STATE AGENCY ACTION REPORT
ON APPLICATION FOR CERTIFICATE OF NEED

A. PROJECT IDENTIFICATION

1. Applicant/CON Action Number

Compassionate Care Hospice of the Gulf Coast, Inc./CON #10337
2625 Drane Field Road, Suite 4
Lakeland, Florida 33811

Authorized Representative: Judith Grey
(201) 919-4905

2. Service District/Subdistrict

Hospice Service Area 8D (Sarasota County)

B. PUBLIC HEARING

A public hearing was not held or requested regarding the proposal to establish a new hospice program in Sarasota County, Hospice Service Area 8D.

Letters of Support

Compassionate Care Hospice of the Gulf Coast, Inc. (CON #10337) submitted 13 letters of support as well as a proclamation from the City of Lakeland declaring November National Hospice month. The applicant also included a study entitled, "*Hospice Care and Resource Utilization in Medicare Beneficiaries with Heart Failure"* in this section of the application.

Letters of Opposition

The sole opposition letter to this proposed project is a 10-page (with four tables) letter of opposition, from Rob Coseo, Vice President, Tidewell Hospice, Inc., the sole existing Hospice Service Area 8D provider. The opposition letter includes 80 letters of appreciation and support of Tidewell's existing hospice operations. Mr. Coseo states objection to the proposed project and offers reasons why the Agency should deny it. These are summarized below.

Tidewell discusses differences in services and objectives in the community between a for profit provider (the applicant) vs. a non-profit provider (Tidewell). According to Tidewell, generally, for-profit hospices prioritize shareholder return to their private investors, while non-profit hospices have a social contract with the communities they serve, and prioritize their charitable community mission.

Tidewell states being Community Health Accreditation Partner (CHAP) accredited with Deemed Status and is certified to provide hospice benefits under all publicly funded and commercially available insurance programs. Tidewell contends all its services are equally available to families on a nondiscriminatory basis.

Tidewell indicates having been, for over 30 years, a responsible and innovative sole provider of hospice program services in Manatee, Sarasota, Charlotte and Desoto Counties and as such, has achieved economies of scale sufficient to provide an abundance of ancillary end-of-life services to patients, their families and the community.

Tidewell reiterates the Agency's hospice no need methodology determination for Hospice Service Area 8D for the current batching cycle.

Tidewell asserts that considering its market penetration rate in Hospice Service Area 8D, it is not a complacent sole provider and discusses what it considers its self-initiated operational innovations, to ensure best practices, eliminate clinical errors and ensure quality care. Tidewell highlights several of these, along with its five-star Agency satisfaction survey records. Tidewell also discusses the Tidewell Nursing System (a nurse tracking system with the ability to dispatch nurses who are closet in proximity and availability). Tidewell further notes its Telehealth monitors in homes of patients with cardiac and pulmonary diagnosis for daily monitoring of vital signs to reduce patient anxiety, eliminate hospital admissions and improve quality of life.

Tidewell contends that its already low net margin will be negatively impacted if it is required to expend limited funds to advertise, market and differentiate itself from a would-be competitor. Per Tidewell, these funds should be better spent to continue otherwise unfunded complementary services.

Tidewell notes support on its quality from a support letter by Erin McLeod, Senior Vice President of Sarasota's Senior Friendship Center. Other positive support letters are also referenced.

Tidewell states providing over $855,000 of in-kind services to the communities it serves, with $415,000 allocated to Hospice Service Area 8D alone, not including significant administrative costs. See the table below.

Community Services	Sarasota County FY 2014
Grief Education and Support	$155,000
Transitions Program	$85,000
Complementary Services	$170,000
Honors	$5,000
Total	$415,000

Source: Letter of Opposition to CON application #10337, page 6, Table 1

According to Tidewell, the above listed community services go beyond the scope of core services and minimal requirements and will be immediately at risk of elimination in the event that Tidewell's admissions are cannibalized and the proposed project is approved, with these funds being reallocated to advertising.

Tidewell indicates that if the proposed project is approved, it estimates a range of five percent to 20 percent decrease in patient days, with a corresponding adverse impact dollar amount. See the table below.

Sarasota County	Actual FY 2014	5% decrease	10% decrease	15% decrease	20% decrease
Patient Days	180,166	171,157	162,149	153,141	144,133
Adverse Impact		($802,483)	($1,604,966)	($2,407,449)	($3,209,932)

Source: Letter of Opposition on CON application #10337, page 7, Table 2, from Rob Coseo on behalf of Tidewell

Tidewell discusses exceeding the regulatory required minimum of five percent matching volunteer hours and stated 20.17 percent matching volunteer hours in its fiscal year 2013-2014, with 70,490.31 volunteer hours, allocating to a $1,542,305.89 value and a volunteer count of 1,100. For the same fiscal year, Tidewell maintains non-matching volunteer hours totaling 38,931.79 with a value of $729,785.51. In total, for the period, when matching and non-matching hours and values are combined, the totals are 109,422.10 hours, with a value of $2,272,091.40, respectively. According to Tidewell, its volunteers performed more than 40,000 individual activities/visits and contributed the equivalent of 52.5 full-time employees (FTE).

In conclusion, Tidewell indicates that the proposed program is not needed to achieve the benefits of competition in Hospice Service Area 8D and would only result in financial loss to the applicant and Tidewell, putting existing quality hospice services at risk of reduction and elimination.

C. PROJECT SUMMARY

Compassionate Care Hospice of the Gulf Coast, Inc. (CON #10337) (also referenced as Compassionate Care, CCHGC, or the applicant), a for-profit, development stage corporation, a wholly owned subsidiary of Compassionate Care Group, Ltd., expects issuance of license in Hospice Service Area 8D (Sarasota County) in September 2015 and initiation of service in October 2015. Milton Heching, an attorney, engineer and ordained Rabbi, is the founder and CEO of CCG, founded in 1993. The applicant's parent operates hospice services in Hospice Service Areas 3E, 6B and 11.

Also in this batching cycle, Compassionate Care seeks approval to establish a new hospice program in Hospice Service Areas 5A (Pasco County) and 6C (Manatee County). The applicant indicates the parent operates 39 programs in 22 states, with 57 office locations.

Compassionate Care is proposing total project costs of $142,965.

Schedule C for CON application #10337 includes the following conditions:

- The applicant will initiate contact and enter into a contract with all Medicaid managed care providers with members in the Subdistrict to enable those entities to comply with Florida Statutes requiring contracting with two hospice providers to provider (sic) its members with choice.
- Compassionate Care Hospice Group, Ltd. will implement its Advanced Care Connections Program immediately upon licensure of Compassionate Care Hospice of the Gulf Coast, which will be made available to all eligible Sarasota County residents.
- The applicant will implement its Promises (renal) program in Subdistrict 8D within year one of operation.
- The applicant will implement its Pulmonary Connections Program in Subdistrict 8D with year one of operation. It will also hire a respiratory therapist to be actively working in this program.
- The applicant has conditioned approval of this application on the provision it become accredited by CHAP upon certification.
- The applicant will provide a home health aide ratio above National Hospice and Palliative Care Organization guidelines at an average of eight to 10 hours per patient per week.
- The applicant has conditioned approval of this application on the provision it will not build or operate freestanding hospice houses in Sarasota County.

- The applicant has conditioned approval of this application on the provision it will not actively fundraise in the Subdistrict 8D market.
- The applicant will implement its Cardiac Connections program upon licensure. It will be made available to all eligible residents with a qualifying cardiovascular disease. As part of this implementation the applicant will ensure:

  - The Medical Director of the Cardiac Connections Program will be a cardiologist
  - The Cardiac Connections Program will have a part-time licensed nurse practitioner
  - At a minimum, the applicant will hold quarterly meetings for area cardiologists to maintain open communications with the community cardiologists to continue to educate them about options in end-of-life care for their patients
  - Cardiac Connections Program patients will receive daily communication from staff either via an in-person visit, or by telephone if an in-person visit is not scheduled on a particular day
  - All Cardiac Connections Program patients will have a Cardiac Comfort Kit with them in their home
  - An annual report is prepared for the Agency how hospital readmissions for heart failure have decreased in the subdistrict relative to the applicant's cardiac admissions

Section 408.043 (4) Florida Statutes states that "Accreditation by any private organization may not be a requirement for the issuance or maintenance of a certificate of need under ss. 408.031-408.045." Also, for any conditions that are required hospice services, the Agency would not require condition compliance reports on mandated services.

Should the proposed project be approved, the applicant's proposed conditions would be reported in the annual condition compliance report as required by Rule 59C-1.013 (3) Florida Administrative Code. Section 408.606 (5) Florida Statutes states that "The agency may deny a license to an applicant that fails to meet any condition for the provision of hospice care or services imposed by the agency on a certificate of need by final agency action, unless the applicant can demonstrate that good cause exists for the applicant's failure to meet such condition."

D. REVIEW PROCEDURE

The evaluation process is structured by the Certificate of Need review criteria found in Section 408.035, Florida Statutes, rules of the State of Florida, and Chapters 59C-1 and 59C-2 of the Florida Administrative Code. These criteria form the basis for the goals of the review process. The goals represent desirable outcomes to be attained by successful applicants who demonstrate an overall compliance with the criteria. Analysis of an applicant's capability to undertake the proposed project successfully is conducted by evaluating the responses provided in the application and independent information gathered by the reviewer.

Applications are analyzed to identify various strengths and weaknesses in each proposal. If more than one application is submitted for the same type of project in the same district (subdistrict or service planning area), applications are comparatively reviewed to determine which applicant best meets the review criteria. In this batching cycle for Hospice Service Area 6A (Hillsborough County), the sole applicant is VITAS.

Section 59C-1.010(3)(b), Florida Administrative Code, prohibits any amendments once an application has been deemed complete. The burden of proof to entitlement of a certificate rests with the applicant. As such, the applicant is responsible for the representations in the application. This is attested to as part of the application in the certification of the applicant.

As part of the fact-finding, the consultant Steve Love analyzed the application in its entirety with consultation from the financial analyst Everett (Butch) Broussard, Bureau of Central Services, who evaluated the financial data as part of the application.

E. CONFORMITY OF PROJECT WITH REVIEW CRITERIA

The following pages indicate the level of conformity of the proposed project with the review criteria and application content requirements found in Sections 408.035, and 408.037, and applicable rules of the State of Florida, Chapters 59C-1 and 59C-2, Florida Administrative Code.

1. Fixed Need Pool

a. Does the project proposed respond to need as published by a fixed need pool? Chapter 59C-1.008, Florida Administrative Code and Chapter 59C-1.0355, Florida Administrative Code.

For the January 2016 planning horizon, a fixed need pool projection of zero was published for Hospice Service Area 8D in Volume 40, Number 193 of the Florida Administrative Register, issued October 3, 2014. The applicant is applying to establish a new hospital program in Hospice Service Area 8D, in the absence of published numeric need. As promulgated in Chapter 59C-1.0355(4)(d) of the Florida Administrative Code, in the absence of numeric need, the applicant must demonstrate that special circumstances exist to justify the approval of a new hospice.

Hospice Service Area 8D is currently served by Tidewell Hospice, Inc. The applicant proposes special and not normal circumstance(s) that it believes will justify an additional hospice in the subdistrict.

b. 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.

3. That there are persons referred to hospice programs who are not being admitted within 48 hours (excluding cases where a later admission date has been requested). The applicant shall indicate the number of such persons.

The applicant contends that section E.1.b.(1) shown immediately above exists, and that aside from the four age/diagnosis cohorts defined by the Agency, other specific populations are: terminally ill patients with end-stage cardiovascular disease, end-stage pulmonary disease, end-stage rental disease and those who sought hospice services outside the subdistrict (outmigrating terminally ill patients).

c. Other Special Circumstances:

Compassionate Care Hospice of the Gulf Coast, Inc. (CON #10337) offers "not normal and special circumstances" that the applicant contends warrant the proposed project. CCHGC contends that the subdistrict is a monopolistic market with only a single hospice provider. CCHGC asserts that the inability to seek and/or compare counsel,

philosophy, approach and clinical team from more than one hospice is archaic and unfortunate. Further CCHGC maintains that for 388,000 persons (and approximately 5,000 deaths per year) to be unable to comparatively shop for hospice services at home is wrong. The applicant also notes that there are nearly 124,000 senior residents in Sarasota County. Also, CCHGC asserts that choice and competition enhance quality of care.

CCHGC discusses that Statewide Medicaid Managed Care (SMMC) requires providers to contract with more than one (i.e. at least two) hospice providers (an exception being when there is a sole hospice provider in the service area). According to the applicant, the requirement of offering a choice if possible demonstrates a preference of offering choices and a recognition of the benefits to patients created by offering a choice of hospice provider.

Pursuant to this application, CCHGC defines outmigration as seeking or enrolling in hospice services in a subdistrict other than Subdistrict 8D. Using MedPar (Centers for Medicare and Medicaid Services-CMS) and NHA Analysis data, CCHGC indicates that it queried to obtain the names of all hospices who had at least one patient defined as a resident of Sarasota County, Florida for calendar year (CY) 2012. The applicant states that totals include both new admissions plus those still on census at the hospice from the prior year. See the table below.

Sarasota County Residents Enrolled in Hospice Programs Medicare Fee for Service Only		
Tidewell Hospice	4,773	90.9%
Other Florida Hospices	149	2.9%
Out of State Hospices	328	6.2%
Total	5,250	100.0%
Total Outmigration	477	9.1%

Source: CON application #10337, page 18

Based on the above data, the applicant extrapolated the resulting annualized patient count for calendar year 2012. See the table below.

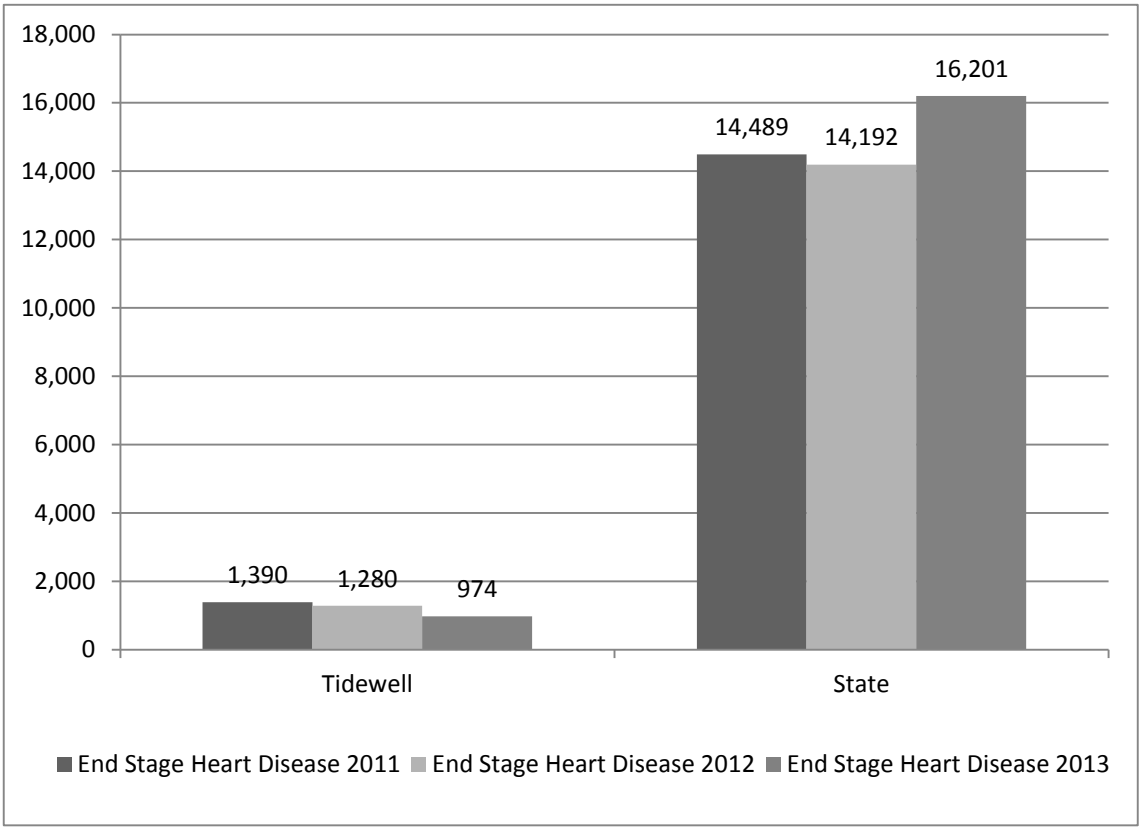
Sarasota County Residents Enrolled in Hospice Programs Annualized Based on 92 Percent Medicare Fee for Service Utilization		
Tidewell Hospice	5,188	90.9%
Other Florida Hospices	162	2.9%
Out of State Hospices	357	6.2%
Total	5,707	100.0%
Total Outmigration	518	9.1%

Source: CON application #10337, page 19

CCHGC estimates, based on the above information, that there is on average 518 patients categorized Sarasota County residents being treated by hospices outside Subdistrict 8D. The reviewer notes that the applicant incorrectly added the numbers above and that the total is 519. CCHGC contends that project approval would enhance access and decrease outmigration from Sarasota County.

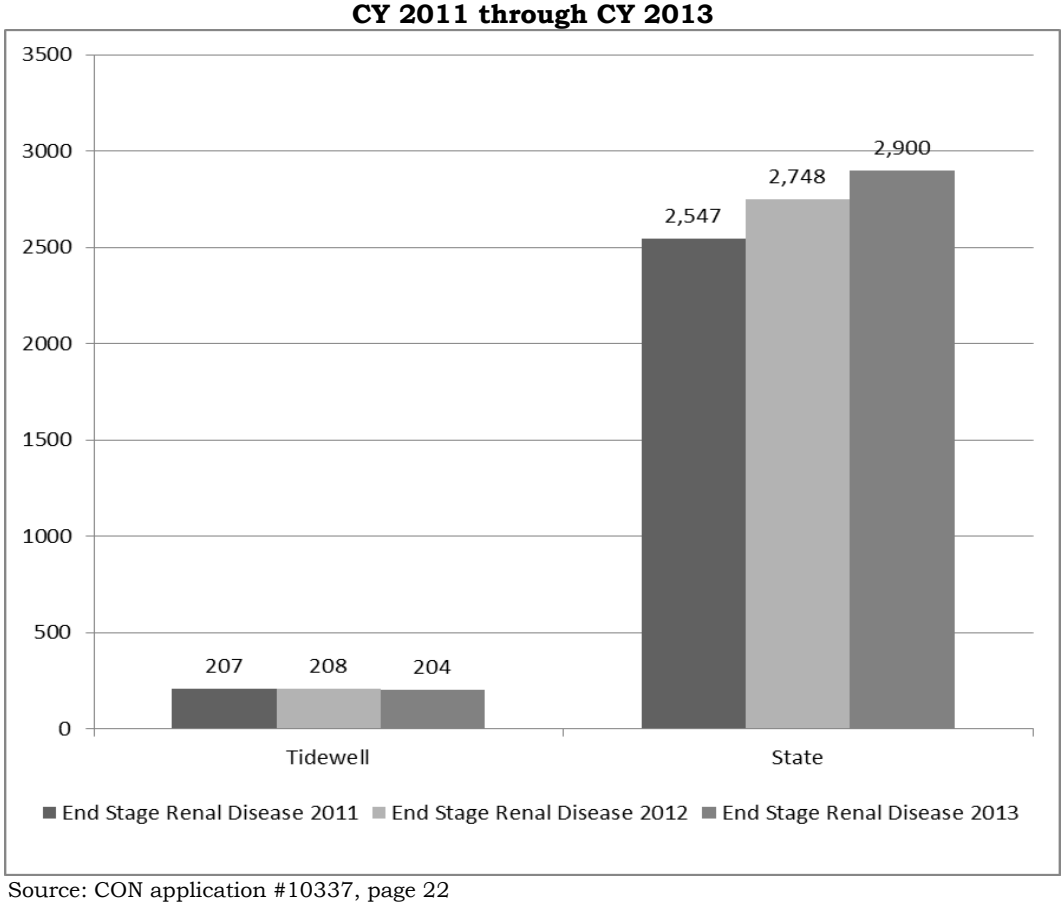
Using Department of Elder Affair's (DOEA) death reporting data for CY 2011 through CY 2013, CCHGC indicates that though deaths are not decreasing in various non-cancer categories, within the subdistrict or the State of Florida, Tidewell has shown consistent decreases in admissions with the diagnosis of end-stage heart disease, end-stage renal disease and end-stage pulmonary disease. See the graphs below.

End-stage Heart Disease Hospice Admissions
CY 2011 through CY 2013



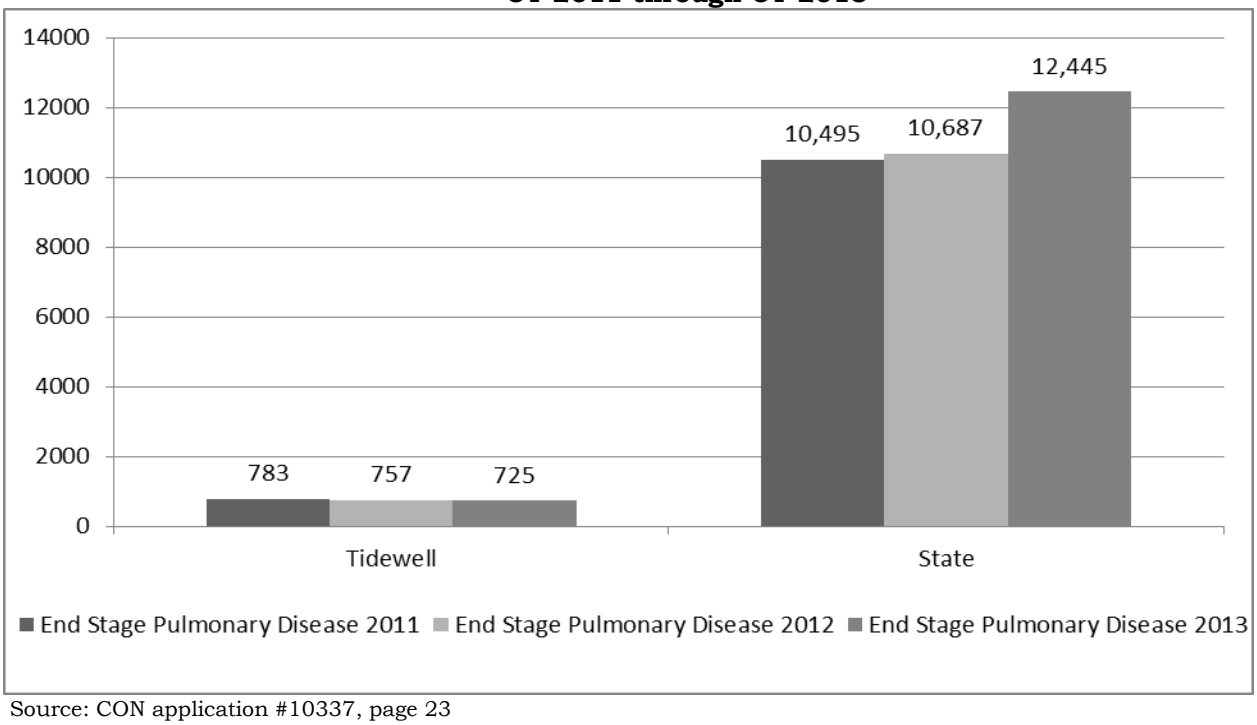
Source: CON application #10337, page 21

End-stage Renal Disease Hospice Admissions
CY 2011 through CY 2013



Source: CON application #10337, page 22

End-stage Pulmonary Disease Hospice Admissions
CY 2011 through CY 2013



Source: CON application #10337, page 23

CCHGC maintains that overall, the major groupings of non-cancer admission categories at Tidewell have demonstrated decreasing access, while hospice admissions in the State of Florida in these disease categories have increased overall. The applicant asserts that it will implement its specialized disease programs within the subdistrict to enhance access for end-stage heart disease, end-stage renal disease and end-stage pulmonary disease.

The reviewer notes that while the applicant compares Tidewell's admissions by selected non-cancer death cohorts to state death counts for those same cohorts and for the same time periods (CY 2011-CY 2013), the applicant does not offer death counts for the same cohorts specific to Sarasota County. Tidewell serves several service areas including Charlotte, DeSoto, Manatee and Sarasota Counties (6C, 8A, 8D).

The reviewer notes to solve the stated "not normal/special circumstances" of chronic diseases (end-stage cardiac and end-stage pulmonary disease) in the proposed project, the applicant offers a Cardiac Connection Program and a Pulmonary Connections Program, respectively. CCHGC previously offered conditions associated with both the Cardiac Connections Program and the Pulmonary Connections Program.

According to the applicant, its Cardiac Connections Program results in a readmission rate of 1.4 percent versus the national average of 23 percent as of October 1, 2014. CCHGC indicates that the national average is more than 16 times CCHGC's experience results in substantial savings for CMS as well as the local hospitals. The applicant discusses the various cost savings items through Cardiac Connections. Per CCHGC, its team approach incorporates therapeutic and pharmacological treatments focused on reducing symptoms of congestive heart failure. Further the applicant contends that treatment will greatly reduce or eliminate visits to the emergency room and hospitalization. CCHGC maintains that by way of Cardiac Connections, patients will not be admitted and readmitted to the hospital for end-stage cardiovascular disease, rather patients will be treated at home and managed at home. CCHGC maintains that the proposed project's Cardiac Connection Program will have the following specialized home care attributes:

- Clinical management of the patient will be overseen by an advanced practice nurse (nurse practitioner) who is cardiac certified. This designated person will visit the patient one to two times per week and additionally as needed.

- Patients will be evaluated by a cardiac nurse practitioner upon admission. The hospice physician, a cardiologist, will visit the patient at home within one week of admission to the hospice program.
- The physician to be appointed as Medical Director of Cardiac Connections within CCHGC will be a board-certified cardiologist.
- Each patient will have a dietary consult from a registered dietician.
- Each patient will be evaluated by a physical therapist.
- Each patient will undergo a nutritional consult.
- Holistic therapies to reduce patients anxiety and other symptoms including message and music therapy will be provided.
- CCHGC staff will maintain daily contact to monitor symptoms and all after-hours symptom calls will receive a nursing visit.
- Patient and family support will be readily available with social services and pastoral care.
- Every Cardiac Connections patient will receive a Cardiac Comfort Kit in their place of residence in the case of emergency. This kit includes specific medication such as ten tablets of nitrogylcerines, 1-40mg bottle of Lasix to be administered by a nurse intravaneou8sly, 2-5mg viles of morphine to be administered by a nurse intravenously and 10 tables of 81mg aspirin. The Cardiac Connections Kit is distributed to every patient in the case of emergency but has only been used in one percent of all Cardiac Connections patients.

The applicant contends that goals of the Cardiac Connection Program are:

- Break the cycle of emergency room visits and hospitalizations
- Manage anxiety
- Comfort the patient's family
- Improve the patient's functional status
- Alleviate dyspnea (shortness of breath, a subjective difficulty or distress in breathing, usually associated with disease of the heart or lungs)
- Alleviate pain

CCHGC discusses programming such as the Pulmonary Connections Program and other related terminally ill patient diagnoses, such as chronic obstructive pulmonary disease (COPD), emphysema and pulmonary fibrosis. CCHGC notes that in 2013, respiratory disease was the third leading category of deaths in Sarasota County, following only

cancer and cardiovascular disease. The applicant also states that last year, 310 residents died of various respiratory diseases of which 271 were 65 and older. The applicant emphasizes that Medicare claims data reveals that in 2012, only 124 Sarasota County residents who died of respiratory diseases were on hospice care.[1] CCHGC notes that Medicare claims data only captures data for Medicare fee for service enrollees (majority ages 65 and older), and these cases categorized as "respiratory" encompass all respiratory related deaths. CCHGC asserts that the Sarasota County penetration rate for terminally-ill residents with respiratory disease will increase materially, if the proposed project is approved. The applicant asserts that its pulmonary hospice team will be committed to controlling severe symptoms which contribute to re-hospitalization. The applicant indicates that the team will accomplish the following:

- Improve overall quality of life
- Boost patient and caregiver confidence in managing symptoms at home
- Prevent hospitalization
- Frequent monitoring by a respiratory therapist and a registered nurse to relay changes in condition to the medical director
- Hospice aide to assist with activities of daily living up to two hours a day and
- Entire hospice team to support physical, emotional and spiritual needs

CCHGC maintains that upon admission, a respiratory therapist will perform a separate evaluation, as well as an environmental assessment of pulmonary patients, with additional screening for a physical therapist.

CCHGC discusses the Promise Program (end-stage renal disease), stating that this is often the most underserved patient population. The applicant states that it offers specialized services to patients receiving hemo-dialysis who are also in need of hospice. CCHGC indicates that it provides a supportive network of medical, nursing and psycho-social interventions for patients who may be considering stopping dialysis treatments.

Additionally, the applicant discusses community outreach, veterans outreach, volunteer services, bereavement services and Rainbows (a bereavement program for children who are experiencing grief through a death or divorce in the family). In addition to its Advanced Care

[1] The reviewer notes that the applicant presented the exact same figures (310 residents, 271 65+ and 124 on hospice care) for Manatee County in CON application #10293.

Connections (Palliative Care Program), the applicant lists holistic therapy services, as follows:

- Transitions
- Massage therapy
- Music therapy
- Energetic care
- Sacred Spaces
- Comfort Corners
- Guided imagery
- Reminiscence therapy
- Pet therapy

CCHGC lists other programs, outreach and services as follows:

- Palliative care program for correctional medical services
- Educational training programs
- Compassionate home care

CCHGC presents the penetration data, using both 2012 and 2013 resident death data to indicate the difference in penetration percentages. The applicant notes that the Agency utilized the 2012 death data but that 2013 death data was available to be viewed and so the applicant supplies both figures. The reviewer collapses the applicant's two tables. See the table below.

Tidewell Hospice Penetration Rate
Current Utilization with 2012 Deaths vs. 2013 Deaths

Tidewell	U65C (1)	65C (2)	U65NC (3)	U65NC (4)	Total
Hospice Admissions	630	2,190	395	4,757	7,972
2012 Resident Deaths	592	1,997	1,554	6,744	10,887
Tidewell Penetration Rate	106.4%	109.7%	25.4%	70.5%	73.2%
2013 Resident Deaths	606	2,100	1,426	7,096	11,228
Tidewell Penetration Rate	104.0%	104.3%	27.7%	67.0%	71.0%

(1) U65C-under the age of 65 with cancer as the primary diagnosis
(2) 65C-older than 65 with cancer as the primary diagnosis
(3) U65NC-under the age of 65 with a non-cancer diagnosis
(4) 65NC-older than 65 with a non-cancer diagnosis
Source: CON application #10337, page 26

The applicant indicates that the underlying cause of the data shown and the discrepancies (greater than 100 percent penetration) are unknown to CCHGC but the applicant states this could be due to overstating the number of hospice patients being served and therefore preventing the need formula from being properly used to calculate fixed need. CCGCH contends that the "potentially" inaccurate admissions are suppressing the need for an additional hospice provider, thus propagating a never-ending monopolistic environment.

Using Florida Department of Health (DOH) Office of Vital Statistics and Agency data, CCHGC asserts that evaluating deaths per hospice program and persons per hospice program within each subdistrict is a metric worth consideration. CCHGC indicates that for CY 2013, Tidewell had the fourth highest deaths of any of Florida's 27 hospice service areas and that service areas with higher death counts tend to have a single hospice program. See the table below.

Hospice Programs per Resident Deaths by Subdistrict
CY 2013 Deaths and Current Hospice Admissions

Subdistrict	2013 Deaths	Hospice Programs*	Deaths per Program
5B	11,340	1	11,340
6A	9,740	1	9,740
8C	6,609	1	6,609
8D	5,078	1	5,078
9C	13,515	3	4,505
6C	3,498	1	3,498
4A	11,839	4	2,960
3A	5,644	2	2,822
5A	5,574	2	2,787
8A	2,652	1	2,652
3E	4,969	2	2,485
3B	4,716	2	2,358
1	6,585	3	2,195
11	19,104	9	2,123
10	14,144	7	2,021
6B	7,713	4	1,928
7B	9,086	5	1,817
9A	1,802	1	1,802
9B	5,158	3	1,719
2B	3,323	2	1,662
7A	6,481	4	1,620
2A	3,187	2	1,594
4B	7,509	5	1,502
7C	2,976	2	1,488
8B	2,909	2	1,455
3D	2,456	2	1,228
3C	2,338	2	1,169
Total	179,945	74	2,432

*Includes both licensed and approved hospice programs
Source: CON application #10337, pages 28 and 29

Using Agency population estimates and hospice program data, CCHGC states that Subdistrict 8D has 5,078 resident deaths per hospice program and that this is more than two times the state average (2,400) with a median at 2,100 (the average being distorted, per CCHGC, by the few monopolies). The applicant contends that if the proposed project is approved, there would be 2,539 resident deaths per hospice, what CCHGC concludes is more consistent with the current average and 20 percent above the non-monopolistic subdistricts.

The applicant discusses the parent's national hospice programs, mission and philosophy (CON application #10337, pages 33-39). CCHGC contends that a fundamental difference between Tidewell's provision of care and a core belief by CCHGC is that patients are entitled to live as fully and as comfortable as possible in the privacy of their own home, with their loved ones. CCHGC indicates that it does not build hospice houses nor is it the intent of the applicant to build one in Sarasota County.

CCHGC describes an interdisciplinary team (IDT) approach that the applicant indicates the proposed project will mirror that is used in Compassionate Care's other hospice programs throughout the country. Team members are stated to be specifically trained in palliative care so that they have the ability and expertise to effectively manage symptoms, control pain and care for psychological, social, economic and spiritual needs of every patient. Per the applicant, at the "circle of care" are the patient and the patient's family. CCHGC provides a narrative description of each of the following IDT members:

- Patient's primary care physician
- Hospice medical director
- Registered nurse
- Social worker
- Certified home health aide
- Therapists (physical, occupational or speech therapy as indicated by the care plan)
- Dieticians
- Bereavement counselors
- Chaplains
- Trained volunteers
- Nurse practitioner

CCHGC provides a diagram of the "Compassionate Care Circle of Care" that lists the functions of the IDT team (CON application #102337, page 42).

CCHGC indicates the provision of routine, general inpatient, respite and continuous care to its terminally-ill patients, with care either provided at home or inpatient within either a nursing home or hospital. The applicant indicates supplemental services as follows:

- Admission response within 24 hours of referral
- In-home evaluation to determine hospice eligibility
- After-hours and weekend admissions
- Nurses available for evening and/or night visits
- Inpatient hospice for symptom control, family breakdown or respite care

- Licensed practical nurses or certified home health aides to assist with personal care and to provide wound care
- Continuous care during crisis

Some additional programming for terminally-ill patients that the applicant indicates include: cancer, Alzheimer's/dementia, stroke, liver disease, Amyotrophic lateral sclerosis (ALS), HIV/AIDS and failure to thrive.

CCHGC explains the Advanced Care Connections (Palliative Care Program) and states that palliative care is appropriate at any stage of life, regardless of diagnosis or prognosis and that the program affirms life during illness by providing holistic and compassionate care to patients and families, by providing access to palliative care. Services provided by Advanced Care Connections include:

- Expert treatment of pain and other symptoms
- Communication between Advanced Care Connections and patient regarding disease and illness prognosis
- Assistance and guidance navigating through the health care system
- Emotional support for the patient and patient's family
- Improved quality of life

The applicant reiterates its Cardiac Connections Program. CCHGC indicates that the program is specifically designed and tailored to address in a given community where the overwhelming need in non-cancer clients are those suffering from end-stage cardiovascular disease. In part, the applicant emphasizes that the Cardio Connections Program helps to avoid multiple hospitalizations and more invasive procedures that have been shown to actually lower patients' life expectancy due the higher incidence of infection and surgical complications.

CCHGC offers a month-by-month breakdown of admissions for year one and year two. See the table below.

Admissions for Compassionate Care Hospice of the Gulf Coast, Inc. Year One (Ending September 30, 2016) and Two (Ending September 30, 2017) Sarasota County			
Year One		**Year Two**	
Month	**Admissions**	**Month**	**Admissions**
1	2	13	17
2	4	14	18
3	5	15	20
4	5	16	21
5	5	17	23
6	10	18	24
7	12	19	26
8	14	20	27
9	14	21	29
10	16	22	30
11	16	23	32
12	17	24	33
Total	**120**	**Total**	**300**

Source: CON application #10337, page 57

The applicant contends that the presented forecasted market penetration and market share projections are reasonable and realistically obtainable. CCHGC also offers a projected disease and age mix during the first two years of the proposed project. See the table below.

Admissions by Projected Disease and Age for CCHGC Year One and Two of Operations Sarasota County		
Diagnosis	**Year One**	**Year Two**
Cancer	30	54
Cardiac	34	120
Respiratory	17	60
Renal Failure	10	30
HIV/AIDS	1	1
Other	29	35
Total	120	300
Under 65	12	30
Over 65	108	270

Source: CON application #10337, page 58

The applicant projects a mix of hospice patients under the age of 65 to hospice patients over the age of 65 is 10:90 and a mix of cancer to non-cancer patients (by year two) of 18:82.

2. Agency Rule Criteria and Preferences

a. Rule 59C-1.0355(4)(e) Preferences for a New Hospice Program. The Agency shall give preference to an applicant meeting one or more of the criteria specified in the below listed subparagraphs:

(1) Preference shall be given to an applicant who has a commitment to serve populations with unmet needs.

The applicant responded to this Agency rule criterion and preference in Item E.1.a. (CON application #10337) of this report. Specifically, CCHGC cited terminally-ill residents with end-stage cardiovascular disease, end-stage pulmonary disease, end-stage rental disease and those who sought hospice services outside the Subdistrict (outmigrating terminally-ill patients).

(2) Preference shall be given to an applicant who proposes to provide the inpatient care component of the hospice program through contractual arrangements with existing health care facilities, unless the applicant demonstrates a more cost-efficient alternative.

The applicant states that it is CCHGC's intent to have contractual agreements with nursing homes and hospitals, as well as other health care providers designed to meet patient needs in Sarasota County. According to CCHGC, this will fulfill its goal to expand awareness and utilization of hospice.

CCHGC provides a list of one hospital and three assisted living facilities (ALFs) that expressed support: Venice Regional Bayfront Health, Springrove Assisted Living Facility, Harbor Inn of Venice and Village on the Isle. The reviewer notes that the listed facilities' written letters of support do not include a statement that commits to a contractual agreement for inpatient care. However, the applicant states plans to seek such agreements, if the proposed project is approved.

(3) Preference shall be given to an applicant who has a commitment to serve patients who do not have primary caregivers at home; the homeless; and patients with AIDS.

The applicant states that in cases where the patient is not able to care for himself/herself and has no caregiver support group or is homeless, CCHGC may recommend placement in an ALF or SNF, in which the hospice will be able to provide residential care. Also, the applicant maintains that the proposed project's social workers will assist patients without financial resources to obtain residential care in a hospice unit within an ALF or SNF.

(4) In the case of proposals for a hospice service area comprised of three or more counties, preference shall be given to an applicant who has a commitment to establish a physical presence in an underserved county or counties.

Hospice Service Area 8D consists of one county - Sarasota. This preference is not applicable.

(5) Preference shall be given to an applicant who proposes to provide services that are not specifically covered by private insurance, Medicaid or Medicare.

The applicant states it will be community based and offer a host of special programs and services that are not specifically covered by private insurance, Medicaid or Medicare. Those services include:

- Advanced Care Connections
- Cardiac Connections
- Pulmonary Connections
- Promise Program
- Veterans outreach
- Hands on Nurse Aide Care
- Complementary Care Program
- Compassionate Care 4 Kids
- First Night at Home
- Various therapies and programs (massage, music, reminiscence and pet therapies; energetic care, Sacred Spaces, and guided imagery)
- Transitions
- Rainbows
- Comfort Corners

b. Chapter 59C-1.0355, Florida Administrative Code contains the following general provisions and review criteria to be considered in reviewing hospice programs.

(1) Consistency with Plans (Rule 59C-1.0355(5), Florida Administrative Code). An applicant for a new hospice program shall include evidence in the application that the proposal is consistent with the needs of the community and other criteria contained in the local health council plan. The application for a new hospice program shall include letters from health organizations, social services organizations, and other entities within the proposed service area that endorse the applicant's development of a hospice program.

The applicant notes the submitted letters of support contained in Tab 5 of CON application #10337 and states the underlying themes in the letters include:

- Choice is a fundamental right
- Choices will provide quality improvements
- Choice will enhance hospice programs and provide consumers with a quality provider that will tailor its programming to meet the needs of Sarasota County residents

(2) Required Program Description (Rule 59C-1.0355(6), Florida Administrative Code): An applicant for a new hospice program shall provide a detailed program description in its certificate of need application, including:

(a) Proposed staffing, including use of volunteers.

As reflected in Schedule 6A of the application, the following is the proposed Subdistrict 8D staffing for each of the first two years of operation.

Compassionate Care Proposed Staffing for Subdistrict 8D Year One Ending September 30, 2016 and Year Two Ending September 30, 2017		
Position	**Number of FTEs Year One**	**Number of FTEs Year Two**
Administrator/Clinical Coordinator	1.00	1.00
Professional Relations Coordinator	0.50	0.50
Secretary	--	1.00
Community Liaison	0.50	1.00
Clinical Coordinator	1.00	1.00
Medical Director	0.20	0.50
RNs	1.00	3.50
Per Diem RNs	0.30	0.50
LPN	0.00	0.50
Nurses' Aides	2.50	11.00
Nurse Practitioner	0.30	0.50
Per Diem Nurses' Aides	0.40	1.00
Continuous Care Per Diem LPN	0.24	1.02
Continuous Care Per Diem Aide	0.24	1.02
Music Therapist	0.20	0.50
Message Therapist	0.20	0.50
Dietary Services	0.20	0.30
Respiratory Therapist	0.20	0.50
Social Worker	0.50	1.50
Volunteer Coordinator	0.30	0.50
Chaplain	0.30	0.50
Total	**10.08**	**28.34**

Source: CON application #10337, Schedule 6A

Compassionate Care indicates that the staffing is based on the anticipated direct nursing and care staff to be utilized in the delivery of hospice services, the support staff required and salaries and benefits per staff position. The reviewer notes that the applicant did not include the proposed use of volunteers.

(b) Expected sources of patient referrals.

The applicant provides a list of potential referral sources including area ALFs, physicians and community health care organizations/members. CCHGC indicates that referrals will come from area physicians, SNFs and other health care providers. The applicant contends that if approved, CCHGC will initiate active discussions and obtain support and referral relationships with the remaining area providers.

(c) Projected number of admissions, by payer type, including Medicare, Medicaid, private insurance, self-pay, and indigent care patients for the first two years of operation.

The applicant provides the following table of projected admissions by payer group.

Projected Admissions by Payer Type

Payer Source	Year One Admissions	Year Two Admissions
Medicare	113	282
Medicaid	4	9
Charity	1	4
Insurance/Managed Care/Other	2	5
Total	120	300

Source: CON application #10337, page 82

(d) Projected number of admissions, by type of terminal illness, for the first two years of operation.

The applicant provides the following table of expected admissions by type.

Diagnosis	Year One Admissions	Year Two Admissions
Cancer	30	54
Cardiac	34	120
Respiratory	17	60
Renal Failure	10	30
HIV/AIDS	1	1
Other	29	35
Total	120	300

Source: CON application #10337, page 82

(e) Projected number of admissions, by two age groups, under 65 and 65 or older, for the first two years of operation.

The applicant provides the following projected number of admissions by age group.

Age Group	Year One Admissions	Year Two Admissions
Under 65	12	30
Over 65	108	270
Total	120	300

Source: CON application #10337, page 83

The reviewer notes that the applicable rule references age groups of under 65 and 65 or older, while the applicant references under 65 and over 65.

(f) Identification of the services that will be provided directly by hospice staff and volunteers and those that will be provided through contractual arrangements.

The applicant indicates that core services include: physician, nursing, social work, pastoral/counseling and dietary counseling and will be provided for by the applicant's staff and volunteers. CCHGC indicates plans to contract for certain services as needed: durable medical equipment, medical supplies, pharmaceuticals and physical, speech and occupational therapy. Non-core services to be provided by the applicant's staff are: massage and music therapy, energetic care, Sacred Spaces, guided imagery, reminiscence, pet and aroma therapy, reflexology, hypnotherapy, life enhancement services and homemaker services.

(g) Proposed arrangements for providing inpatient care.

The applicant states it will have contractual arrangements with SNFs and hospitals—the most cost efficient alternative for inpatient and respite needs for its proposed patients and easily met by existing hospital and SNFs.

(h) Proposed number of inpatient beds that will be located in a freestanding inpatient facility, in hospitals, and in nursing homes.

The applicant states that based on its field investigation, CCHGC is very confident of its ability to enter into sufficient contracts with existing facilities for beds to meet needs.

(i) Circumstances under which a patient would be admitted to an inpatient bed.

The applicant provides a list of clinical criteria that should be present for a patient to be considered appropriate for admission to general inpatient care on pages 84-85 of CON application #10337. The applicant affirms that it would make an admission decision after an evaluation and in consultation with the patient's attending physician or hospice physician.

To assure continuity of care between home and the inpatient setting, the applicant states that a specific policy focused on communication among team members, hospital staff, physicians and others are used. Compassionate Care states that this policy assures that there are no gaps in services, treatment or patient needs.

(j) Provisions for serving persons without primary care givers at home.

The applicant states that in cases where the patient is not able to care for himself/herself and has no caregiver support group--CCHGC may recommend placement in an ALF or SNF where the hospice will be able to provide residential care. The applicant asserts that it is intimately familiar with appropriate methods for the provision of care to special needs populations including those without caregivers.

(k) Arrangements for the provision of bereavement services.

The applicant indicates that the CCHGC Bereavement Services policy is to provide appropriate and coordinated bereavement services and counseling to families and caregivers for at least 13 months following the death of the patient. In addition, the applicant states that such services may be provided to residents and staff of SNFs, ALFs and other medical facilities, as needed, for at least 13 months after the patient's death.

According to CCHGC, an initial bereavement risk assessment will be completed by the social worker, bereavement coordinator or another qualified designee within five days of admission. The applicant provides additional information on bereavement procedures on pages 85-87 as well as a Bereavement Service Policy in Volume 3, Tab 21 of CON application #10337.

(l) Proposed community education activities concerning hospice programs.

The applicant states the provision of extensive community education activities surrounding the benefits of hospice to increase hospice awareness and utilization. The applicant also reiterates FTEs for a professional relations coordinator and clinical liaison in year one and year two of the proposed project. CCHGC also indicates plans to host hospice educational events at senior organizations, religious affiliated groups, Hispanic organizations, Veterans organizations, health fairs to educate residents in Sarasota County, regarding hospice end-of-life care.

(m) Fundraising activities.

The applicant states that Compassionate Care Hospice has a relationship with Compassionate Care Hospice Foundation (stated to be an unrelated not for profit 501(c)(3) organization). Per the applicant, if approved, the proposed project will not actively raise funds from the community but if an individual wants to make a charitable donation, CCHGC will direct those individuals to the Foundation's website.

b. Rule 59-1.0355(8) Florida Administrative Code: Semi-Annual Utilization Reports. Each hospice program shall report utilization information to the Agency or its designee on or before July 20th of each year and January 20th of the following year.

The applicant states that it will comply with all reporting requirements.

3. Statutory Review Criteria

a. Is need for the project evidenced by the availability, quality of care, efficiency, accessibility and extent of utilization of existing health care facilities and health services in the applicant's service area? ss. 408.035(1)(a) and (b), Florida Statutes.

Compassionate Care Hospice of the Gulf Coast, Inc. (CON #10337) is applying to establish a new hospice program in Hospice Service Area 8D in the absence of published numeric need.

The following chart illustrates hospice admissions for the past five years, ending June 30, 2014. As shown below, admissions increased from 3,445 as of June 30, 2010 to 3,553 as of June 30, 2014.

Hospice Admissions for Hospice Service Area 8D June 30, 2010 – June 30, 2014	
12 Months Ending	**Admissions**
June 2014	3,553
June 2013	3,423
June 2012	3,587
June 2011	3,374
June 2010	3,445

Source: Agency for Health Care Administration Florida Need Projections for Hospice Programs, issued October 2010-October 2014.

There is one licensed hospice provider in Hospice Service Area 8D – Tidewell Hospice, Inc.

For the 12-month period ending June 2014, Tidewell reported 3,553 total admissions to its hospice program in Service Area 8D. Resident deaths (with age stated) in Hospice Service Area 8D during CY 2012 totaled 5,005, which equates to a 70.99 percent penetration rate for Tidewell in Sarasota County. The statewide hospice penetration average for the 12-month period ending June 2014, for both single-provider service

areas and multi-provider service areas, was 65.99 percent. Single-provider service areas in the state averaged 66.52 percent penetration during the 12-month period ending June 30, 2014.[2]

The Agency notes that Tidewell penetrated Hospice Service Area 8D at a 5.00 percent higher rate than the average for all hospice service areas statewide and at a 4.47 percent higher rate than the average for single-provider service areas statewide, for the 12-month period ending

June 30, 2014. This shows that, for the period, Tidewell surpasses the statewide penetration rates on both single-provider and multiple-provider hospice service areas.

The most recently published Florida Need Projections for Hospice Programs publication dated October 3, 2014 indicates a projected hospice patient count (3,592) over current hospice patient count (3,553) or 39, a number 311 patients short of the 350 count established in Chapter 59C-1.0355(4)(a), Florida Administrative Code, as demonstration of numeric need for an additional program. Therefore, numeric need was not published for this service area.

The following table illustrates projected admissions for years one and two for the applicant:

Total Projected Admissions for Years One and Two

CON application #	Applicant	Year One	Year Two
10337	CCHGC	120	300

Source: CON application #10337, page #57

The applicant reiterates the seven reasons it proposes the project based on "not normal and special circumstances" as:

- Hospice monopoly in the subdistrict
- Medicaid managed care statute regarding "hospice choice"
- Outmigration of hospice patients from the subdistrict
- Chronic disease, now terminal, patients with low and reducing access
- Questionable market statistics relative to admissions
- Deaths and persons per hospice in the subdistrict
- Community support

[2] The nine single-provider hospice service areas in Florida in the 12-month period ending June 30, 2014 totaled 30,988 hospice admissions, with resident deaths (with age stated) of 46,581. The nine single-provider hospice service areas are as follows: 3D, 3E, 5B, 6A, 6C, 8A, 8C, 8D and 9A.

The applicant reiterates its quality of care features and characteristics and states being in compliance with Conditions of Participation as well as the Medicaid Program. The applicant states it has never had any Medicare cap issues or other investigations or focused reviews. The applicant also reiterates its proposed conditions.

CCHGC states that it is a subsidiary of a much larger organization that has 20+ years of experience and has developed several quality hospice programs throughout the nation. The applicant notes its parent company's comprehensive policies and procedure manual.

Compassionate Care indicates that it will contract for certain services through the most appropriate and efficient contracts—whether that be through existing national contracts, extending contracts it has in other Florida markets or through local contracts. The applicant states it will ensure staff is educated in the provision of appropriate, high quality effective and efficient services enabling patients to receive the most appropriate pain and symptom management to meet the needs.

The applicant concludes that hospice services in Sarasota County are limited due to the fact that a monopoly in the market and region exists and that by approving the proposed application, hospice services will become more accessible and available for the community. CCHGC asserts that its proposed specialized programs will enhance access to non-cancer patients. The applicant also maintains that its model of care is a significantly different model of care than the existing hospice and will therefore provide the community with an accessible alternative.

b. Does the applicant have a history of providing quality of care? Has the applicant demonstrated the ability to provide quality care? ss. 408.035(1)(c), Florida Statutes.

The Agency published results of its statewide Hospice Provider Satisfaction Survey, available at the Florida HealthFinder.gov website at http://www.floridahealthfinder.gov/Hospice/CompareHospiceStats.aspx. The most recent results of this survey range from January 2014 through March 2014. The proposed provider and the existing Hospice Service Area 8D provider are shown in the table below. These two entities attained a five-of-five star rating in each of the five survey questions. The five-star rating is the highest attainable and indicates respondents were 90 to 100 percent satisfied with the hospice's performance.

Hospice Provider Satisfaction Survey Results
January 2014 – March 2014

Hospice	Main Office (City)	Lowest # of Respondents	Highest # of Respondents
Compassionate Care Hospice of Central Florida, Inc.	Lakeland	4	6
Tidewell Hospice, Inc.	Sarasota	309	428

Source: Florida HealthFinder.gov website run date of 11/10/2014

In October 2014, the DOEA published results of its statewide 2014 Report on Hospice Demographic and Outcome Measures, available on the DOEA's website at: http://elderaffairs.state.fl.us/doea/Evaluation/2014%20Hospice%20Report.pdf. The report results are shown as percentages for three Outcome Measures—1, 2 and 2A.

Outcome Measure 1 measures the percentage of patients who had severe pain (seven or higher on the 0-to-10 scale) at admission and whose pain was reduced to a level of five or less by the end of the fourth day of care in the hospice program.

Outcome Measure 2 includes the following question:

- Did the patient receive the right amount of medicine for his or her pain?

Outcome Measure 2A includes the following question:

- Based on the care the patient received, would the patient and/or responsible party recommend hospice services to others?

The proposed provider and the existing hospice participated in this report and is listed in the table below.

DOEA 2014 Report on Hospice Demographic and Outcome Measures for CY 2013

Hospice Name/City	Outcome Measure			Number of Patients
	1	2	2A	
Compassionate Care Hospice of Miami-Dade, Inc. / Lakeland	100%	92%	98%	468
Tidewell Hospice, Inc. / Sarasota	83%	94%	97%	7,181
State Average Outcomes	83%	95%	96%	
State Total Number of Patients				116,958
State Average of Patients				2,720

Source: DOEA, 2014 Report on Hospice Demographics and Outcomes Measures, issued October 2014 for CY 2013, pages 8 through 10, Table 6.
Note: Florida hospices reported pain level data for 53,025 patients at the time of admission and 9,092 patients reported severe pain on admission. There were 19,435 survey responses to Outcome Measure 2 and 24,876 responses to Outcome Measure 2A. The number of responses for each outcome measure, by hospice, was not provided

The DOEA's report for CY 2013 indicates that pain measure results (Outcome Measure 1) may vary by hospice, as some hospices start reporting pain on the day of admission while others start on the first day of care received. In addition, when multiple pain scores were reported on the fourth day, the score selected varied. Some hospices use the first pain score reported, some use the lowest pain score reported, and others use the highest pain score reported.

CCHGC maintains that as a development stage corporation, it has no operational history. However, the applicant indicates that its parent and subsidiaries have been providing quality hospice care since 1993. The applicant discusses the quality of Compassionate Care Group, Ltd.'s Florida operations and others around the nation. The applicant contends that CCHGC operations have had no licensure violations and no Medicare cap issues. The applicant also contends that all programs are either already enrolled in the Medicare and Medicaid Programs or are actively awaiting certification. The applicant maintains that CCHGC is a member of the National Hospice and Palliative Care Organization (NHPCO) and ascribes to its policies and procedures. The applicant offers a sampling of hospice program policies and procedures in Volume 3, Tab 21of CON application #10337. CCHGC asserts that all of CCH's existing hospice operations either have or are in the process of obtaining CHAP accreditation. According to CCHGC, companywide, CCH surpasses NHPCO standard staffing ratios and guidelines that are direct patient care roles.

CCHGC states plans to comply with the companywide Compassionate Care Hospice Quality Assessment and Performance Improvement Plan (QAPI). According to the applicant, all hospice employees are expected to participate in the QAPI Program and are informed of ongoing Performance Improvement Projects (PIPs). The QAPI is stated to have 45 events or indicators that are monitored (on a quarterly basis) to include four quality areas: patient/family outcomes, operations, service and process care. Some of the listed criteria are:

- Medication errors
- Adverse drug reactions
- Patient falls with injuries
- 911 calls by patient/families/caregivers
- Unwanted hospitalizations
- Infection control
- Medical record review
- Pain assessment and control review
- Comfort within 48 hours of admission
- Concurrent patient satisfaction survey
- Family satisfaction survey

- Performance improvement projects (PIPs)
- Community bereavement support
- Access to ethics committee

The applicant indicates that CCHGC has a contractual arrangement with OCS Home Care, a stated consulting firm that delivers business intelligence to home health and hospice providers. CCHGC indicates that there are 10 benchmarked components:

- Patient/family centered care
- Ethics and consumer rights
- Clinical excellence and safety
- Inclusion and access
- Organizational excellence
- Workforce excellence
- Standards
- Compliance
- Stewardship and accountability
- Performance measurement

CCHGC discusses patient/family satisfaction surveys and continuing education/in-service training and memberships in quality associations (pages 101-102 of CON application #10337).

The parent serves the following service areas in Florida: 3E (Lake and Sumter Counties), 6B (Hardee, Highlands and Polk Counties) and 11 (Miami-Dade and Monroe Counties). Agency records indicate that statewide, the applicant had two substantiated complaints during the three-year period ending November 19, 2014. The substantiated complaint categories were for quality of care/treatment and resident/patient/client assessment.

c. What resources, including health manpower, management personnel, and funds for capital and operating expenditures, are available for project accomplishment and operation? ss. 408.035(1)(d), Florida Statutes.

Analysis:
The purpose of our analysis for this section is to determine if the applicant has access to the funds necessary to fund this and all capital projects. Our review includes an analysis of the short and long-term position of the applicant, parent or other related parties who will fund the project. The analysis of the short and long-term position is intended to provide some level of objective assurance in the likelihood that funding will be available. The stronger the short-term position, the more likely cash on hand or cash flows could be used to fund the project. The

stronger the long-term position, the more likely that debt financing could be achieved if necessary to fund the project. We also calculate working capital (current assets less current liabilities) a measure of excess liquidity that could be used to fund capital projects.

Compassionate Care Hospice of the Gulf Coast, Inc. is a start-up corporation with $300,000 in cash, no liabilities, an accumulated deficit of $70,000 from start-up costs and no operations. The applicant stated that funding will be provided by operating cash flows of Compassionate Care Group, Ltd. (parent). In support of this claim, the applicant provided a letter of financial commitment from its parent company. In addition, the applicant and parent state that the parent has a $2,000,000 line of credit and provided a copy of letter from TD Bank dated June 27, 2014, to support that claim.

Capital Requirements and Funding:
On Schedule 2, the applicant indicates capital projects totaling $458,895 which includes this project and two other hospice CON applications ($142,965 each). As noted above, the applicant's audit report indicates $300,000 in cash at December 2, 2014. This level of cash is not sufficient to finance this and the two other CONs of the applicant. The applicant indicates on Schedule 3 of its application that funding for the project will be provided by funds from operations of the parent and proceeds from a line of credit available to the parent. Staff is unable to verify the parents' ability to finance the project with funds from operations as audited financial statements of the parent were not provided. However, the bank confirmation of the $2.0 million line of credit was provided. In the absence of an audit, a six month old bank letter does introduce a level of uncertainty to the availability of funds. However, given the relatively small size of the project funding is likely available on the line of credit.

Conclusion:
Funding for this project and all capital projects is likely but not guaranteed.

d. What is the immediate and long-term financial feasibility of the proposal? ss. 408.035(1)(f), Florida Statutes.

Analysis:
The immediate and long-term financial feasibility of the project is tied to expected profitability. Profitability for hospice is driven by two factors, volume of patients and length of stay/condition of the patient. A new hospice program in a service area with published need is more likely than not to be financial feasible since patient volume and mix is

presumed to be available in sufficient amounts to sustain a new program. The focus of our review will be on the reasonableness of projections, specifically the revenue.

The vast majority of hospice days are paid by Medicare (Medicaid is the next largest payer with similar reimbursement rates). As such, revenue is predictable by day and service type. Schedule 7 includes revenue by service type. We have divided the applicant's projected revenues by the estimated Medicare reimbursement rates for each level of service in year two to estimate the total patient days that would be generated by that level of revenue. The results were then compared to the applicant's estimated number of patient days. Calculated patient days that approximate the applicant's projected patient days are considered reasonable and support the applicant's assumptions of feasibility. Calculated patient days that vary widely from the applicant's projected patient days call into question the applicant's profitability assumptions and feasibility. The results of the calculations are summarized below.

CON 10337	Compassionate Care Hospice of the Gulf Coast, Inc.				
Sarasota **Base Rate Calculation**	**Wage Component**	**Wage Index**	**Adjusted Wage Amount**	**Unadjusted Component**	**Payment Rate**
Routine Home Care	$109.48	0.9516	$104.18	$49.86	$154.04
Continuous Home Care	$638.94	0.9516	$608.02	$290.97	$898.99
Inpatient Respite	$89.21	0.9516	$84.89	$75.60	$160.49
General Inpatient	$453.68	0.9516	$431.72	$255.09	$686.81
Year Two Comparison	**Inflation Factor Year Two**	**Inflation Adjusted Payment Rate**	**Schedule 7 Revenue Year Two**	**Continuous Service Hours Provided**	**Calculated Patient Days**
Routine Home Care	1.066	$164.17	$2,272,438		13,842
Continuous Home Care	1.066	$958.07	$119,092	19.2	99
Inpatient Respite	1.066	$171.04	$2,476		14
General Inpatient	1.066	$731.95	$83,385		114
		Total	**$2,477,391**		**14,070**
			Days from Schedule 7		16,140
			Difference		**2,070**
			Percentage Difference		**12.82%**

The applicant's projected patient days are 12.82 percent or 2,070 days more than the calculated patient days. This difference appears to be due to the following payment rates used by the applicant:

Service	Applicant	Staff
Routine Home Care	$140.85	$154.04
Continuous Home Care	$822.04	$898.99
Inpatient Respite	$150.44	$160.49
General Inpatient	$633.12	$686.81

We reviewed the applicant's stated methodology and it is consistent with the methodology used by staff with a slight difference in inflation factor. The net effect is that the applicant has understated revenues, which is considered a conservative assumption.

Even with the understated revenue, operating profits from this project are expected to increase from an operating loss of $346,492 for year one to an operating profit of $100,829 for year two.

Conclusion:
This project appears to be financially feasible.

e. Will the proposed project foster competition to promote quality and cost-effectiveness. ss. 408.035(1)(g), Florida Statutes.

Analysis:
The type of competition that would result in increased efficiencies, service, and quality is limited in health care in general and in hospice specifically. Cost-effectiveness through competition is typically achieved via a combination of competitive pricing that forces more efficient cost to remain profitable and offering higher quality and additional services to attract patients from competitors. Since Medicare and Medicaid are the primary payers in hospice, price-based competition is almost non-existent. With the revenue stream essentially fixed on a per patient basis, the available margin to increase quality and offer additional services is limited. This service area only has one existing provider so approval of this application will, by definition, introduce competition to the market for the first time. However, given the existing barriers to price based competition it is not clear that a new entrant will have a material impact on quality and cost-effectiveness.

Conclusion:
This project is not likely to have a material impact on competition to promote quality and cost-effectiveness.

f. Are the proposed costs and methods of construction reasonable? Do they comply with statutory and rule requirements? ss. 408.035(1)(h), Florida Statutes and Ch. 59A-3 or 59A-4, Florida Administrative Code.

The applicant is requesting approval to establish a new hospice program. There are no construction costs and methods associated with the proposed project.

g. Does the applicant have a history of providing health services to Medicaid patients and the medically indigent? Does the applicant propose to provide health services to Medicaid patients and the medically indigent? ss. 408.035(1)(i), Florida Statutes.

Hospice programs are required by federal and state law to provide hospice patients with inpatient care when needed (42 Code of Federal Regulations 418.108). Hospice care also must be provided regardless of ability to pay and regardless of age, race, religion, sexual orientation, diagnosis, payer source or financial status.

The applicant states that Compassionate Care Group, Ltd. (the parent) through its other Compassionate Care subsidiaries has significant experience providing to Medicaid and medically indigent patients, throughout the country. According to CCHGC, Compassionate Care Hospice has provided between $2.2 and $2.3 million in charity care in the last three calendar years (including 2014 annualized to date). CCHGC indicates that it will admit patients to the proposed program, regardless of their ability to pay.

The applicant estimates 3,860 total patient days for year one (ending September 30, 2016) and 16,140 total patient days for year two (ending September 30, 2017). The majority of patients days are estimated to be Medicare in year one (3,631 patient days or 94.1 percent) and again Medicare in year two (15,185 patient days or 94.1 percent). The applicant provided the following information on self-pay, charity and Medicaid patient days for year one and year two.

Compassionate Care of the Gulf Coast, Inc.
Self-Pay, Charity and Medicaid Patient Days
12 Months Ending September 30, 2016 (Year One)

Payer Source	Patient Days	Percentage
Self-Pay/Charity	50	1.3%
Medicaid	115	3.0%
Total Medicaid/Self-Pay/Charity	**165**	**4.3%**
Total Patient days	**3,860**	**100.0%**

Source: CON application #10337, Schedule 7A

12 Months Ending September 30, 2017 (Year Two)

Payer Source	Patient Days	Percentage
Self-Pay/Charity	206	1.3%
Medicaid	483	3.0%
Total Medicaid/Self-Pay/Charity	**689**	**4.3%**
Total Patient days	**16,140**	**100.0%**

Source: CON application #10337, Schedule 7A

F. SUMMARY

A fixed need pool of zero was published for a new hospice program in Hospice Service Area 8D – Sarasota County.

There is one licensed hospice provider in Hospice Service Area 8D – Tidewell Hospice, Inc.

Compassionate Care Hospice of the Gulf Coast, Inc. (CON #10337), a for-profit corporation and wholly owned subsidiary of Compassionate Care Group, Ltd., is proposing total project costs of $142,965. The parent operates hospice services in Hospice Service Areas 3E, 6B and 11. Also in this batching cycle, Compassionate Care seeks approval to establish a new hospice program in Hospice Service Areas 5A (Paso County) and 6C (Manatee County).

The applicant proposes nine conditions on its Schedule C.

After weighing and balancing all applicable review criteria, the following relevant factors are listed with regard to the establishment of a new hospice program in Hospice Service Area 8D:

Need/Access:

CCHGC contends that the following "not normal and special circumstances" exist in Sarasota County:

- Hospice monopoly in the subdistrict--there is only one existing hospice in the subdistrict and 408.043, Florida Statutes, was drafted to discourage regional monopolies
- Medicaid managed care statute regarding "hospice choice"--a subdistrict that has only one hospice provider is contrary to the intent of providing patients with a choice in hospice providers
- Outmigration of hospice patients from the subdistrict--Medicare/Medpar data demonstrates that there are 518 Sarasota county residents being treated outside the subdistrict

- The existing subdistrict's hospice has decreasing utilization in end-stage heart disease, end-stage pulmonary disease and end-stage renal disease
- Questionable market statistics relative to admissions--admissions in the service area suggest more admissions than deaths in the cancer categories and this raises concerns of the reliability of the data
- Deaths and persons per hospice in the subdistrict--Subdistrict 8D is in the top quartile of deaths per hospice and population per hospice statewide and Subdistrict's 8D metrics are substantially greater than statewide average and median
- Community support for Compassionate Care Hospice

The applicant maintains that it has developed several programs to address the identified underserved populations, including the Cardiac Connections Program, Pulmonary Connections Program and the Promise Program.

The applicant did not demonstrate that circumstances exist to justify the approval of a new hospice in Sarasota County. Regarding the availability of hospice services in the area, CCHGC did not substantiate a basis for an additional hospice. The application submitted did not provide data to prove that the need for the health service proposed outweighs the lack of a numeric need.

Quality of Care:

The applicant provided evidence of providing quality hospice service in its existing hospice service areas and identifies it quality in the context of:

- Quality of the parent's operations in Florida and nationwide
- No licensure and no Medicare cap issues
- Extensive experience and accreditations
- Surpasses NHPCO standard staffing ratios and guidelines that are direct patient care roles
- Implementation of QAPI program and PIP programs
- Contracting with OCS Home Care to further capture quality features within 10 benchmarked components
- The applicant's affiliate hospice provider participated in the Agency's most recent Hospice Provider Satisfaction Survey (January 2014-March 2014), with the lowest number of respondents at four and the highest at six. This affiliate hospice provider attained a five-of-five star rating on each of the five survey questions.

- The applicant's affiliate hospice provider participated in the DOEA's most recent 2014 Report on Hospice Demographics and Outcome Measures. The report indicates this affiliate hospice provider realized a 100 percent for Outcome Measure #1 and 92 percent for Outcome Measure #2, total patients at 468 and the state average number of patients at 2,720.
- Agency records for the three-year period ending November 19, 2014, reflect two substantiated complaints for the parent's total Florida hospice operations.

Financial Feasibility/Availability of Funds:

Funding for this project and all capital projects is likely but not guaranteed. This project appears to be financially feasible.

This project is not likely to have a material impact on competition to promote quality and cost-effectiveness.

Medicaid/Charity Care:

Hospice programs are required by federal and state law to provide hospice patients with inpatient care when needed (42 Code of Federal Regulations 418.108). Hospice care also must be provided regardless of ability to pay and regardless of age, race, religion, sexual orientation, diagnosis, payer source or financial status.

The applicant's Schedule 7A proposes 1.3 percent for self-pay and charity care in years one and two of operations. Compassionate Care's Medicaid percentage is projected to be 3.0 percent for year one and two.

G. RECOMMENDATION

Deny CON #10337.

AUTHORIZATION FOR AGENCY ACTION

Authorized representatives of the Agency for Health Care Administration adopted the recommendation contained herein and released the State Agency Action Report.

DATE: _____

_____
Marisol Fitch
Health Services and Facilities Consultant Supervisor
Certificate of Need