STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

COMPASSIONATE CARE HOSPICE OF
THE GULF COAST, INC.,

Petitioner,

vs. Case No. 15-2005CON

AGENCY FOR HEALTH CARE
ADMINISTRATION,

Respondent,

and

TIDEWELL HOSPICE, INC.,

Intervenor.
_____/

RECOMMENDED ORDER

An administrative hearing was held in this case on March 8 through 10 and March 14 through 17, 2016, in Tallahassee, Florida, before James H. Peterson, III, Administrative Law Judge with the Division of Administrative Hearings (DOAH).

APPEARANCES

For Compassionate Care Hospice of the Gulf Coast, Inc.:

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For Tidewell Hospice, Inc.:

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STATEMENT OF THE ISSUE

Whether the Agency for Health Care Administration (AHCA) should approve the application of Compassionate Care Hospice of the Gulf Coast, Inc. (Petitioner, the Applicant, or CCH), for Certificate of Need (CON) No. 10337 to provide hospice services in Sarasota County, Florida.

PRELIMINARY STATEMENT

Petitioner timely filed its application for CON 10337 (Application) to establish a new hospice program in Service Area 8D, Sarasota County, in the October 2014 AHCA Hospice Program Batching Cycle. AHCA deemed the Application complete, reviewed it, and preliminarily denied the Application. Petitioner timely filed a Petition challenging AHCA's preliminary decision to deny its Application and requesting a hearing pursuant to section 120.57, Florida Statutes.[1/]

Tidewell Hospice, Inc. (Tidewell or Intervenor), an existing hospice program provider in Service Area 8D, timely petitioned to intervene, seeking entry of a final order denying CCH's Application. Intervention was granted subject to proof of legal standing at hearing. The Tidewell and CCH petitions were referred to DOAH on April 13, 2015 and scheduled for final hearing.

At the final hearing, CCH presented the testimony of Elizabeth A. Lillo, accepted as an expert in nursing, cardiac nursing, and hospice nursing; Dana Rowse, accepted as an expert in respiratory therapy; Eileen D. Hession, CCH's chief quality officer; Catherine Cuthbert-Allman, accepted as an expert in the management and administration of hospice; Donald Haas, M.D., accepted as an expert in cardiology and end-stage heart failure; Rana McClelland, CCH's parent's regional program director in Florida; Brent Brady, accepted as an expert in hospice and palliative care administration and hospice chaplaincy; and Patricia Greenberg, accepted as an expert in healthcare planning and healthcare finance. CCH offered the deposition testimonies of Missy Bassinger, Exhibit P-137; Barbara Cogswell, Exhibit P-138; Carolyn Copenhaver, Exhibit P-139; Stella Hardy, Exhibit P-140; Michael Jones, Exhibit P-141; Rosa Juarez, Exhibit P-142; Michael Juceam, Exhibit P-143; Thomas Kelly, Exhibit P-144; Lauren Kusznir, Exhibit P-145; Michael Levine, Exhibit P-146;

Wendy Merlino, Exhibit P-147; Abby Riddle, Exhibit P-148; Bruce Robinson, M.D., Exhibit P-149; Louis Rosenfeld, M.D., Exhibit P-150; and Nicole Williams, Exhibit P-151, which were received into evidence.

In addition, CCH Exhibits P-1 through P-8, P-13 through P-18, P-20 through P-29, P-31, P-32, P-35 through P-39, P-43, P-44, P-46 through P-49, P-57 through P-63, P-70, P-153, P-159, and P-163A through P-163E were presented and received into evidence. CCH Exhibits P-9 through P-12 were withdrawn. CCH Exhibits P-19, P-30, P-34, P-40 through P-42, P-45, P-50 through P-52, P-55, and P-56 were offered, but not received into evidence. CCH Exhibits P-33, P-53, P-54, P-64 through P-69, and P72 through P-136 were not received into evidence, but were proffered. Exhibit P-71 was proffered with the understanding that its admissibility would be ruled upon in this Recommended Order. Upon further consideration of the proffer, it is concluded that the objection to the admission of Exhibit P-71 is sustained, that the exhibit is more prejudicial than probative, and that other evidence of Tidewell's quality outweighs the negative inferences that could be drawn from the exhibit.[2/]

Tidewell presented the testimony of: Robert Coseo, accepted as an expert in Business Administration; Mary Heath, accepted as an expert in hospice nursing administration, healthcare management, and hospice interdisciplinary care; Linda

Niles, accepted as an expert in hospice nursing and hospice inpatient care; Ken Kinzie, accepted as an expert in grief and bereavement; Christina Speir, accepted as an expert in professional relations and hospice outreach; Irene Henderson, accepted as an expert in hospice nursing, hospice volunteer services and hospice complimentary services; Vicklon Jaynes, accepted as an expert in healthcare risk management, healthcare compliance, and nursing; Stacy Groff, accepted as an expert in hospice volunteer services; Thomas Davidson, accepted as an expert in healthcare planning and in healthcare finance; and Denise Pope, accepted as an expert in healthcare philanthropy and healthcare fund development. Tidewell offered the depositions of Stella P. Grant, Exhibit I-88; David Hoops, Exhibit I-89; Tanya Prete, Exhibit I-90; Kathleen Spoonmore, Exhibit I-91; Noemi Sanchez, Exhibit I-92; Renee Luchtman, Exhibit I-93; and Erica Floyd Thomas, Exhibit I-94; plus a late-filed exhibit consisting of two pages that the parties agreed were meant to be attached to Exhibit I-94; all of which were received into evidence. In addition, Tidewell Exhibits I-1 through I-38, I-40 through I-44, and I-46 through I-97 were received into evidence. Tidewell Exhibits I-39 and I-45 were offered, but not received into evidence. Tidewell Exhibit I-45 was proffered.

AHCA presented the testimony of Marisol Fitch, who was accepted as an expert in CON and healthcare planning. AHCA offered Exhibit R-1 which was received into evidence.

The proceedings were recorded and a transcript was ordered. The parties were given 40 days from the filing of the transcript within which to file proposed recommended orders. The Transcript of the final hearing, consisting of 11 volumes, was filed on April 1, 2016. The parties were thereafter granted extensions of time, until June 6, 2016, to file their proposed recommended orders. Both CCH and Tidewell timely filed their respective Proposed Recommended Orders. AHCA did not file a proposed recommended order. Following an Order granting Tidewell's unopposed motion to amend to correct scrivener's errors, Tidewell filed an Amended Proposed Recommended Order on June 13, 2016. The Proposed Recommended Orders submitted by CCH and Tidewell were considered in the preparation of this Recommended Order.

FINDINGS OF FACT

I. THE PARTIES

1. AHCA is the state agency authorized to evaluate and render final determinations on CON applications pursuant to section 408.034, Florida Statutes.

2. CCH is a development stage, Florida for-profit, privately-owned corporation, formed for the purpose of

initiating hospice services in the Gulf Coast region of Florida, including Sarasota, Manatee, and Pasco Counties.

3. Compassionate Care Group, LTD (CCH-LTD), the Applicant's parent, is a national, for-profit hospice provider, headquartered in Parsippany, New Jersey, operating 39 hospice programs in 22 states, with 57 offices. CCH-LTD (or its affiliate(s)) currently provides hospice services in Service Area 6B consisting of Polk, Highlands, and Hardee Counties; Service Area 3E, consisting of Lake and Sumter Counties; and Service Area 11, consisting of Miami-Dade and Monroe Counties. The hospice services offered in Service Area 6B is CCH-LTD's only mature program in Florida. The other two are still in the start-up phase.

4. Tidewell is a Florida, not-for-profit corporation, currently licensed to provide hospice services and is currently the sole hospice provider in three geographically contiguous Hospice Service Areas, including Service Areas 8D, Sarasota County; 8A, Charlotte and DeSoto Counties; and 6C, Manatee County.

5. Tidewell currently serves on an annual basis approximately 8,000 patients and their families, employs 500 to 600 fulltime, and 100 to 150 part-time, employees and has approximately 1,000 active volunteers. Tidewell has a total average daily census of approximately 1,130 patients.

Tidewell's average daily census in Service Area 8D, Sarasota County, is approximately 500 patients.

II. STIPULATED FACTS AND LAW

6. CCH submitted its Application for CON 10337 to establish a new hospice program in Service Area 8D, Sarasota County, in the October 2014 AHCA Hospice Program Batching Cycle.

7. CCH's Application was deemed complete, reviewed, and preliminarily denied by AHCA.

8. CCH timely petitioned for a hearing, pursuant to section 120.57.

9. Tidewell timely petitioned to intervene. Intervention was granted subject to proof of legal standing at hearing.

10. All of the review criteria in section 408.035 and Florida Administrative Code Rules 59C-1.008, 59C-1.030 and 59C-1.0355 were at issue in this proceeding, except the following subsections of section 408.035(1): (h) is not applicable to this proceeding; (j) is not applicable to this proceeding; and (d) for which the parties stipulated that CCH has access to sufficient resources, including health personnel, management personnel, and funds for capital and operating expenditures for project start-up as described in its Application, except for manpower specifically associated with CCH's proposed Cardiac Connections, Pulmonary Connections, and Promises programs.

11. Florida law requires a hospice program to provide a continuum of palliative and supportive care for terminally-ill patients and their families.

12. "Palliative care" means services or interventions which are not curative, but are provided for the reduction or abatement of pain and suffering.

13. A terminally-ill patient is defined under sections 400.601(3), (7), and (10), Florida Statutes, as having a medical prognosis of 12 months or less life expectancy.

14. The goal of hospice is to provide physical, emotional, psychological, and spiritual comfort and support to dying patients and their families.

15. Hospice care is provided pursuant to an individualized plan of care developed by an interdisciplinary team consisting of physicians, nurses, home health aides, social workers, bereavement counselors, spiritual care counselors, chaplains, and others.

16. There are four levels of service in hospice care: routine home care; continuous care; general inpatient care; and respite care. Routine home care (provided where patients reside) accounts for the vast majority of admissions and patient days.

17. Continuous care, sometimes called "crisis care," is provided in a home care setting or in any setting where patients

reside. Continuous care is provided for short durations when symptoms become so severe that around-the-clock care is necessary for pain and symptom management.

18. General inpatient level of care is provided in either a hospital setting, a skilled nursing unit, or in a freestanding hospice inpatient unit.

19. Respite care is generally designed for caregiver relief. It allows patients to stay in facilities for brief periods to provide breaks for caregivers.

20. The Medicare hospice benefit requires terminally-ill patients to have a life expectancy prognosis of six months or less to be eligible to elect the Medicare benefit. Like Florida law (chapter 400, Florida Statutes), the Federal Medicare benefit excludes patients seeking curative treatments from hospice eligibility.

21. Medicare is the largest payor source for hospice services. Other sources include Medicaid, private insurance, managed care plans including Medicaid Managed Care, other government payors and charity.

22. Hospices are required to accept all patients regardless of ability to pay.

III. STATUTORY REVIEW CRITERIA

A. The need for the healthcare facilities and health services being proposed. § 408.035(1)(a), Fla. Stat.

23. On October 3, 2014, AHCA published a numerical fixed need of zero for new hospice programs in Hospice Service Area 8D, comprised of Sarasota County, for the October 2014 "Other Beds and Programs" batching cycle with a planning horizon of January 2016. The published need of zero was not timely challenged by any party and is, therefore, the numerical need applicable to this case. A published need of zero creates a rebuttable presumption that a new hospice is not needed. Florida Administrative Code Rule 59C-1.0355(3)(b) provides:

> (b) Conformance with Statutory Review Criteria. A Certificate of Need for the establishment of a new Hospice program or construction of a freestanding inpatient Hospice facility shall not be approved unless the applicant meets the applicable review criteria in Sections 408.035 and 408.043(2), F.S., and the standards and need determination criteria set forth in this rule. Applications to establish a new Hospice program shall not be approved in the absence of a numeric need indicated by the formula in paragraph (4)(a) of this rule, unless other criteria in this rule and in Sections 408.035 and 408.043(2), F.S., outweigh the lack of a numeric need.

24. Conceding the absence of a published numerical need in the batch cycle, CCH filed the Application seeking to establish a new hospice program in Service Area 8D, Sarasota County, based on the existence of "not normal and special circumstances."

25. CCH asserts that there are a number of not normal and special circumstances in Sarasota County that outweigh the lack of a numerical fixed need in the overall weighing and balancing of the statutory and rule review criteria. The not normal and special circumstances alleged by CCH include:

> a. Tidewell is a regional monopoly provider, operating the sole hospice in three contiguous hospice service areas. Per section 408.043(2), Florida Statutes, and Rule 59C-1.0355(3)(c), F.A.C., the lack of published numeric need is outweighed by the need to promote competition and discourage regional monopolies.
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> b. There are over 46,979 Medicaid recipients living in Sarasota. Pursuant to section 409.967(2)(c), Florida Statutes, under the new Medicaid managed care model, AHCA established Medicaid Managed Care Requirements to ensure there is an "adequate network" of health care providers in place to provide Medicaid patients with choices when seeking health care services. An "adequate network" of hospices requires a minimum of two hospice providers per county. The Applicant asserts Medicaid recipients in Service Area 8D are being underserved because they do not have an adequate network of providers to choose from in Sarasota.
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> c. Patients, families, physicians, long term care facilities, home health agencies, and other typical hospice referral sources for hospice lack any choice of provider in Service Area 8D. This is especially important for those who have had negative experiences with Tidewell. There are numerous large scale referral sources in Sarasota that are unhappy about, reluctant to, or in some instances even refusing to refer patients to Tidewell because of their negative experiences. The patients not

being referred to hospice because Tidewell is the only option are underserved.

d. Almost 10 percent of Sarasota County residents who received hospice services in 2012, 528 out of 5,707 patients, left Sarasota County to do so. While there is no statistical way to determine why these residents opted to leave Service Area 8D for their hospice care, the number is significant given the large scale referral sources, including home health agencies and long term care providers, dissatisfied with Tidewell or who prefer choice.

e. Hospice patients with end-stage heart, pulmonary, and renal diseases, are underserved in Service Area 8D. Tidewell's decreasing trends on admitting these patients is inconsistent with national, Florida, and Sarasota County data demonstrating increasing needs for hospice care for these patients. The cost and difficulty of caring for these patients often causes hospices to avoid admitting them. The Applicant has developed disease specific programs targeting these patients.

26. In addition to the alleged not normal and special circumstances summarized above, CCH asserts that the AHCA's numeric need calculation of zero should be given little weight in determining whether to approve the Application because there are anomalies in Tidewell's reported admissions that distort the apparent penetration rate used in the calculation. At the final hearing, CCH pointed out that, while AHCA allows double counting for purposes of the fixed need calculation, from a health planning perspective, the apparent penetration rate can be distorted by routinely double counting admissions. CCH provided

an example where Tidewell reported admitting more than 100 percent of the potential cancer deaths over 65. Based on this analysis, CCH argues that because of a distorted penetration rate, the presumption of no need for a new hospice should be given little weight.

27. CCH's attempt to demonstrate an error in the fixed need pool calculation, however, is untimely. Subsections 2 and 3 of rule 59C-1.008(2)(a) state:

> 2. Any person who identifies an error in the Fixed Need Pool numbers must advise the Agency of the error within 10 days of the date the Fixed Need Pool was published in the Florida Administrative Register. If the Agency concurs in the error, the Fixed Need Pool number will be adjusted and re-published in the first available edition of the Florida Administrative Register. Failure to notify the Agency of the error during this time period will result in no adjustment to the Fixed Need Pool number for that batching cycle.
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> 3. Except as provided in subparagraph 2. above, the batching cycle specific Fixed Need Pools shall not be changed or adjusted in the future regardless of any future changes in need methodologies, population estimates, bed inventories, or other factors which would lead to different projections of need, if retroactively applied.

28. Therefore, CCH's purported evidence of an error in the calculation of the fixed need pool has not been considered, and

the rebuttable presumption that a new hospice is not needed has not been diminished by CCH's criticism of the fixed need calculation.

29. CCH's alleged not normal and special circumstances are addressed below in the same order as summarized in paragraphs 25.a. through e., above.

1. Regional Monopoly

30. Section 408.043(2), Florida Statutes, provides in pertinent part:

> HOSPICES.— When an application is made for a certificate of need to establish or to expand a hospice, the need for such hospice shall be determined on the basis of the need for and availability of hospice services in the community. The formula on which the certificate of need is based shall discourage regional monopolies and promote competition . . . .

31. Tidewell is the sole hospice provider in three adjoining hospice service areas (Service Areas 8D, 8B, and 6C), encompassing Manatee, Sarasota, Charlotte, and Desoto Counties. This situation is unique in the state. There is no other part of the state consisting of multiple contiguous hospice service areas with only a single hospice provider. In fact, there is no other part of the state where there are even two adjoining service areas with a single hospice provider.

32. The four counties that comprise the three hospice service areas where Tidewell operates as the sole provider are

recognized as a "region" by the U.S. Bureau of the Census and the Office of Management and Budget. These four counties constitute a recognized combined statistical area used for federal planning and budgeting decisions.

33. Multiple witnesses confirmed Tidewell operates as a single integrated regional provider. All of Tidewell's licensed hospices have the same officers and directors; adhere to the same policies, procedures, and protocols; and share multiple support services, such as information technology and human resources. Practically speaking, Tidewell functions as a single hospice in the four counties which comprise Service Areas 8D, 8B, and 6C.

34. While neither the applicable statute nor rule defines "monopoly," its commonly understood meaning is that there is an exclusive or sole provider of services or goods in an area. Tidewell is the only hospice provider in the four counties that make up Service Areas 8D, 8B, and 6C. It is found, under the circumstances, that Tidewell has a regional monopoly in those contiguous service areas.

35. The fact that Tidewell is a regional monopoly, standing alone, however, is not a sufficient basis to justify approval of a new hospice program in Service Area 8D.

2. Enhancing Access for Medicaid Managed Care Eligible Patients

36. AHCA recently transitioned its Medicaid program to a managed care delivery model. In so doing, the state was required to develop "adequate network" standards for healthcare services offered to Medicaid patients, including hospice services. Section 409.967(2)(c), Florida Statutes, requires AHCA to develop standards governing the number, type, and regional dispersal of healthcare providers to ensure access.

37. There are two separate components of the Statewide Medicaid Managed Care Program: (1) Managed Medical Assistance (MMA), and (2) Medicaid Long Term Care (LTC). AHCA developed model contracts for managed care plans seeking to become approved Medicaid plan providers under the MMA or LTC programs. The model contracts included "adequate network" standards for the various healthcare providers, including hospices. Under the MMA and LTC model contracts, there must be a minimum of two hospice providers per county.

38. The "adequate network" standards contained in the model contracts were developed through a deliberative process between AHCA and the federal government's Center for Medicare and Medicaid Services (CMS) as part of the Medicaid Waiver Program issued by CMS. AHCA and CMS used the existing CMS standards from other programs as a starting point, and then made

informed decisions on particular adjustments to the standards as necessary. Ultimately, some of the standards adopted for Florida were more stringent than the CMS standards and some were less stringent, depending on Florida use rates. The hospice standard adopted for Florida is two hospices per county. One of the reasons that the standard of two hospices per county was adopted is to provide for patient choice in hospice care.

39. Fifty-six of Florida's 67 counties have two or more licensed hospices. Nevertheless, Abbie Riddle, AHCA's Medicaid Plan Management Operations Bureau Chief, testified that there is nothing unusual or not normal about a county not meeting the hospice "adequate network" standards because she had issued waivers in numerous counties throughout the state where there were fewer than two licensed hospices, including Sarasota County.

40. Tidewell argues that because Service Area 8D MMA and LTC contracts are operating under a waiver, there is no reason to be concerned about the lack of an "adequate network." There is no evidence, however, that the decision to issue waivers for fewer than two hospices within a county was based upon an adequacy analysis or determination. Rather, Ms. Riddle, on behalf of AHCA, granted waivers to all counties that did not have at least two hospices with a physical address within the county.

41. Further, AHCA's waiver authority under the model contract does not suggest that the issuance of a waiver is a determination of network adequacy. Rather, Section VI, B., 3. of the model contract provides:

> If the Managed Care Plan is able to demonstrate to the Agency's satisfaction that a region as a whole is unable to meet network requirements, the Agency may waive the requirement at its discretion in writing. As soon as additional service providers become available, however, the Managed Care Plan shall augment its network to include such providers in order to meet the network adequacy requirements. Such a written waiver shall require attestation by the Managed Care Plan that it agrees to modify its network to include such providers as they become available.

42. The addition of another hospice program in Service Area 8D, Sarasota County, would be consistent with the applicable "adequate network" standards for hospice services. This finding, however, is not the equivalent of finding that there is an underserved population in Sarasota County.

3. Lack of Choice and Out-Migration

43. CCH relies on 13 letters of support from the community and 13 deposed witnesses who all urge that choice and competition are sufficient reasons to support approval of CCH's Application. The letters and witnesses, however, express personal opinions that are not based upon any demonstrated

expertise in health planning. Those opinions, therefore, have not been given significant weight.

44. CCH also presented evidence that some residents of Sarasota County receive hospice services from hospices located in surrounding counties. That evidence, however, was insufficient to demonstrate a cause for the outmigration. The observations of outmigration, alone, do not support a conclusion that the outmigration would be prevented by the addition of another hospice provider.

4. Specific Terminally-Ill Populations Not Being Served

45. The Special Circumstances provision in the hospice rule recognizes that a CON may be granted in the absence of need when there are specific terminally-ill populations that are not being served. This can include a specific disease category.

46. The health planners testifying at the final hearing agreed that a given population does not have to be completely unserved to rise to a level of special circumstance. Rather, it is adequate to demonstrate that a given population is underserved compared to the statewide use rate of hospice services for that population.

47. CCH asserts that hospice patients with end-stage heart, pulmonary, and renal diseases are underserved in Service Area 8D. CCH described its programs especially designed to meet

the needs of patients with those diseases. CCH failed, however, to demonstrate that patients in Service Area 8D in those disease categories are underserved.

48. In describing its Cardiac Connections Program, Pulmonary Connections Program, and Advanced Care Connection Programs, CCH relied on evidence from those who created and operate the programs. Documenting an ability to provide care under specialty programs with alternative or additional clinical protocols, however, is not the equivalent of documenting substandard care by an existing provider, an underserved group, or "special circumstances" sufficient to find a need for the Applicant who is offering those alternative protocols.

49. Only 40 percent of CCH-LTD affiliate program offices have implemented the Cardiac Connections Program. Even where implemented, not all of CCH-LTD's end-stage heart failure patients are enrolled in Cardiac Connections.

50. CCH acknowledged that CCH-LTD hospices are still able to deliver acceptable and appropriate care to end-stage heart disease hospice patients without the Cardiac Connections Program.

51. CCH described the Cardiac Connections Program as an enhanced service and agreed that the failure of CCH-LTD affiliate facilities to provide its end-stage heart failure patients with Cardiac Connection Program services does not

constitute "substandard service" to those patients. In fact, CCH agrees that adequate palliative hospice care can be provided to end-stage heart patients without the Cardiac Connections Program.

52. As an example of the significance of the Cardiac Connections Program, CCH cites the fact that its Cardiac Connections Program admits inotrope and left ventricle assist device (LVAD) patients. CCH suggests that, because inotropes must be started in an intensive care setting and are expensive, many hospices will not provide inotropes in a home setting for their patients.

53. Tidewell, however, also admits LVAD patients and patients being infused with inotropes. Those patients are included in Tidewell's complex case management protocol when the patient is going to be infused at home and Tidewell pays for all infused medications related to the patient's primary diagnosis.

54. The evidence further demonstrated that Tidewell understands the needs of end-stage heart failure patients and provides high quality care hospice services for those patients consistent with best practices and generally accepted guidelines.

55. As argued with regard to end-stage heart failure patients and its Cardiac Connections Program, CCH contends that end-stage pulmonary disease patients in Sarasota County are an

underserved group because those patients do not have access to CCH's Pulmonary Connections Program.

56. CCH-LTD's national Pulmonary Connections Program coordinator, however, acknowledged that hospice patients with a primary diagnosis of end-stage pulmonary disease, who are not enrolled in its Pulmonary Connections Program, should not be presumed to be receiving substandard care.

57. Tidewell demonstrated that Tidewell provides high quality palliative care to its end-stage pulmonary disease patients, consistent with best practices, including the necessary patient and family training for the symptoms associated with shortness of breath.

58. Although CCH also argued that its Renal Advanced Care Connections program would enhance access for renal failure patients in Sarasota County, the evidence in that regard was not sufficiently developed at hearing to support any findings of fact with regard to an unmet need that would be served by that program.

59. In addition to describing its specialty programs, CCH relies on admissions data and general demographic or disease prevalence information to support its contention that there is an unmet hospice need in Service Area 8D for end-stage cardiac, pulmonary, and renal patients. For instance, CCH provided evidence showing that heart disease is the number one leading

cause of hospitalization nationally and in Florida, and that it has a high mortality rate. It was also shown that, nationally, there were over 5.7 million heart disease hospitalizations in 2008, and that figure is projected to grow to over 10 million by 2037.

60. Using admissions data, CCH made various data comparisons to demonstrate the need for CCH's Cardiac Connections Program in Sarasota County. CCH compared the rate of re-hospitalization (within 30 days) for patients in the Cardiac Connections Program, with general readmission rates (i.e. not specifically from hospice programs) for end-stage heart failure patients nationally, and all end-stage heart failure readmissions to Sarasota County and surrounding hospitals. CCH also compared the rates of re-hospitalization of cancer patients with heart failure patients.

61. CCH did not, however, offer evidence to allow a comparison of Tidewell's re-hospitalization rates for Service Area 8D end-stage heart failure hospice patients with rates for Cardiac Connections Program patients. Nor did CCH provide data to allow a comparison of the hospital readmission rates for Cardiac Connections Program patients with the re-hospitalization rates for CCH-LTD affiliate end-stage heart failure patients where end-stage heart failure patients are not enrolled in the Cardiac Connections Program.

62. CCH also submitted admissions data showing that Florida has the second highest number of pulmonary disease cases in the U.S. behind California, which has double the population. The evidence showed that Florida ranks number one for pulmonary disease with a prevalence rate of six percent, followed by California at four percent. Sarasota County is even higher with a 7.37 percent prevalence rate, closely followed by Manatee County at 6.5 percent.

63. Relying primarily on comparative admissions data, CCH argues that the population requiring hospice care for heart, pulmonary and renal failure has been going up, while the percentage of patients served by Tidewell for those populations has declined.

64. The admissions data for Tidewell submitted by CCH in support of its argument of allegedly underserved populations, however, does not properly utilize death rates necessary to determine "penetration rates."

65. Rather than relying on general demographic and disease prevalence information or merely comparing differences in the number of admissions in trying to determine whether underservice exists, it is more accurate to compare penetration rates. Penetration rates for an area within a given time period are calculated by dividing the number of hospice admissions by the resident deaths for the area during the time period.

66. Using penetration rates calculated and published by AHCA, Tidewell's overall annual penetration rates for Service Area 8D range from four to nine percent higher than the Florida average penetration rates during the period from 2004 to 2014. While CCH has criticized the calculations for Tidewell's penetration rates as inflated due to AHCA's double counting of readmissions, the numbers hold up in other contexts, indicating that Tidewell is available and accessible for those persons eligible for hospice to a greater degree than the average Florida hospice.

67. When annual Service Area 8D hospice admissions for end-stage heart failure patients as a percentage of annual Service Area 8D end-stage heart failure deaths from 2011 to 2014 (from Department of Elder Affairs' admissions data that does not include readmissions and death statistics from the Florida Bureau of Vital Statistics, respectively) are compared to the average penetration rate for all Florida hospices, it shows that, although the state average fluctuates annually, Tidewell's rate increased incrementally year over year, and approximated, or exceeded, the state average rate three out of four years.

68. Comparing Service Area 8D to all of Florida, using hospice end-stage pulmonary disease and end-stage renal disease admissions as a percentage of end-stage pulmonary and renal disease deaths, respectively, for the years 2011 to 2014, shows

that annual variations in the average rates exist in both Service Area 8D and Florida, but there is no pattern of historical or remarkable underservice to hospice eligible patients of Service Area 8D for either disease.

69. To the extent the state average penetration exceeds Tidewell's in any one year, it does not support the notion that the difference represents a "gap" in service. Gaps, for purposes of the special circumstance applications, must be a material or sustained trend, not a blip.

B. Availability, quality of care, accessibility, and extent of utilization of existing healthcare facilities, and health services in the service district of the applicants. § 408.035(1)(b), Fla. Stat.

70. Sarasota County, with a population of over 400,000 residents, has a healthcare delivery system with 6 acute care hospitals, 31 skilled nursing facilities, 61 assisted living facilities, 53 home health agencies, 9 adult family care homes, 54 homemaker and companion services, 20 surgical centers, 1,100 doctors, and over 5,000 registered nurses.

71. As the sole provider of hospice services in Sarasota County, Tidewell is governed by a 15-member volunteer Board of Trustees who all live in and are representative of Tidewell's Service Areas. The Board provides independent accountability to the communities served by Tidewell, including Sarasota County, Service Area 8D.

72. In addition to its principle administrative office in Sarasota, Tidewell has located two of its eight satellite offices within the geographic boundaries of Service Area 8D, Sarasota County.

73. In addition, Tidewell owns and operates seven hospice houses with a total of 65 licensed general inpatient beds, which can also be used for residential patients and respite care. Two of Tidewell's hospice houses are located in Service Area 8D, with six beds in the hospice house located in Venice and 12 beds in Sarasota.

74. A hospice house residential patient is a patient receiving the hospice routine home level of care when the patient does not have anywhere else available or safe to receive the care (e.g. homeless patients and patients without a caregiver).

75. Although Tidewell maintains contracts with all the hospitals and nursing homes in its Service Areas to utilize facility beds for general inpatient, respite care and residential care, Tidewell's hospice houses provide a more homelike environment, and are more accessible and preferred by families.

76. Tidewell makes all of its hospice program services, hospice houses, and community services available to patients

regardless of their ability to pay, religious preference, race, nationality, ethnicity, or sexual orientation.

77. Tidewell is Medicaid and Medicare certified to serve patients and families eligible for those program benefits, and is accredited, with "deemed" status, by the Community Health Accreditation Program (CHAP) (i.e. AHCA defers to and accepts CHAP accreditation surveys in lieu of routine AHCA operational surveys). CHAP's standards and practices mirror those contained in the Federal Medicare Hospice Conditions of Participation (CoPs).

78. Tidewell is accredited by the National Institute for Jewish Hospice, and Tidewell has a full time Rabbi available and accessible in Service Area 8D.

79. Tidewell effectively competes with other types of post-acute care providers, like private duty home health companies in its Service Areas.

80. Tidewell allocates its excess revenue philanthropic contributions to operating reserves and to provide additional and enhanced services for patients, families, and the community at large.

81. In Sarasota County, Service Area 8D, Tidewell deploys one assisted living facility (ALF) team, two home teams, one nursing home team, and three hospice house teams, and has coverage from its crisis/continuous care, admissions, and triage

(after hours and weekends) teams. Each of these service teams in Sarasota County includes seven to eight registered nurse (RN) case managers (one RN for every 12 patients), one licensed practical nurse (LPN), four to five certified nursing assistants (CNA), three social workers (SW), and one chaplain.

82. Tidewell also employs, for use in Service Area 8D, additional clinical staffing personnel for upticks in census, after hours and triage, admissions and crisis care, including 20 as-needed CNAs, 25 crisis care LPNs, 20 RNs and one LPN for triage and after hours, a wound care coordinator, and a certified child life specialist. Tidewell has access to contracted RNs and LPNs if the census ever exceeds employed staffing ratios.

83. Beyond the interdisciplinary group (IDG) positions required by the CoPs, Tidewell supplies each IDG team with an experienced hospice RN clinical director and a team coordinator. Tidewell also employs an RN wound care program coordinator to assist RN case managers in managing patients with wounds and a specialist trained in therapeutic play for children and how to support parents of chronically ill children.

84. Tidewell maintains a state-of-the-art call center to immediately dispatch and track triage RNs and to respond to requests for information from patients, families, and physicians during evenings and weekends.

85. Tidewell gives all patients eligible for general inpatient, residential, and respite care a choice of all contracted venues and hospice houses that have a bed available. Families often choose the geographically closest hospice house available, without regard to the Service Area where they reside.

86. In hospice, the location where the patient receives care is considered the patient's residence. When the geographically nearest hospice house selected by a patient and family for their convenience is in a Tidewell Service Area, other the one in which the patient is currently receiving care, AHCA requires that the transfer to the new Service Area be reported as a new admission on the hospice's semi-annual utilization report to AHCA. AHCA considers this approach to be consistent with the requirements of rule 59C-1.0355(8)(a)2., which links reported admissions to Service Areas.

87. Tidewell's size and economies of scale allow it to provide an array of enhanced counseling services to patients, families, and the community. Tidewell operates a grief education and support center (the Center), managed by an expert in bereavement, with 10 full-time grief specialists who hold either a license as a clinical social worker or a Master's degree in counseling, or both. Three Tidewell grief counselors are assigned to hospice patients and families in Sarasota

County. In addition to counseling individuals, the Center organizes grief groups in the community.

88. In fiscal year 2015, in Sarasota County, 865 hospice family members accessed Tidewell community group bereavement services beyond the 13-month Medicare hospice benefit period, and Tidewell also served 1,623 community group attendees with no prior hospice connection.

89. The Center also provides, at no charge, emergency counseling interventions. Tidewell grief counselors are on call and respond to calls from law enforcement, fire-rescue, and medical personnel in the community to deal with grief associated with serious accidents and disasters.

90. Tidewell has an extensive and well-organized professional relations and outreach program to ensure that existing and new physicians, nursing homes, ALFs, and other potential referral sources are aware of Tidewell's services. Tidewell provides literature to physicians, nurse practitioners, and physician assistants for use in promoting end-of-life conversations with patients early, and to let physicians know that Tidewell is available 24/7, every day, to evaluate their patients for hospice eligibility.

91. Tidewell provides a significant number of well-organized, well-staffed, professional programs to patients, families, and the community free of charge, which are not

otherwise required or reimbursed under the Medicare hospice benefit. The programs include complementary services, the Tidewell Honors Veterans program, and the Transitions program.

92. Complementary services are methods of intervention that work in conjunction with traditional medicine and nursing interventions to provide the patient with moments of joy, stress relief, and lasting legacies for the family. Complementary service therapies include pet therapy, massage, horticultural intervention, expressive arts, music therapy, humor, Reiki, aromatherapy, care and touch, life legacy and reminiscence.

93. The complementary therapy department is staffed by two massage therapists and one expressive arts facilitator, contracts with two horticulture contractors and one expressive arts contractor, and relies heavily on volunteers.

94. Sarasota Service Area 8D had a total of 1,201 complementary visits from Tidewell staff, contractors, and volunteers in fiscal year 2015.

95. In fiscal year 2015, Tidewell served 478 veterans in its Tidewell Honors Veterans hospice program and 42 patients in its Transitions program in Sarasota County. The Tidewell Honors Veterans is a program that recognizes veterans and expresses the community's gratitude for military service.

96. The Transitions program is a pre-hospice, volunteer-operated program that offers practical assistance to those in

the community with a diagnosis of one year or less life expectancy, but who have not elected hospice care.

97. Tidewell employs a child life specialist and participates in Florida's Partners in Care (PIC) program, which allows pediatric patients with chronic terminal illnesses to receive curative care while also electing hospice palliative care. Tidewell currently has 21 children enrolled in its PIC program and four pediatric hospice patients.

98. The PIC program operates at a deficit because the reimbursement rate from the waiver program is insufficient to fully compensate the staff. Other than the waiver program funding, there are no grants or other funding services for the PIC program.

99. Tidewell has a contract with music therapists for a combined 30 hours a week to see PIC patients and consult with pediatric hospice patients.

100. Currently, Tidewell has a total of 1,002 volunteers that are active and available for assignment. Tidewell employs an expert in non-profit management to organize and maintain its volunteer services. Tidewell has four volunteer coordinators physically located in Sarasota County. Each of the Sarasota volunteer coordinators works with 120 to 150 volunteers.

101. CCH submitted anecdotal evidence that one cardiologist (Dr. Rosenfeld) and two nursing facilities

(according to Dr. Robinson) have had difficulty with referrals to Tidewell. That evidence, however, from a health planning perspective, especially in view of the credible evidence submitted by Tidewell demonstrating the quality, accessibility, and extent of utilization of Tidewell services in Sarasota County, is entitled to little weight.

102. Persuasive evidence submitted by Tidewell showed significant volume of admissions at Tidewell, effective overall outreach to physicians, and Tidewell's success in penetrating Service Area 8D.

C. The ability of Applicant to provide quality of care and Applicant's record of providing quality of care. § 408.035(1)(c), Fla. Stat.

103. In the State Agency Action Report (SAAR), AHCA addressed CCH-LTD's history of providing quality of care in its existing Florida operations and found that CCH-LTD attained a "five-of-five star rating" in each of five survey questions, meaning "respondents were 90 to 100 percent satisfied with the hospice's performance."

104. CCH-LTD has an established Quality Assessment Performance Improvement (QAPI) program in place throughout all of its operations, with continual assessment of quality measures, ongoing and periodic audits of patient medical charts, quarterly meetings between 12 Regional QAPI coordinators and local programs, and monitoring to assure follow-up on

improvement items. In addition, CCH-LTD conducts internal periodic surveys to assure ongoing compliance.

105. All of CCH-LTD's 39 programs have been accredited by CHAP, which is considered as the "gold standard" for hospice quality.

106. According to CCH-LTD's current Florida regional director, the CCH-LTD affiliate in Florida Service Area 6B had a "miscommunication" with AHCA in 2015 regarding its hospice license renewal application. In February 2015, AHCA required CCH-LTD to close its affiliate's hospice in Service Area 6B for failure to submit a renewal application and to discharge or transfer its approximately 230 patients to other hospices, until the affiliate obtained a new license in June of 2015. This incident, in all probability, interfered with the continuity of care for those patients because of CCH-LTD's miscommunication with AHCA.

107. CCH, however, cooperated in the transfer of patients and the transfers were made in an orderly process until the issue with the temporary lapse in license was fully resolved. After that, AHCA reissued CCH its license, and AHCA has subsequently surveyed the program and found it to be without deficiencies.

D. The availability of resources, including health personnel, management personnel, and funds for capital and operating expenditures, for project accomplishment and operation. § 408.035(1)(d), Fla. Stat.

108. CCH demonstrated that it has the resources available, or can secure the necessary resources, for accomplishment of the proposed project.

E. The extent to which the proposed services will enhance access to healthcare for residents of the service district. § 408.035(1)(e), Fla. Stat.

109. While the addition of another hospice would provide a choice for hospice care in Sarasota County, considering the present zero fixed need determination for Service Area 8D, as well as evidence of the quality services and accessibility currently provided by Tidewell, it is found that approval of the Application would not materially improve access to hospice care for residents of Service District 8D. To the contrary, evidence presented by Tidewell demonstrated that approval of CCH's proposed program will, immediately and over the long term, have a material adverse impact on Tidewell and the hospice services provided by Tidewell to the Sarasota community.

110. Tidewell, using reasonable assumptions regarding length of stay, number of patients that would be lost to CCH, and variability of Tidewell's expenses, demonstrated that a reasonable expectation from approval of the Application will cause Tidewell to incur a lost contribution margin per patient

day of $72.92, totaling at least $1.2 million for each year that CCH captures 300 or more of Tidewell's Service Area 8D admissions.

111. If CCH captures 300 admissions annually, Tidewell reasonably and conservatively expects, based on a calculation of average historical donations per admission, to lose at least $145,000 in philanthropy annually.

112. Considering available options to absorb the contribution margin and philanthropic losses in the event CCH is approved, and because Medicare hospice benefit core services are required by law, Tidewell determined that operational and administrative costs for core patient and family services costs would not be cut (except for reducing the variable costs associated with the 300 lost admissions accounted for in Tidewell's contribution margin analysis).

113. Given the impact, approval of the Application would require Tidwell to look for reductions to costs in its enhanced patient services (not otherwise required by the Medicare hospice benefit) and community education and support services, which Tidewell currently provides and for which Tidewell incurred costs in fiscal year 2015 of approximately $1.5 million exclusive of grants.

114. Specifically, and within two years of CCH's second year of operation, Tidewell reasonably estimated that it will

need to eliminate: 100 percent of Tidewell's community grief education and support groups; the Transitions Program; 100 percent of complementary services to patients; 100 percent of its volunteer program; and Tidewell's Childrens Program.

115. Tidewell has cut community services in the past when operating revenue dropped significantly. Between fiscal year 2012 and fiscal year 2014, when operating revenue dropped $10 million, Tidewell had to cut $346,000 from bereavement services and over $300,000 from complementary services. This history indicates a willingness and likelihood Tidewell would make similar cuts if a competitor reduces Tidewell's contribution margin by $1.5 million.

116. CCH contends that Tidewell can easily absorb any lost margin because Tidewell had an increase in unrestricted net assets in 2015 of approximately $10 million. However, approximately $6 million of Tidewell's 2015 asset increase came from philanthropy, of which $2.5 million came from a single donor. Another $1 million of the increase came from investments. Neither philanthropy nor investment income are considered assured for purposes of projecting future net assets and funding losses. In reality, and disregarding philanthropy and interest, a net operating revenue of only approximately $2.7 million would have been available to Tidewell to absorb a contribution margin loss of $1.2 million in 2015.

117. It is fair to characterize the impact of terminating these Tidewell programs as significant and adverse in the short- and long-term for Tidewell and the services it provides to the Sarasota community.

F. The immediate and long-term financial feasibility of the proposal. § 408.035(1)(f), Fla. Stat.

118. Assuming CCH secures 300 admissions in year two of its proposed project, its project appears financially feasible in the near and long-term.

G. The extent to which the proposal will foster competition that promotes quality and cost effectiveness. § 408.035(1)(g), Fla. Stat.

119. While approval of the Application would increase competition, in view of other findings regarding the negative impact on Tidewell and likely interference with its thriving hospice program with complementary, voluntary and overall quality, it is concluded that competition of the type proposed by CCH is not needed in Service Area 8D, nor would it promote quality and cost effectiveness.

H. The applicant's past and proposed provision of healthcare services to Medicaid patients and the medically indigent. § 408.035(1)(i), Fla. Stat.

120. CCH demonstrated a history of providing services to both Medicaid and charity patients. The Applicant projects 4.3 percent of patient days to be provided to Medicaid and

charity patients and conditioned the Application on contracting with the Medicaid managed care plan provider.

CONCLUSIONS OF LAW

Jurisdiction

121. The Division of Administrative Hearings has jurisdiction over the parties and the subject matter of these proceedings. §§ 120.569, 120.57(1), and 408.039(5), Fla. Stat.

Standing

122. In order for an existing healthcare facility to have standing to intervene in a CON proceeding, it must show that it will be "substantially affected" by approval of the certificate of need application at issue. § 408.039(5)(c), Fla. Stat. In order to be substantially affected by the outcome of a proceeding, a party must show: (1) injury in fact of sufficient immediacy, and (2) that the person's substantial injury is of a type or nature which the proceeding is designed to protect. Agrico Chem. Co. v. Dep't of Envtl. Reg., 406 So. 2d 478 (Fla. 2d DCA 1981).

123. Tidewell proved by a preponderance of the evidence that it has standing to participate as a party in this proceeding. Tidewell demonstrated that approving CCH's Application will have an immediate and long-term adverse, unnecessary impact on Tidewell in the absence of need. The adverse impact on Tidewell, as outlined in the Findings of Fact,

above, is of the type or nature of injury against which this proceeding is designed to protect, and is substantial enough to establish standing.

Burden of Proof

124. The petitions in this case commenced a de novo proceeding intended to formulate final agency action, "not to review action taken earlier and preliminarily." Fla. Dep't of Transp. v. J.W.C. Co., 396 So. 2d 778, 786-87 (Fla. 1st DCA 1981)(citing McDonald v. Dep't of Banking & Fin., 346 So. 2d 569 (Fla. 1st DCA 1977)); § 120.57(1), Fla. Stat. Therefore, the Agency's preliminary decision on a CON application, including findings in a SAAR, is not entitled to a presumption of correctness. Id.

125. CCH, as an applicant for a CON, has the burden of demonstrating that its Application should be granted. Boca Raton Artificial Kidney Ctr. v. Dep't of HRS, 475 So. 2d 250 (Fla. 1st DCA 1985). The award of a CON must be based on a balanced consideration of applicable statutory and rule criteria. Dep't of HRS v. Johnson and Johnson Home Healthcare Inc., 447 So. 2d 361 (Fla. 1st DCA 1984); Balsam v. Dep't of HRS, 486 So. 2d 1314 (Fla. 1st DCA 1988). The weight to be given each criterion is not fixed but varies depending on the facts of each case. Collier Med. Ctr., Inc. v. Dep't of HRS, 462 So. 2d 83 (Fla. 1st DCA 1985).

Fixed Need Pool

126. Two times a year, the applicable fixed need pool rule projects future numerical need for hospices in each Service Area and compares it with the current and future capacity of existing providers to meet that need. Fla. Admin. Code R. 59C-1.0355.

127. The published fixed need pool numerical projections for hospices in each Service Area accounts for the growth of all terminally ill populations who may benefit from hospice. Alternative methodologies, which substitute comparative admission data or penetration rates for a particular disease cohort, are not admissible to displace a numerical need calculation of zero. Lifepath, Inc. v. AHCA, Case No. 00-3203CON et seq., RO at 116-118 (DOAH March 17, 2003; AHCA July 8, 2003).

Regional Monopoly

128. As found as a matter of fact, Tidewell's hospice programs occupy three contiguous Service Areas recognized as a "region" by the U.S. Bureau of the Census and the Office of Management and Budget. As the sole provider of hospice services in the region, Tidewell meets the common definition of monopoly.[3/]

129. Section 408.043(2) provides in pertinent part:

> (2) Hospices.— When an application is made for a certificate of need to establish or to expand a hospice, the need for such hospice

> shall be determined on the basis of the need for and availability of hospice services in the community. The formula on which the certificate of need is based shall discourage regional monopolies and promote competition.

(Emphasis added).

130. Section 408.043(2) does not prohibit regional monopolies, nor does it require the formula to do so. Rather, it requires the formula to "discourage regional monopolies and promote competition."

131. While the formula in rule 59C-1.0355 found a numeric need of zero despite the presence of a regional monopoly, it cannot be said that the rule, in and of itself, encouraged (or failed to discourage) a regional monopoly. Even if it did, rule 59C-1.0355 has not been challenged in this proceeding, and the fact that Tidewell has a regional monopoly, standing alone, is an insufficient basis to approve another hospice program in Service Area 8D.

Special Circumstances – Alleged Underserved Populations

132. Rule 59C-1.0355(3)(b) provides in pertinent part:

> Applications to establish a new Hospice program shall not be approved in the absence of a numeric need indicated by the formula in paragraph (4)(a) of this rule, unless other criteria in this rule and in Sections 408.035 and 408.043(2), F.S., outweigh the lack of a numeric need.

133. Rule 59C-1.0355(4)(d) provides in pertinent part:

> (d) Approval Under Special Circumstances. In the absence of numeric need identified in paragraph (4)(a), the applicant must demonstrate that circumstances exist to justify the approval of a new Hospice. Evidence submitted by the applicant must document one or more of the following:
>
> 1. That a specific terminally ill population is not being served.
>
> 2. That a county or counties within the service area of a licensed Hospice program are not being served.

134. Florida's CON program for hospices requires, in the absence of a published numerical need, that a CON applicant identify a specific underserved group, of sufficient size and underservice, and that the addition of a new program in the absence of published numerical need is justified. Even if such an underserved group is sufficiently identified and quantified, the CON should not be awarded unless each applicable statutory criteria is weighed individually, and balanced collectively, in relation to the alleged special circumstances.

135. The Applicant did not demonstrate, by the preponderance of evidence, that hospice patients and families are not being adequately served by the existing provider, or that the existing provider is not an accessible, available, high quality hospice program provider.

136. Specifically, the evidence showed that end-stage heart failure, renal failure, and end-stage pulmonary disease hospice patients are adequately served by Tidewell consistent with current best clinical practices. Although CCH may have different protocols for managing these patients, a different approach to serve a group already being adequately served does not demonstrate underservice.

137. CCH has not otherwise demonstrated a sufficient future market growth of allegedly underserved patients to support another provider without diminishing the market share of the exiting provider.

138. To the extent that the evidence demonstrated what the fixed need pool "would have been" in Sarasota County if Tidewell's transfers had not been counted in the applicable planning horizon, the demonstration suffers from at least two flaws: the demonstration should have been the subject of a timely filed challenge to the fixed need pool publication of numerical need, pursuant rule 59C-1.008(2)(a)2. and; even if proper to consider here, CCH's approach fails to discount the transfers reported by other multi-service area providers.

139. Rule 59C-1.0355(8) requires semi-annual utilization reports to be filed by hospices with AHCA. The reports, with regard to the "number of new patients admitted" expressly requires in pertinent part:

> (a) For the number of new patients admitted:
>
> 1. The 6-month total of admissions under age 65 and age 65 and over by type of diagnosis (e.g., cancer; AIDS).
>
> 2. The number of admissions during each of the 6 months covered by the report, by service area of residence.

140. It is reasonable, pursuant to that rule, for AHCA to require hospices with multiple service areas to report, as an admission, any transfer of a patient between service areas.

141. Considering all of the evidence, review criteria and applicable law, CCH did not sufficiently identify or quantify an underserved group, nor did CCH prove the existence of special circumstances that outweigh the applicable statutory criteria and the foreseeable adverse impact of a new program on the existing provider and community.

RECOMMENDATION

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

RECOMMENDED that the Agency for Health Care Administration enter a final order denying CON Application No. 10337.

DONE AND ENTERED this 19th day of September, 2016, in Tallahassee, Leon County, Florida.

JAMES H. PETERSON, III
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Filed with the Clerk of the
Division of Administrative Hearings
this 19th day of September, 2016.

ENDNOTES

[1/] Unless otherwise noted, all citations to the Florida Statutes and Florida Administrative Code are to current versions.

[2/] See § 90.403, Fla. Stat. (relevant evidence excluded where probative value substantially outweighed by danger of unfair prejudice). On the same grounds, although admitted into evidence, Exhibit I-46, consisting of a Stipulation and Order of Settlement and Dismissal entered into between a CCH-LTD New York affiliate and the United States, has been given no weight in the findings and conclusions set forth in this Recommended Order.

[3/] The primary definition of "monopoly" found in Blacks Law Dictionary, 812 (5th ed. 1979), provides:

> A privilege or peculiar advantage vested in one or more persons or companies, consisting in the exclusive right (or power) to carry on a particular business or trade, manufacture a particular article, or control the sale of the whole supply of a particular commodity. A form of market structure in which one or only a few firms dominate the total sales of a product or service.

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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.