278.)

61. The new formula is based on statutory-based days out of compliance, resulting in higher fines rather than taking 75% off the top reflected in the administrative complaints. T 274, 297.

62. The Agency performed the same calculations for each Respondent. PE 27-28 and 30-32. T 156-57.

63. The Agency has attempted to codify its decision to change the manner in which the fines are calculated in the first amended administrative complaints by publishing a Notice of Development of Rulemaking and proposing to amend Rule 56C-1.021(3)(a), Certificate of Need Penalties, as follows: "Facilities failing to comply with any conditions . . . will be assessed a fine, not to exceed $1,000 per failure day. In assessing the penalty the agency shall take into account the degree of noncompliance. The degree of noncompliance means the result of the mathematical calculation of the difference between the conditioned level of compliance and the reported level of compliance." (emphasis in original). Aside from this notice, there is no evidence that the Agency has proceeded further to adopt the proposed rule.

64. According to the Agency, it would be "completely impractical" to promulgate a rule listing all the conditions that would mitigate noncompliance. T 924-26, 940.

65. The proposed fines were increased above the fines requested in the administrative complaints as follows: Port St. Lucie -- $13,085 to $52,024; Winter Haven -- $18,022 to $71,642; Ocala -- $18,724 to $74,830; Orlando -- $25,540 to $103,132; and Citrus County -- $19,992 to $79,409.

VI. The Amount of the Fine Using the Agency's Methodology

66. It is determined that the fines should be calculated for each Respondent by including the stipulated number of "dual eligible" Medicaid patient days, arriving at a dollar figure and then subtracting 75%.[13]

67. The Agency used a methodology to calculate the fines in the original administrative complaints. That methodology is applied herein. See RE 26.

A. Port St. Lucie

68. The difference between the minimum CON condition percentage (47%) and the actual Medicaid percentage (43.66%) is 3.34%, which is then divided by 47% and yields 0.0710638 times $365,000, which yields $25,938. Twenty-five percent of $25,938 yields a total fine of $6,485 (25% fine for pilot diversion program or 75% fine reduction), without consideration of any other factors discussed below. Compare with RE 26 at 5.

B. Winter Haven

69. The difference between the minimum CON condition percentage (60.60%) and the actual Medicaid percentage (58.36%) is 2.24%, which is then divided by 60.60% and yields 0.0369636 times $365,000, which yields $13,492. Twenty-five percent of $13,492 yields a total fine of $3,373 (25% fine for pilot diversion program or 75% fine reduction), without consideration of any other factors discussed below. Compare with RE 26 at 11.

C. Orlando

70. The difference between the minimum CON condition percentage (31.19%) and the actual Medicaid percentage (29.34%) is 1.85%, which is then divided by 31.19% and yields 0.0593 times $365,000, which yields $21,645. Twenty-five percent of $21,645 yields a total fine of $5,411 (25% fine for pilot diversion program or 75% fine reduction), without consideration of any other factors discussed below. Compare with RE 26 at 9.

D. Citrus County

71. The difference between the minimum CON condition percentage (45.64%) and the actual Medicaid percentage (43.14%) is 2.50%, which is then divided by 45.64% and yields 0.0547765 times $365,000, which yields $19,993. Twenty-five percent of $19,993 yields a total fine of $4,998 (25% fine for pilot diversion program or 75% fine reduction), without consideration of any other factors discussed below. Compare with RE 26 at 3.

E. Ocala

72. No fines should be imposed on the Ocala facility as it exceeded the Medicaid condition for calendar year 2006.

VII. Consideration of Reasons Why Respondent Nursing Homes Were Unable to Meet CON Medicaid-Patient-Days Conditions and the Amount of the Fine Considering Other Factors

73. Prior to filing its first amended administrative complaints and its Notice of Development of Rulemaking, the Agency considered several factors when deciding whether a

nursing home complied or was unable to comply with a Medicaid condition, and whether a fine was appropriate under the circumstances for noncompliance. See generally Finding of Fact 44 for some of the compliance factors.

74. Respondents offered testimony that they used their best efforts to meet the Medicaid-patient-days conditions, including the relative demand levels for Medicaid services in the areas served of Respondents, income levels of seniors, and other reasons. See generally T 547-48, 557, 826, 829, 852, and 876; RE 4-7.

75. Respondents suggested that the existence of various State diversion and transition programs in the counties where they are located should also be considered in mitigation. See generally T 694-95.

76. The nursing home diversion program operated in 26 counties in Florida in 2006, and Respondents are located in five of those counties. (Potential nursing home patients are diverted to other health care settings under this and other similar programs.)

77. Generally, these diversion programs have been successful in diverting Medicaid-eligible residents from nursing homes. To some extent, these diversion programs have impacted Respondent nursing homes. T 534.

78. Respondents also provided other factors in support of noncompliance with the Medicaid-patient-days conditions such as Medicaid utilization, which may be affected by the moratorium (with some exceptions) on new CONs for nursing homes, the existence of other community-based facilities, the effects of various diversion programs, the income level of various population centers where some of the Respondents are located, high Medicare admissions, declining Medicaid demand, and the relative age of Respondent facilities. Respondents also provided evidence of their marketing efforts. See PE 15-16, 18-20; RE 4-7; T 535-36, 540-44, 556-57, 560-61, 570-71, 627-30, 638, 671-72, 711-23, 728-32, 846-47, 849, 858-60, 875-77. See also PE 39 at 3-4, regarding reported impacts of the moratorium. But see endnote 7.

79. The Agency considered a nursing home's occupancy when it considered mitigation. T 266-67, 484-85.[14]

80. Respondents also suggest that the Agency has applied other factors either to forgo action against a nursing home facility by waiving a fine or by reducing a fine contrary to the Agency's treatment of Respondents. See, e g., Respondents' Proposed Recommended Order at 36-44. For example, in the past, the Agency has reduced or eliminated a calculated fine for a nursing home if it was less than one percent out of compliance. See RE 44 and 45; T 206. There have been instances when the

Agency has not taken action against a nursing home that had missed the Medicaid condition by five percent or less. RE 24 at 19-28; RE 45 at 61-66. (Here, after calculating the fines using the Agency's pre-first amended administrative complaint methodology and including consideration of "dual eligible" patients, see Findings of Fact 68 through 72, none of the Respondents missed their Medicaid-patient-days conditions by more than four percent.)

81. Conversely, the Agency provided evidence that each Respondent provided Medicaid patient days on a percentage basis below the average for other nursing homes in their respective subdistricts. However, the Agency has not used the comparison to impose a fine on a nursing home. T 259-65; see also RE 26 at 2, middle calculations. None of the Respondents is located in the same subdistrict with another Life Care facility which exceeds its Medicaid-patient-days condition. None of the Respondents (except Ocala that exceeded its Medicaid-patient-days condition) was within one percent of the Medicaid-patient-days conditions, even considering the "dual eligible" patient days. None of the Respondents reported experiencing an operational loss. (According to the Agency, these factors were not always applied in every noncompliance case. T 927-39.)

82. The Agency also offered evidence that nursing home facilities within a five-mile radius of, e.g., the Respondent

Ocala facility in Marion County, had a higher percentage of their days provided to Medicaid patients than the Ocala facility, T 910-11. See also T 908-15. The Agency also offered evidence that the percentage of Medicaid patient days/census provided by Respondents has reduced between 2000 and 2006. T 891-908.

83. Based in part on the foregoing, Respondents suggest that no fines should be imposed, whereas the Agency suggests that fines should be imposed.

84. No party has cited to any Medicaid condition fine case that was resolved after an evidentiary hearing and the entry of a recommended order and a final order. Rather, the examples of alleged inconsistent Agency action appear to have been resolved by settlements.

85. It is difficult to apply the factors considered in this subsection of the Recommended Order in an objective fashion so as to determine, with any reliability and predictability, whether and to what extent Respondents should be further relieved of meeting the Medicaid-patient-days conditions.[15]

86. On a final note, the Agency abruptly (toward the end of the discovery portion of this proceeding) changed its policy regarding, in part, the method of determining the fines for noncompliance. The Agency did not adopt a rule codifying the change in policy despite opportunities to do so in the past and

did not persuasively explain the reasons for departing from its policy, which pre-dated the filing of the first amended administrative complaints.

CONCLUSIONS OF LAW

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

88. In this penal proceeding, the Agency has the burden to prove the allegations against each Respondent by clear and convincing evidence. Dep't of Banking & Fin. v. Osborne Stern & Co., 679 So. 2d 932 (Fla. 1996).

89. Notwithstanding the Agency's affirmative duty to take into account as mitigation the degree of noncompliance (Subsection 408.040(1)(e), Florida Statutes), Respondents have the ultimate burden of proving any mitigation if noncompliance is demonstrated. Balino v. Dep't of Health & Rehabilitative Servs., 348 So. 2d 349 (Fla. 1st DCA 1977).

90. "If the holder of a [CON] . . . fails to comply with a condition upon which the issuance of the [CON] . . . was predicated, the agency may assess an administrative fine against the certificateholder . . . in an amount not to exceed $1,000 per failure per day . . . In assessing the penalty, the agency shall take into account as mitigation the degree of noncompliance." § 408.040(1)(e), Fla. Stat. (emphasis added);

Fla. Admin. Code R. 59C-1.013(5). See also Fla. Admin. Code R. 59C-1.021(1) and (3)(a).

91. When a statute or rule does not specifically define words of common usage, courts must construe such words according to their plain and ordinary meaning. Fla. East Coast Industries, Inc. v. Dep't of Cmty. Affairs, 677 So. 2d 357, 362 (Fla. 1st DCA 1996); State v. Hoyt, 609 So. 2d 744, 747 (Fla. 1st DCA 1992).

92. A court "must also consider whether the words have a definite meaning to the class of persons within the purview of the statutes," or rules. State v. Hoyt, 609 So. 2d at 747.

93. Also, "[w]hen an agency committed with authority to implement a statute construes a statute in a permissible way, that interpretation must be sustained even though another interpretation may be possible or even, in the view of some, preferable." Humhosco, Inc. v. Dep't of Health & Rehabilitative Servs., 476 So. 2d 258, 261 (Fla. 1st DCA 1985) (citation omitted).

94. Stated otherwise, an agency is accorded broad discretion and deference in the interpretation of the statutes which it administers, and an agency's interpretation should be upheld when it is within a range of permissible interpretations and unless it is clearly erroneous. Pan Am. World Airways, Inc. v. Fla. Pub. Serv. Comm'n, 427 So. 2d 716 (Fla. 1983); see also

Bd. of Podiatric Med. v. Fla. Med. Ass'n, 779 So. 2d 659, 660 (Fla. 1st DCA 2001). The same principle has been applied "to *rules* which have been in effect over an extended period and to the meaning assigned to them by officials charged with their administration." Pan Am. World Airways, Inc., 427 So. 2d at 719 (italics in original).

95. "On the other hand, 'judicial adherence to the agency's view is not demanded when it is contrary to the statute's plain meaning.'" Sullivan v. Dep't of Envtl. Prot., 890 So. 2d 417, 420 (Fla. 1st DCA 2004) (citations omitted).

96. "Without question, an agency must follow its own rules . . ., but if the rule, as it plainly reads, should prove impractical in operation, the rule can be amended pursuant to established rulemaking procedures. However, 'absent such amendment, expedience cannot be permitted to dictate its terms.' . . . That is, while an administrative agency 'is not necessarily bound of its initial construction of a statute evidence by the adoption of a rule,' the agency may implement its changed interpretation only by 'validly adopting subsequent rule changes.'" Cleveland Clinic Fla. Hosp. v. Agency for Health Care Admin., 679 So. 2d 1237, 1242 (Fla. 1st DCA 1996) (citations omitted).

97. It has been established that "if an agency changes a non-rule-based policy, it must either explain its reasons for

its discretionary action based upon expert testimony, documentary opinions, or other appropriate evidence . . . or it must implement its changed policy or interpretation by formal rule making." Courts v. Agency for Health Care Admin., 965 So. 2d 154, 159 (Fla. 1st DCA 2007) (citations omitted).

98. The terms "utilized" and "eligible" used in Subsection 408.040(1)(b), Florida Statutes, and "eligible" in Subsection 408.040(1)(d) are not defined by statute or rule. Also, the sentence, "[i]n assessing the penalty, the agency shall take into account as mitigation the degree of noncompliance," in Subsection 408.040(1)(e), Florida Statutes, is not expressly defined by rule.

99. In the administrative complaints, the Agency proposed to fine each Respondent because they did not provide the percentage of Medicaid patient days required in the CON for calendar year 2006. In each case, the Agency accepted the actual Medicaid patient day percentage, without giving any facility credit for "dual eligible" Medicaid patient days, and calculated the applicable fine (maximum fine times the percent difference). See, e.g., RE 26 at 5 for the Port St. Lucie facility. Then, the Agency reduced the applicable fine in each case by 75%, which reflects a 25% fine in light of the pilot diversion programs existing in each county. The Agency's application of the 75% reduction is consistent with other prior

Agency action in fine cases involving Medicaid-patient-days condition cases and nursing homes.

100. In response to the third amended administrative complaints filed by Respondents and the allegations regarding the Agency's alleged use of statements as unadopted rules, the Agency filed the first amended administrative complaints advising that it intended to impose fines based solely on Subsection 408.040(1)(e), Florida Statutes. The Agency interpreted the terms "the agency shall take into consideration as mitigation the degree of noncompliance" to mean that the fine would be calculated by giving each facility credit for the specific Medicaid patient days provided, thus resorting to approximately the original "applicable fine" without consideration of any other factors in mitigation, including but not limited to a 75% reduction for the pilot diversion programs. For example, for Port St. Lucie, the proposed fine was increased from $13,085 in the administrative complaint to $52,024 in the first amended administrative complaint. See PE 27 for the calculation of the fine for Port St. Lucie.

101. It has been persuasively demonstrated that "dual eligible" Medicaid patients should be counted for the purpose of determining Respondents' compliance with each CON Medicaid-patient-days condition. The Agency's interpretation of Subsections 408.040(1)(b) and (d), Florida Statutes, and the

terms "utilized" and "eligible" has been carefully considered. It is ultimately concluded that the Agency's interpretation in light of the persuasive evidence is not reasonable.

102. Further, the Agency did not persuasively explain its changed policy of not considering several factors to determine as mitigation the degree of noncompliance. The Agency's abrupt change is inconsistent with established Agency administrative policies and is rejected. See generally Brookwood-Walton County Convalescent Ctr. v. Agency for Health Care Admin., 845 So. 2d 223, 228-29 (Fla. 1st DCA 2003).

103. Respondents allege that the Agency is relying on several statements as unadopted rules in this proceeding to the detriment of Respondents. See, e.g., Port St. Lucie's Third Amended Petition for Formal Administrative Proceeding at 6-7, ¶ 15. a.-f. Some of these statements if applied to Respondent would inure to Respondents' benefit. Id. at ¶ 15. a., c., d., and e. Respondents are not substantially affected by the Agency's past consideration of these statements. The remaining statements, id. at ¶ 15. b. and f., are the Agency's interpretation of Section 408.040, Florida Statutes, although not controlling. See generally Envtl. Trust v. State, Dep't of Envtl. Prot., 714 So. 2d 493, 498 (Fla. 1st DCA 1998) ("An agency statement explaining how an existing rule will be applied in a particular set of facts is not itself a rule.") As a

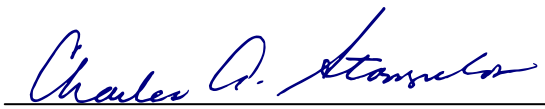
result, Respondents' challenge to several Agency statements as unadopted rule statements is rejected.

104. Finally, Respondents' request for attorney's fees and costs pursuant to Sections 120.57 and 120.595, Florida Statutes, is denied.

RECOMMENDATION

Based upon the foregoing, it is recommended that the Agency enter a final order imposing the following fines: Port St. Lucie -- $6,485; Winter Haven -- $3,373; Orlando -- $5,411; and Citrus County -- $4,998. No fines should be imposed on the Ocala facility as it exceeded the Medicaid-patient-days condition.

DONE AND ENTERED this 15th day of March, 2010, in Tallahassee, Leon County, Florida.



CHARLES A. STAMPELOS
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 15th day of March, 2010.

ENDNOTES

[1]/ All references to statutes in this Recommended Order are to the 2006 version unless otherwise stated. T 185.

[2]/ For the reporting year 2006, the Agency determined that approximately 24 nursing home facilities did not meet their CON Medicaid conditions. The Agency filed seven administrative complaints, with six filed against the Life Care facilities and one against the Lady Lake facility. T 301, 311; RE 54. (The case against Life Care's Jacksonville facility was resolved during the pendency of these proceedings.)

[3]/ According to the Agency, every effort should be made to preserve access to nursing home care for Medicaid-eligible recipients. T 474-75. On this record, there is no persuasive evidence that there are Medicaid-eligible persons unable to access a nursing home in the subdistricts where a Respondent facility is located. See, e.g., T 544. It appears that there is no Agency database used to determine whether there is an access problem for Medicaid beneficiaries. T 497; see also T 919-20.

[4]/ Subject to stated exceptions and other requirements, the Agency's Handbook also discusses "bed-hold reservations" and provides in part that "Medicaid pays to reserve a bed for a maximum of eight days for each hospital stay. Days may also be reserved for therapeutic days." RE 46 at 2-2; see also T 568-69.

[5]/ According to Ms. Smith, in the context of Medicaid provider reimbursements, a "dually eligible individual, generally, means an individual who has both Medicare and Medicaid coverage." T 385. For Ms. Sorel "[a] dual-eligible resident is a resident that [has both] Medicaid and Medicare as payer sources." T 549. See also T 665, 674-75.

[6]/ The Agency's calculation formula sheet used to determine the fines for the initial administrative complaints listed the Ocala facility's CON Medicaid-patient-days condition as a modified condition of 28.05%. See RE 26 at 2. Based on the ultimate determination made herein, it is irrelevant whether the condition is 33% or 28.05%. On the other hand, there is some evidence that the Agency took action in 2008 to reduce the Medicaid-patient-days conditions for three Life Care Center nursing homes and applied those new conditions (percentages) to reporting year 2006 and apparently were determined to have met

their conditions. RE 26 and 30; T 252-53. Whether Respondents' CON Medicaid-patient-days conditions for calendar year 2006 should be modified is not the subject of this proceeding. Notwithstanding, Respondents submitted formal reports to the Agency, which set forth what Respondents believed to be the applicable Medicaid-patient-days condition percentage for each facility and those representations are adopted herein and reflected in the Table, Finding of Fact 36. PE 15-16 and 18-21; PE 21-22, and 24-26.

[7]/ At the time the administrative complaints were filed, the Agency determined to fine each Respondent because they were not in compliance and because the mitigating factors provided, according to the Agency, were not convincing that Respondents had made appropriate efforts to meet their conditions, including but not limited to marketing efforts. T 479-80, 518-19.

[8]/ Rule 59C-1.013 provides for monitoring procedures and includes subparagraph (4)(a)1.-7. requiring the CON holder to provide information in the annual compliance report. Rule 59C-1.021 provides for CON penalties.

[9]/ When this proceeding began with the filing of the administrative complaints, the Agency considered (in order to determine compliance) whether any of the Respondents had been above or below the subdistrict average. T 929-30. But, the Agency noted that the Respondents generally provided the lowest level of Medicaid as a percentage of their total patient days, while their occupancy was generally higher. T 115-18, 368, 929.

[10]/ The Agency reduced the fine by 75% if the facility was located in a county with a NH diversion project.

[11]/ "[T]he Agency amended its administrative complaints to explicitly utilize only § 408.040(1)(e), Fla. Stat., thereby seemingly responding to Life Care's allegations. The coincidental result was to increase the requested fines." Agency's Proposed Recommended Order at 17, ¶ 19.g.

[12]/ Medicaid hospice days are paid by the hospice program directly to the nursing home. Charity days are counted notwithstanding that the nursing home certifies that it does not receive reimbursement for a patient. T 201-03.

[13]/ The Agency does not maintain an index of fines or orders imposing fines when determining the type of fine to impose. T 510.

[14]/ Given its annual occupancy for 2006, using the Agency's total number of patient days, Ocala had vacant beds to serve Medicaid patients if clinical requirements were met. RE 41-42; T 547-48, 820-24. See also T 920-23. Given their occupancy levels, the other Respondent facilities would have had to turn away, each day, residents with other payor sources in the expectation of finding traditional Medicaid patients. Id. Having empty beds does not inure to the benefit of the Respondent facilities. A nursing home does not necessarily lose money by serving a traditional Medicaid patient, although they may be more profitable serving, e.g., private pay patients. The Agency considers a facilities occupancy rate in light of the Medicaid patient days provided. T 268-71.

[15]/ In reaching settlements with some nursing homes, the Agency has settled for less than the calculated fines in this proceeding. T 294, 307-08, 521. In the post-rule development period and consistent with the action taken by the Agency in the third amended administrative complaints, the Agency will propose a fine of $1,000 a day for those days that the nursing home is not in compliance, thereby giving the facility credit for days of compliance. No other mitigation is considered. T 525-26.

COPIES FURNISHED:

Thomas W. Arnold, Secretary
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308-5403

Richard J. Shoop, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308

Justin Senior, General Counsel
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308

James H. Harris, Esquire
Agency for Health Care Administration
Sebring Building, Suite 330D
525 Mirror Lake Drive, North
St. Petersburg, Florida 33701

Richard Joseph Saliba, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Building 3
Tallahassee, Florida 32308

John E. Terrel, Esquire
John F. Gilroy, III, Esquire
John F. Gilroy, III, P. A.
1695 Metropolitan Circle, Suite 2
Tallahassee, Florida 32308

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.