BEFORE THE OFFICE OF JUDGES/HEALTH CARE AUTHORITY

RE: STONEWALL JACKSON MEMORIAL HOSPITAL, COMPANY
CON File No. 21-7-12157-H
A.P. Docket No. 22-HC-03

REPLY BRIEF AND RESPONSE BRIEF FILED ON BEHALF OF STONEWALL JACKSON MEMORIAL HOSPITAL, COMPANY

Respectfully Submitted by:

Thomas G. Casto, (W.Va. Bar No. 676)
Lewis Glasser PLLC
300 Summers Street, Suite 700
Post Office Box 1746
Charleston, West Virginia 25301
(304) 345-2000 – telephone
(304) 343-7999 – facsimile
tcasto@lewisglasser.com

I. INTRODUCTION AND REOCEDURAL HISTORY

Stonewall Jackson Memorial Hospital, Company ("Stonewall") submits this appeal from a decision of the West Virginia Health Care Authority ("the Authority") denying an application ("the Application") for a certificate of need filed pursuant to the provisions of W.Va. Code § 16-2D-1 *et seq*. In the Application, Stonewall sought a certificate of need to construct a replacement hospital in Lewis County, West Virginia. St. Joseph's Hospital of Buckhannon ("SJB"), a critical access hospital ("CAH") located in Upshur County applied for and was designated by the West Virginia Health Care Authority ("the Authority") as an affected person in the matter and appears here. SJB is a member of the West Virginia United Health System ("WVUHS"), the largest health care system in the State.

W.Va. Code § 16-2D-12 provides that a certificate of need may not be issued by the Authority unless it finds that the applicant demonstrated that the project is both needed and consistent with the State Health Plan. The section the of the State Health Plan that is applicable to this appeal is the Renovation-Replacement of Acute Care Facilities and Services chapter of the Certificate of Need Standards ("the Standards"). *Attached hereto as* ***Exhibit 1.***

A decision on the Application was issued by the Authority on June 13, 2022 ("the Decision") finding that the project was needed and consistent with the Standards, but not consistent with the provisions of W.Va. Code § 16-2D-12(b)(1). Specifically, the Authority stated that "the proposed project is not the superior alternative in terms of cost, efficiency and appropriateness." Decision, p. 37. Stonewall appealed the Decision to the Office of Judges/ Health Care Authority ("OOJ") on the grounds that the Decision was deficient for a number of reasons including the lack of proper analysis to support the finding that the project was not consistent with the provisions of W.Va. Code § 16-2D-12(b)(1).

SJB filed a cross appeal on one issue contained in the Decision regarding the Authority's interpretation of Section VIII of the Standards, entitled Accessibility on the grounds that the Authority misinterpreted and misapplied the section in finding that Stonewall's application was consistent with its provisions.

A Scheduling Order was entered by the OOJ, and Stonewall filed an initial Brief on August 15, 2022, pursuant to the Scheduling Order ("Stonewall Brief"). On September 15, 2022, SJB filed a Response Brief, responding to Stonewall's initial Brief ("SJB Response"), as well as a Brief regarding the Cross Appeal ("SJB Brief"). On September 15, 2022, the Authority filed its Response Brief to Stonewall's initial brief ("Authority Brief"). This Brief is filed in Reply to the both the Authority Brief and the SJB Response and in Response to the SJB's Brief.

II. REPLY ARGUMENT TO SJB RESPONSE AND AUTHORITY BRIEF

The sole issue at the heart of Stonewall's appeal rests upon the Authority's finding that the project proposed in the Application is not the superior alternative. The code section detailing "superior alternative" states:

> (b) The authority may not grant a certificate of need unless, after consideration of the appropriateness of the use of existing facilities within this state providing services similar to those being proposed, the authority makes each of the following findings in writing:
> (1) That superior alternatives to the services in terms of cost, efficiency and appropriateness do not exist within this state and the development of alternatives is not practicable.

W.Va. Code § 16-2D-12(b)(1). The parallel finding in the Decision states:

> The Authority finds that Stonewall's proposed project would cause SJB to lose its CAH [critical access hospital] status which would have a significant detrimental financial effect on SJB. The evidence of record showed that the loss of CAH status would result in SJB suffering significant annual monetary losses. Stonewall produced no evidence from WVUHS that it would supplement any financial losses incurred by SJB.

> The Authority further finds that Stonewall has not proved that the development of alternatives is not practicable. Stonewall admitted it had not explored other sites for the project other than the proposed location. (Exhibit 23, p. 54). Stonewall produced no evidence that it had completed a market analysis of the surrounding area to determine if any other suitable property might exist. The burden of proof is on the Applicant to show that the development of alternatives to the project are not practicable. Stonewall has failed to meet this burden.

Decision p. 38-39. Stonewall takes issue with several factual and legal conclusions in the Decision.

First, the Authority found that "[t]he evidence of record showed that the loss of CAH status would result in SJB suffering significant annual monetary losses. Stonewall produced no evidence from WVUHS that it would supplement any financial losses incurred by SJB." Decision p. 38. However, this conclusion does not reflect the entire record in this matter. In fact, the evidence in the record showed that SJB would suffer annual losses if all things remained static and they did nothing to adjust to the loss of the critical access status. Although it is not Stonewall's burden to outline how SJB and its parent company could adjust to the loss of CAH status, there is evidence in the record about the methods of such an adjustment.

For example, one method of adjusting to the loss would be for SJB to relocate its facility. There is evidence in the record that SJB already intends to renovate its existing facility. The plans call for a renovation expenditure that is comparable to Stonewall's planned expenditure for a new hospital. Further, there is email in the record that includes a conversation among top administrators at the WVUHS, SJB's parent company, that "if Stonewall even tries to move, we will move too." *Hearing Exhibit 3*. The same email includes a report that SJB's Chief Executive Officer was looking for property to build a new facility in a location that would maintain SJB's CAH status. However, that evidence was not analyzed or even mentioned in the Decision. Such a finding, without analyzing simple alternatives to the

loss of the critical access status in the present location is contrary to the evidence of record, baseless, arbitrary and capricious. *See Stephens v. Wayne County Bd. Of Educ.*, 2011 W. Va. LEXIS 497 at *21-22 (Nov. 15, 2011) (Finding that an action is generally considered arbitrary and capricious if an administrative agency did not rely on criteria intended to be considered, explained, or reached the decision in a manner contrary to the evidence before it).

Moreover, Stonewall plans to construct a new hospital that is essentially the same size as SJB but will not be a critical access hospital and will not receive the very beneficial reimbursement SJB receives. The Authority found in the Decision that Stonewall's new facility will be financially feasible. In other words, Stonewall can operate a non-critical access hospital in Weston, but the Authority found that SJB cannot do so in Buckhannon, only about 11 miles away. The basis for this reasoning is not stated or clear in the Decision. However, it is clear that the Authority did not analyze this or discuss it in the Decision. The result of this finding is that Stonewall cannot locate the new hospital at the site that it believes is the best to serve the citizens of its service area. Instead, Stonewall must adjust the site to allow SJB to maintain its critical access status, but SJB can stop that location and do nothing to attempt to mitigate its losses. That is simply not reasonable and is certainly an arbitrary finding not based in law or reason.

Next, the Authority found that "Stonewall produced no evidence from WVUHS that it would supplement any financial losses incurred by SJ[H]." Decision p. 38. In its Response Brief the Authority argued that Stonewall's arguments on this matter are speculation. Authority Brief, p. 12. There is a difference between speculation and circumstantial evidence. It is true that Stonewall did not call any witnesses from WVUHS or SJB. However, there was evidence in the record that several hospitals in the WVUHS lose money on an annual basis

and yet remain open and operating. *See CON File, Exhibit 20*, Attachments 3-5 (showing losses for two WVUHS hospitals totaling approximately $20,000,000 for Camden Clark Medical Center and approximately $3,500,000 for Reynolds Memorial Hospital over the 4 year period covered in the exhibit). Arguing that SJB would not close when other hospitals in the WVUHS lose money and do not close is not speculation, it is a reasonable assertion based on circumstantial evidence. Again, the Authority made a finding in the form of a simple statement that is, on its face, not consistent with the provisions of W.Va. Code § 16-2D-12(b)(1), without analyzing all the evidence contained in the Decision's record. Failing to consider such evidence is an abuse of discretion, as the Authority wrongfully exercised its discretion to an end not justified by the evidence set forth in this matter. *See e.g. Reed v. Winesburg*, 241 W. Va. 325, 330 (upholding an administrative decision to lawfully revoke a driver's license and reversing the circuit court's finding of the administrative agency abusing its discretion by properly considering the evidence presented to it in the "totality of the circumstances"). An abuse of discretion is reversible error.

Finally, the Authority found that:

> Stonewall has not proved that the development of alternatives is not practicable. Stonewall admitted it had not explored other sites for the project other than the proposed location. Stonewall produced no evidence that it had completed a market analysis of the surrounding area to determine if any other suitable property might exist.

Decision p. 38-39. There are both factual and legal issues with this finding.

First, the testimony in the record regarding the proposed site was that Stonewall had planned to construct a new facility at the intersection of Interstate 79 and Route 33 for decades. Those plans pre-dated SJB's conversion to a critical access hospital. Hearing Tr. p. 64. Second, Stonewall planned for this location for several valid reasons. Such reasons were well

stated in the record of the case. *See Tr. p. 15-16, 20-21, 56-59.* Those reasons include the fact that nearly all the economic development that has occurred in the Weston area has occurred in the proposed location. Further, there is existing infrastructure, and the site is ready to build on without expensive and extensive sitework.

The statute provides that a certificate cannot be approved unless it is shown that superior alternatives to the project in terms of cost, efficiency and appropriateness do not exist and the development of alternatives is not practicable. *See* W.Va. Code § 16-2D-12(b)(1). The Authority's ruling is contrary to the intent of W.Va. Code § 16-2D-12(b)(1) and would force Stonewall to choose another site that is not ready for building, where infrastructure does not exist, and is apart from bulk of the population Stonewall serves. That means that the new hospital will be exponentially more expensive to construct as the topography of other sites suggested would mean extensive site work would have to be done to prepare a site for hospital construction. It would mean that infrastructure would have to be brought to the site as none exists on any of the suggested sites. Finally, it would mean that access will be harder for those patients Stonewall serves. The Authority's finding is that a more expensive project that will not improve accessibility to patients is the superior alternative in terms of cost, efficiency, and appropriateness simply because it saves SJB if SJB chooses not to relocate or otherwise adjust to the loss of CAH status. That finding is not consistent with the terms of W.Va. Code § 16-2D-12(b)(1) for the reasons explained herein and must be reversed.

The development of a more expensive hospital facility in a location that does not offer the access the proposed location does is a possible alternative. Thus, the development of it is possible. However, W.Va. Code § 16-2D-12(b)(1) provides that the alternative must be practicable, not just possible. Spending millions of dollars in additional construction expense

is possible, but not practicable. Decreasing patient access is possible, but it not practicable. Neither is the superior alternative. The Authority's ruling on this issue seemingly substitutes the word "practicable" with "possible" resulting in a Decision that is inconsistent with the terms of W.Va. Code § 16-2D-12(b)(1) as well as with the terms of W.Va. Code § 16-2D-1, which provides that:

> It is declared to be the public policy of this state: (1) **That the offering or development of all health services shall be accomplished in a manner which** is orderly, **economical** and consistent with the effective development of necessary and adequate means of providing for the health services of the people of this state and to avoid unnecessary duplication of health services, **and to contain or reduce increases in the cost of delivering health services.**

W.Va. Code § 16-2D-1(1).

The very basis of the Authority's existence is to see that the development of all health services shall be accomplished in a manner which is economical and either contains or reduces increases in the cost of delivering health services. *See* W.Va. Code § 16-2D-1. The Decision is the opposite of the public policy of the legislature. It would result in the more expensive, less economical development of a service the Authority found to be needed.

Third, Stonewall did not need to explore other sites as there were none that were available and viable. SJB presented several possible alternative sites in their case. However, Stonewall's Chief Administrative Officer testified that he was aware of all the sites and aware of the serious issues each site carried. Hearing Tr. p. 56-62. Those issues ranged from a lack of existing infrastructure to topography and even the fact that the proposed locations were not even for sale. All the issues are boiled down to one problem: the costs of constructing a hospital on each of the SJB proposed sites, all of which Stonewall was aware of, were astronomically more expensive than the site proposed by Stonewall. So again, the Authority's

finding and decision is that Stonewall must relocate its new facility to a site that would not be as accessible to the citizens that it is charged with serving and would add to the costs of the construction, while SJB does not have to adjust in any way to either maintain its critical access status or manage without it. It is the Authority's decision on this issue, that is the superior alternative in terms of cost, efficiency and appropriateness is actually more expensive, less efficient, and not appropriate. That finding is not consistent with the statute. Again, that is totally inconsistent with the terms of W.Va. Code § 16-2D-12(b)(1).

In the Decision the Authority ruled that "[w]hile the proposed project may be the superior alternative in terms of cost, efficiency, and appropriateness as it relates to Stonewall, the review of the project does not end with the Applicant. The Authority must also determine whether the proposed project is the superior alternative as it relates to an Affected Person and the citizens of the State of West Virginia. *See* W. Va. Code§ 16-20-1. The citation to W. Va. Code§ 16-20-1 was discussed in the previously filed Stonewall Brief. That section provides no support for the Authority's position here. However, more importantly, none of the certificate of need statutes provide support for the Authority's position that an applicant like Stonewall must adjust it plans to its detriment and to the detriment of those citizens it is charged with serving, while an affected party like SJB can do absolutely nothing to adjust to the changed circumstances. Further, Stonewall's charge is to serve the citizens of its service area, not all of the citizens of West Virginia. The Authority's reference to the "citizens of the State of West Virginia" is overreach. That is not the law.

The statute provides that Stonewall's proposal must be the superior alternative in terms of cost, efficiency and appropriateness and that other options do not exist within this

state. In addition, the development of alternatives is not practicable. *See* W.Va. Code § 16-2D-12(b)(1). It does not provide that to be the superior alternative Stonewall must construct a hospital in an inferior, more expensive location and that SJB can do nothing. The Authority's analysis and ruling on this issue takes the provisions of W.Va. Code § 16-2D-12(b)(1) and turns them inside out. The superior alternative in terms of cost, efficiency and appropriateness is to make Stonewall expand millions more on a facility that is not in a location to best serve the citizens it is charged with serving. The decision on this issue is simply wrong and inconsistent with the terms of W.Va. Code § 16-2D-12(b)(1). For these reasons, the Decision must be reversed.

Finally, the Authority's ruling contained a passage that is totally outside of the requirements set for the in the statute. The ruling provided that "Stonewall produced no evidence that it had completed a **market analysis** of the surrounding area to determine if any other suitable property might exist." Decision, p. 39 (emphasis added). First, the issue of the availability of other property that was appropriate to construct a hospital was discussed at the hearing and has been discussed above. SJB presented a list of property that it asserted was appropriate for the site of a hospital. Testimony showed that all of the property on the list was not appropriate for a number of reasons discussed in the record and above. Thus, the Authority's finding that there is no evidence in the record about other sites is simply wrong. The Authority has chosen to ignore evidence that was presented. Further, the Authority adds the requirement that Stonewall must complete a "market study" to show that such property does not exist. That requirement is not contained in any of the Authority's statutes, the State Health Plan, or in any other decision issued by the Authority. It was invented by the Authority for this case to support a decision that is not supported by the evidence or law. An

administrative agency cannot simply invent requirements. *State ex rel. Hoover v. Berger*, 199 W.Va. 12, 16, 483 S.E.2d 12, 16 (1996) ("An administrative agency is but a creature of statute and has no greater authority than [that] conferred under the governing statutes.").

The standard that governs this Court's review of this matter is limited, but not restricted. The terms are generally outlined in West Virginia Code 29A-5-4(g). The West Virginia Supreme Court of Appeals elaborated on those terms as follows:

> [U]nder the review standards set forth in West Virginia Code 29A-5-4(g) (1980 Replacement Vol.), an agency's determination of matters within its area of expertise is entitled to substantial weight. This does not mean a court should shirk its obligation to make a searching and careful inquiry into the facts: But that function must be performed with conscientious awareness of its limited nature. The enforced education into the intricacies of the problem before the agency is not designed to enable the court to become a superagency that can supplant the agency's expert decision-maker. To the contrary, the court must give due deference to the agency's ability to rely on its own developed expertise. **The immersion in the evidence is designed solely to enable the court to determine whether the agency decision was rational and based on consideration of the relevant factors.**

Princeton Community Hosp. v. State Health Planning, 174 W. Va. 558, 564-565, 328 S.E.2d 164, 171 (1985) (citing *Ethyl Corporation v. Environmental Protection Agency*, 176 U.S. App. D.C. 373, 541 F.2d 1 (D.C. Cir. 1979), cert. denied, 426 U.S. 941, 96 S. Ct. 2663 (1976) (citations omitted). Emphasis added.

The Authority's finding on this issue is counter to the evidence, not consistent with the terms of the statute that it based its ruling and is, in fact, reversable error. This Court's review of the Decision and the facts and evidence underpinning it is to enable the court to determine whether the Decision was rational and based on consideration of the relevant factors. The Authority's finding that Stonewall must spend millions more dollars to construct a hospital to make it the superior alternative in terms of cost is simply wrong. It is not rational and based on

consideration of the relevant factors. The Authority's finding that if Stonewall locates its new facility at a site where patient access would be harder and more expensive for those patients it would be more efficient is simply wrong. It is not rational and based on consideration of the relevant factors.

None of these finding makes sense when the provisions of W.Va. Code § 16-2D-12(b)(1) are compared to the evidence in the record. As a result, the Decision is made in violation of constitutional or statutory provisions; it is made in excess of the statutory authority or jurisdiction of the Authority; it is made upon unlawful procedures; it is affected by other errors of law; it is clearly wrong in view of the reliable, probative, and substantial evidence on the whole record; and it is arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion. The Decision should be reversed, and the Authority should be directed to grant the certificate of need for Stonewall to construct its new facility.

III. RESPONSE ARGUMENT TO SJB BRIEF

The section of the Standards that is applicable to SJB's Cross Appeal is Section VIII, Accessibility, attached hereto. That section provides:

> The proposal shall not adversely affect the continued viability of an existing hospital or health care services that serves a population of at least 10,000 not having 30-minute access to another hospital or critical access hospitals (CAH).

The Authority's Decision on this issue was:

> Stonewall submits that there are no existing hospitals or health care services potentially impacted by this proposal that serve a population of at least 10,000 that do not have a 30-minute access to another hospital; therefore, this criterion is not applicable.
>
> SJB argues the criterion is applicable because "30-minute access" means more that driving time between two facilities, but includes a host of other factors that could include traffic congestion, weather, ambulance response time, etc. SJB also asserts that the

> criterion provides that no proposal shall adversely affect the continued viability of a critical access hospital regardless of population or access time.
>
> The Authority expressly rejects SJB's interpretation of this criterion. The Authority finds that "30-minute access" means the average drive time from one location to another. Additionally, the Authority finds that "critical access hospitals" as used in this criterion means 30-minute access to a critical access hospital.

CON Decision, p. 26.

There are several issues at play with the Authority's Decision and this section of the Standards. First, as discussed both above and below, Stonewall does not believe that the continued viability of SJB is at risk if it loses its CAH status as a result of the location of the project proposed in the Application. Stonewall agrees that SJB will lose its critical access hospital status if Stonewall is allowed to relocate, and it does not itself relocate. However, the testimony of witnesses for SJB that the facility will simply shut its doors if it loses the favorable reimbursement that CAH's receive, is not supported by the record of this case.

The Standard provides that continued viability of a hospital should not be adversely affected. SJB asserts that its viability is impacted because the loss of CAH status and the resulting loss of the favorable reimbursement it brings will lead to closure. The imminent closure of SJB is a red herring at best. There are several options available to SJB beyond closure, all of which have been discussed, but including relocating to new site itself or operating at its existing site as an acute care hospital, just as Stonewall does.

Further, SJB wants all parties to ignore the fact that it now sits in a completely different position than it was prior to gaining its CAH designation. Prior to gaining CAH designation, it was not a member of WVUHS, the largest health care system in West Virginia. Now, SJB is part of WVUHS with access to capital and management that was unavailable to it previously. SJB is

simply not in the same position as it was prior to the CAH conversion and cannot credibly argue the same. SJB's argument that its continued viability is in doubt is an argument that the largest hospital system in West Virginia is incapable of maintaining financial viability of a smaller acute care hospital unless it receives the favorable reimbursement of a CAH. As noted in the previously filed Brief, WVUHS has other hospitals in its system that are not profitable, one having lost over $20 million over a four-year period. *See Exhibit 20,* Attachments 3-5. Yet, those unprofitable hospitals are still open and operating. SJB's argument that, as soon as it loses CAH status, WVUHS will close it is simply not consistent with the historic or current operation of WVUHS with similarly situated scenarios.

The second part of SJB's argument on this issue is that the full language of the in Section VIII of the Standards only applies to hospitals and health care services, not critical access hospitals like SJB. It argues that the 10,000 population/30-minute time frame provided for in Section VIII of the Standards does not apply to it as a CAH. In other words, SJB argues that the Standard could be reworded as follows:

> *The proposal shall not adversely affect the continued viability of an existing hospital or health care services that serves a population of at least 10,000 not having 30-minute access to another hospital. The proposal shall not adversely affect the continued viability of a critical access hospitals (CAH).*

The Authority disagreed and ruled that the 10,000 population/30-minute time frame applies to all hospitals, including critical access hospitals, not excluding them. SJB presents arguments regarding the importance of CAH's to communities and the state as a basis for its interpretation of the section. CAH's, while certainly not unimportant to the communities they serve, are not more important than acute care hospitals such as Stonewall. An argument could be made that full service acute care hospitals are more important as they provide a wider range of services and are more in

need of protection given that CAH's have special reimbursement rules that allow them to receive preferential reimbursement from the government. In any event, these are simply arguments made to support or refute a position about the section when the real issue in is one of statutory construction and the deference to be shown to an administrative agency.

The *Chevron* case and various cases decided by the WVSCA were cited in the previous section of this Brief. The argument there was regarding the first prong of the *Chevron* analysis, when the statute or legislative rule is clear. SJB argues in this matter that the Accessibility section of the Standards is clear. However, Stonewall and the Authority disagreed with the SJB interpretation and believe the section's 10,000 population/30-minute time frame applies to all hospitals, including critical access hospitals. Thus, the first question in the *Chevron* analysis should apply. That question is "...whether the Legislature has directly spoken to the precise question at issue. If the intention of the Legislature is clear, that is the end of the matter, and the agency's position only can be upheld if it conforms to the Legislature's intent. No deference is due the agency's interpretation at this stage" Syl. Pt. 3, *Appalachian Power Co. v. State Tax Dep't of W Virginia*, 195 W. Va. 573, 466 S.E.2d 424 (1995).

When the intention of the Legislature is not clear or the specific issue has not been spoken on by the Legislature, the Court will then ask the second question of the *Chevron* analysis:

> If legislative intent is not clear, a reviewing court may not simply impose its own construction of the statute in reviewing a legislative rule. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute. A valid legislative rule is entitled to substantial deference by the reviewing court. As a properly promulgated legislative rule, the rule can be ignored only if the agency has exceeded its constitutional or statutory authority or is arbitrary or capricious. W. Va. Code, 29A-4-2 (1982).' Syl. Pt. 4, *Appalachian Power Co. v. State Tax Dep't of W. Va.*, 195 W. Va. 573, 466 S.E.2d 424 (1995).

Syl. Pt. 6, *Murray Energy Corp v. Steager*, 241 W. Va. 629, 827 S.E.2d 417 (1995) (*quoted in Amedysis*, 2021 W. Va. LEXIS 314 at *20).

Stonewall and the Authority believe the intent of the section is clear and the language is not vague. The issue that is addressed by the section in question is whether a project will impact the accessibility to health care services for citizens in the area of a replacement-renovation project. The Authority decided that the measure for that analysis is if, as a result of a project, more than 10,000 people will not have 30-minute access to a hospital, acute care or critical access, then access is adversely impacted, and the project may be denied. It makes no sense that this measure only applies to acute care hospitals and not critical access ones because the key issue is not the financial health of either class of hospitals, but the accessibility to hospital services by citizens in the area. The Authority's review of this matter found that the measure was not met by SJB. There is no reasonable evidence that if the project was approved and SJB closes, which is a dubious suggestion to begin with, that more than 10,000 people in Upshur County will not have access to hospital services within 30 minutes.

SJB disagrees with this interpretation of the section by the Authority. That sole reason does not make the interpretation incorrect or somehow cast the section into being ambiguous. However, even if the section is ambiguous, the Authority's interpretation of it as applying the 10,000 people/ 30-minute test to both acute care hospitals and critical access hospitals is not an impermissible construction or interpretation for the reasons stated above. There is no policy reason for the Authority to protect critical access hospitals but not acute care hospitals. In terms of importance to a community, there is no difference between a critical access hospital like SJB and an acute care hospital like Stonewall. The sole reason that SJB believes critical access hospitals should be afforded extra protection under the section is because they are a critical access hospital.

The section is not vague or ambiguous and the Authority's interpretation and application of the 10,000/30-minute test is perfectly valid, perfectly consistent with the evidence in the record of the case and in keeping with sound health care policy. Even if this Court would find that the section is ambiguous, the same reasons apply to the Authority's finding. Thus, the agency's answer is based on a permissible construction of the section and this Court should not simply impose its own construction of the statute in reviewing this matter. For these reasons, the Authority's finding and application of the accessibility section should be upheld because Stonewall's project and the Application are consistent with the plain meaning and a reasonable interpretation of Section VIII of the Standards.

III. CONCLUSION

The Decision denying the application for a certificate of need issued by the Authority in this matter was made in error. The Authority cannot amend the requirements, adding requirements that do not exist in any statute or in the Standards. The Decision is made in violation of constitutional and statutory provisions; is in excess of the statutory authority and jurisdiction of the Authority; is made upon unlawful procedures; is affected by other errors of law; is clearly wrong in view of the reliable, probative and substantial evidence on the whole record; is arbitrary and capricious; and is characterized by abuse of and clearly unwarranted exercise of discretion. As a result, Stonewall respectfully requests the Office of Judges/Health Care Authority reverse the Decision.

Further, SJB's argument that the Authority's interpretation of Section VIII of the Standards that critical access hospitals are exempt from the mileage and population access requirements of the Section is not consistent with the law or with the plain language of the Section. The Authority cannot add requirements or language to the Standards, but it can apply to plain language of a

section to reach a reasonable and supportable conclusion. That is what it did in the matter raised by SJB in its cross appeal. Stonewall respectfully requests the Office of Judges/ Health Care Authority to deny SJB's cross appeal and uphold the Authority's decision on the consistency of the application to Section VIII of the Standards.

STONEWALL JACKSON MEMORIAL HOSPITAL, COMPANY,
By its Counsel,

Thomas G. Casto (W.Va. Bar No. 676)
Lewis Glasser PLLC
300 Summers Street, Suite 700
Charleston, West Virginia 25301
(304) 345-2000 – telephone
(304) 343-7999 – facsimile
tcasto@lewisglasser.com

EXHIBIT 1

State Health Plan, Certificate of Need Standards

Renovation-replacement of Acute Care Facilities and Services

Approved by Governor 06/02/10

RENOVATION-REPLACEMENT OF ACUTE CARE FACILITIES AND SERVICES

I. DEFINITIONS

A. Acute Care: Inpatient hospital care provided to patients requiring immediate and continuous attention of short duration. Acute care includes, but is not limited to, medical, surgical, obstetric, pediatric, psychiatric, ICU and CCU care in a hospital.

B. Acute Care Bed: Any licensed inpatient bed dedicated to the use of patients requiring acute care.

C. Admission Rate: The number of patients entering the hospital for acute care services per 1,000 population.

D. Average Daily Census: The average number of licensed acute care beds in the hospital that are used by inpatients.

E. Average Length of Stay: The average number of days a patient stays in the hospital.

F. Bed: A general measure of hospital size and capacity.

G. Capital Expenditure: Those expenditures as defined in W.Va. Code § 16-2D-2, including a series of expenditures exceeding the expenditure minimum and determined by the Health Care Authority to be a single capital expenditure subject to review.

H. Coronary Care Unit (CCU): A special unit of the hospital equipped to provide maximum surveillance and support of vital function and definitive therapy to patients with acute or potentially reversible life-threatening impairment of the cardiovascular system.

I. Critical Access Hospital (CAH): A hospital designated as such by the West Virginia Office of Rural Health Policy in conformance with the requirements of the Medicare Rural Hospital Flexibility Program.

J. Discharge Planning: A coordinated effort to ensure that each patient to be discharged from a health care facility has a planned program of needed continuing care and follow up that seeks optimum functioning of that patient and the earliest practicable discharge.

K. Discharge Rate: The number of patients who have received acute care services discharged per 1,000 population.

L. Inpatient: A patient who has been admitted to the hospital for an overnight stay or longer.

M. Intensive Care Unit (ICU): Care provided in a specially licensed unit set up for the purpose of providing maximum surveillance and support of vital functions and definitive therapy for patients suspected of having acute, or potentially reversible life-threatening impairment of single or multiple vital systems (pulmonary, cardiovascular, renal or nervous systems). Such a unit requires special equipment and specially trained staff.

N. Level I Obstetrical Unit: A hospital obstetric unit, the function of which is to provide services primarily for uncomplicated maternity and newborn patients.

O. Level II Obstetrical Unit: A hospital obstetric and neonatal unit, the function of which is to provide a full range of maternal and newborn services for uncomplicated births and for the majority of complicated obstetrical problems and certain neonatal illnesses.

P. Level III Obstetrical Unit: A hospital obstetric and neonatal unit, the function of which is to provide care for normal births but especially for all the serious types of maternal-fetal and neonatal illnesses and abnormalities.

Q. Levels of Care: A system of categorizing services according to complexity and sophistication. Normally, acute care is divided into three levels: primary, secondary, and tertiary, with the primary level being comprised of the most basic services and the tertiary level being comprised of the most complex services.

R. Licensed Beds or Hospital Beds: The basic index of hospital capacity, consisting of the beds in each hospital which are licensed for acute care use. In the case of state-operated acute care facilities, it is the number set up and staffed.

S. Neonatal: A term used to refer to an infant less than 29 days old.

T. Neonatal Intensive Care Unit: A specialized medical treatment unit of the hospital set up to provide extraordinary care to critical infants.

U. Observation Services: Services ordered by a patient's physician and provided by a hospital on the hospital's premises. These services include the use of a bed and periodic monitoring by the hospital's nursing or other staff, which are reasonable and necessary for a possible admission to the hospital as an inpatient. Observation beds are not licensed acute care beds.

V. Observation Equivalent Days: The total observation hours divided by 24. Observation equivalent days may be added to acute care days to demonstrate peak occupancy.

W. Obstetrics: The branch of medicine that deals with the care of women before, during, and directly after childbirth.

X. Occupancy Rate: The average percentage of licensed beds in a hospital or one of its units that are filled as of midnight each day. To demonstrate peak occupancy, the hospital may also document the occupancy rate at a different time of the day.

Y. Outpatient: A patient who is not admitted to the hospital for an overnight stay.

Z. Patient Flow: A hospital's pattern of patient admissions and discharges.

AA. Patient Origin Study: A special study of hospital's patient flow designed to determine the particular geographic areas from which an institution draws its patients and the institutions to which residents from an area go for hospitalization.

BB. Pediatric: The branch of medicine that deals with the care of children under 14 years of age.

CC. Peer Review: The evaluation of health professionals and their performance by their peers. This term relates to programs such as utilization review and professional review organizations.

DD. Psychiatric: The branch of medicine connected with mental disorder.

EE. Replacement: A project for the erection, construction, creation or other acquisition of a physical plant or facility. All beds in the replacement facility must be located within the same county or within fifteen (15) miles of the original facility.

FF. Renovation: A project for modernization, improvement, alteration or upgrading of an existing physical plant or equipment.

GG. Swing Beds: Beds used in small rural hospitals that may be used interchangeably as either general/medical/surgical beds or skilled nursing beds. Reimbursement is based upon the specific type of care provided. Swing bed days may be added to acute care days to demonstrate peak occupancy.

II. CURRENT INVENTORY

The Authority shall provide a current inventory of existing acute care beds and hospital beds by specialty to each applicant.

III. NEED METHODOLOGY

A. The Authority will consider for approval proposals for renovation or replacement of hospital beds or services, if the applicant submits reliable, probative, and substantial evidence that the project is necessary. Such necessity may only be proven by establishing one or more the following:

1. The service(s) provided by the applicant requires space, or the facility requires replacement or renovation to meet minimum requirements documented by written recommendations from appropriate accreditation or licensing agencies or documentation based upon comparisons to the minimum departmental square footage requirements of comparable services.

2. There are significant operating problems that can most effectively be corrected by the proposed replacement or renovation as documented by data regarding specific projected cost savings that would be achieved if the project were completed, and the proposed level of investment is appropriate in relation to such projected cost savings.

3. The replacement or renovation is being proposed to correct deficiencies that place the facility's patients' or employees' health and safety at significant risk. Such deficiencies must be demonstrated by reference to the minimum requirements of licensing, regulatory, and accrediting organizations.

B. Regardless of the provisions of Section III (A) above, the Authority will not approve a renovation or replacement if the proposed project will perpetuate or result in excess capacity of acute care beds. For the renovation or replacement of a patient care area, the following requirements also apply:

1. The Authority will not approve any renovation or replacement to a patient care area of a hospital where the number of licensed acute care beds, after completion of the renovation or replacement project, will equal or exceed 160% of the average daily census of the hospital for the past twelve (12) months. The Authority may consider an adjustment by the hospital to its average daily census for observation equivalent days and swing bed days. The Authority may also consider the impact of a distinct part unit on the hospital's average daily census.

2. An applicant must remove acute care beds from its license to meet the 160% requirement. The applicant must submit an amended license to demonstrate the reduction in acute care beds during substantial compliance review.

3. If the removal of acute care beds from the hospital's license would cause a breach of a covenant in a bond instrument, or other debt instrument to which the applicant is a party, the removal of beds from service may be used to meet the requirements of these standards. In this case, the applicant must meet the requirements of the "Addition of Acute Care Beds Standards" to return said beds to service.

4. The Authority may grant an exception to the reduction of beds to meet the 160% average daily census requirement if the applicant has experienced significant fluctuations in its occupancy levels and (a) the applicant is the sole hospital in a county or (b) the applicant has exceeded an 85% acute care occupancy level for two consecutive months during the past twelve (12) months.

5. An acute care facility which has removed acute care beds from its license pursuant to the requirements of Section III (B)(1) of these Standards, may restore acute care beds to its license if it meets the following requirements:

   a. The facility has experienced significant fluctuations in its occupancy levels;

   b. The facility has exceeded an 85% acute care occupancy level for two consecutive months during the past twelve (12) months;

   c. The facility may add up to 10% of the number of acute care beds on its current license on an annual basis without undergoing certificate of need review, however it may not exceed the number of acute care beds on its license immediately prior to the reduction of beds pursuant to Section III (B)(1) of these Standards; and,

   d. The facility must notify the Authority a minimum of ten (10) days prior to requesting an amendment increasing acute care beds on its license.

C. Critical access hospitals are not subject to the requirements of Section III (B).

IV. QUALITY

The applicant making the proposal for renovation or replacement for hospital beds must be in compliance with applicable licensing or certification organization requirements or have in place a substantive and detailed plan to come into compliance with applicable licensing or certification requirements.

V. CONTINUUM OF CARE

A. The applicant must demonstrate that the replacement or renovation under consideration is the most cost effective or otherwise most appropriate alternative to provide the needed services to the population to be served.

B. The applicant must demonstrate that it has an effective utilization review, peer review, quality assurance and discharge planning process.

VI. COST

A. The applicant must demonstrate financial feasibility of the facility following completion of the replacement or renovation. The applicant must also demonstrate that the capital related costs of the project are consistent with the Authority's rate setting methodology in effect as of the date of application. The applicant must further

demonstrate that the charges and costs used in projecting financial feasibility are equitable in comparison to prevailing rates for similar services in similar hospitals are defined by the Authority.

B. The applicant must demonstrate that the project is the superior alternative, after considering in significant detail the costs and effectiveness of the following alternatives:

1. Maintaining extant facilities;

2. The alternative project, if any, which is likely to result in the greatest increases in operating and cost efficiencies;

3. The alternative project, if any, which would use the lowest cost construction methods complying with licensing, accreditation, and building code requirements;

4. A combined analysis of items two and three above considering and analyzing the trade-offs between increases in operational efficiency juxtaposed with lower cost construction alternatives;

5. Merger, consolidation of facilities or sharing of services, and/or delivery of the service in an alternative setting; or

6. Closure of the service and/or such other alternative as may be suggested by the Authority.

C. The applicant shall submit reliable, probative and substantial evidence to demonstrate that the proposed square footage, construction cost per square foot and cost of fixed equipment for all nursing units, ancillary services and support areas directly affected by the replacement and/or renovation are appropriate and reasonable for the types and volumes of patients which are projected to utilize the hospital's services in the fifth year following completion of the project.

In preparing this objective analysis, the applicant must show that it has given prudent consideration to internal and external factors that will impact the operating environment of the hospital upon completion of the project.

The factors to be considered must include:

1. Trends in the demand for specific hospital services and recent demographic and/or medical practice changes that are likely to modify the trends.

2. The forecast of demand for the hospital's services based upon the most probable assumptions. The applicant must submit a comprehensive listing of the assumptions underlying the forecast.

3. If the physical layout of the hospital, following completion of the replacement or renovation, will be conducive to efficient staffing and transportation of patients.

4. If the physical layout of the hospital, following completion of the replacement of renovation, will seek to maximize the amount of net usable square footage available for patient care.

5. A search of the literature and an architect's certification regarding the amount of net usable square feet required for the performance of hospital activities at projected volume levels. The literature search shall include, but not be limited to, the requirements for state licensing or JCAHO Accreditation.

6. How the cost per square foot for replacement projects compares to the normal cost of good quality hospital construction as evidenced by recognized trade journals. For renovations, the applicant must consider how the cost per square foot for renovation of hospital areas compares to – and should not exceed – the normal cost of replacement. Where practicable, the applicant should reference recognized trade journals, such as Means Square Foot Costs, BOECKH, Engineering News Record or Marshall and Swift. In determining normal cost adjustment, consideration should be given for the hospital departments involved, terrain, geographic area and other factors relevant to the source(s) utilized.

7. If the facility design and construction methods employed in the proposal will allow for flexibility to accommodate future changes in the mix of inpatient versus outpatient utilization at the hospital and the mix of services by the hospital.

8. How the hospital will accommodate disruption of normal operations during the period of construction and how savings in operating cost relate to increased capital cost incurred to minimize such disruptions.

9. The steps the hospital is taking to transfer inactive storage and other non-patient activities to less expensive off site areas.

10. Such other factors as may be requested by the Authority.

VII. SPECIALIZED ACUTE CARE

A hospital may change its bed complement, within its approved licensed beds, among specialized units for services that are currently offered by the hospital and which do constitute the addition of a new institutional health service, or the deletion of an existing health service.

In addition to the criteria set forth elsewhere for the replacement or renovation of acute care facilities, proposals involving specialized acute care units must comply with the following requirements:

A. Tertiary Pediatric Care Unit: An application for the replacement or renovation of a tertiary pediatric care unit shall be in substantial compliance with the following:

Tertiary pediatric care units will be operated in only three West Virginia hospitals: West Virginia University Hospitals, Inc., Charleston Area Medical Center, and Cabell-Huntington Hospital.

B. Neonatal Intensive Care Unit: An application for the replacement or renovation of Neonatal Intensive Care Unit (NICU) beds shall be in substantial compliance with the following guidelines.

1. The number of NICU beds shall not exceed four beds per 1000 live births in the service area.

2. Level III NICU services shall be centralized at West Virginia University Hospitals, Inc., Charleston Area Medical Center and Cabell-Huntington Hospital.

3. Level II NICU services shall be considered for approval only at hospitals performing at least 1100 deliveries per year.

C. Obstetric Unit: An application for the replacement or renovation of obstetric unit beds shall be in substantial compliance with the following guidelines.

1. Level II and Level III obstetric units shall perform at least 1100 deliveries per year.

2. Level I obstetric units shall perform at least 750 deliveries per year.

3. New Level I obstetric units may be considered for approval based upon less than 750 deliveries per year if the absence of the service would result in a population of at least 5000 being more than 30 minutes normal driving time from another obstetric unit.

D. Critical Care Unit: An application for the replacement or renovation of Intensive Care Unit (ICU) beds or Coronary Care Unit (CCU) beds (collectively referred to as critical care units) shall be in substantial compliance with the following guidelines.

1. An ICU or CCU shall be staffed with qualified personnel under the direction of one or more appropriately trained on-site physicians. A hospital offering ICU or CCU services shall have a physician on-site for immediate consultation twenty-four hours a day. A CCU shall have a cardiologist or internist with adequate training in cardiology available for immediate consultation twenty-four hours a day.

2. Hospitals providing ICU or CCU services shall have in place with surrounding hospitals established protocols for the referral of stabilized patients. Hospitals which do not have ICU or CCU should have protocols to see that patients requiring such service be transferred as soon as possible after stabilization.

E. Psychiatric Unit: An application for the replacement or renovation of psychiatric beds shall be in substantial compliance with the following guidelines.

1. A unit within a general acute care facility shall be specifically designated for the treatment of psychiatric patients and shall be designed to accommodate the special privacy, security and treatment requirements of the patients.

2. The applicant must demonstrate that each patient will have a treatment plan which includes a prioritization of major problems, stated in specific terms, with clear, concise and realistic goals and coordinated treatment modalities.

3. The applicant must clearly demonstrate that individuals requiring inpatient treatment will be discharged as soon as they are able to function in a less restrictive setting.

VIII. ACCESSIBILITY

The proposal shall not adversely affect the continued viability of an existing hospital or health care services that serves a population of at least 10,000 not having 30-minute access to another hospital or critical access hospitals (CAH).

IX. OTHER CONSIDERATIONS

The applicant must demonstrate that the renovation or replacement is in concert with the applicable sections of the applicant's long-range facility and strategic plan.

X. DEMONSTRATION PILOT PROJECT

A. The Authority recognizes that occasionally certain acute care facilities which provide psychiatric services have excess capacity in their psychiatric units while other facilities in the same service area may need additional beds. In addition, existing State owned psychiatric beds operated by the Department of Health and Human Resources are insufficient to meet the needs of West Virginia.

As part of the Authority's health planning research activities and responsibility to gather information on access to care, and notwithstanding any contrary provisions in the Renovation-Replacement Standards, the Authority will allow a limited number of acute care facilities with excess capacity to lease psychiatric beds under the conditions and circumstances described below. During this Demonstration Project, the Authority will gather data on the success of these programs and will evaluate whether this arrangement should be allowed on a permanent basis in West Virginia.

B. The Authority will allow no more than two Demonstration Pilot Projects at acute care facilities for the provision of short term psychiatric services.

C. Acute care facilities that wish to apply for the Demonstration Pilot Project must submit their requests on forms prepared by the Authority.

D. Acute care facilities that wish to apply for the Demonstration Pilot Project must submit a signed copy of a collaborative agreement with all parties, including the Department of Health and Human Resources.

E. The application shall be a joint application with the Lessor facility and the Lessee facility. The following criteria must be met by the applicants:

1. The Lessor acute care facility must have a psychiatric unit with excess capacity.

2. The Lessee acute care facility must be a facility which currently provides psychiatric services and is in compliance with all federal and state requirements related to this service.

3. The Lessee must have a need for additional short term psychiatric beds.

4. The Lessee and Lessor must be located in the same acute care service area as defined by the State Health Plan.

F. The Demonstration Pilot Project will be for a two year period. The Lessor facility will report to the Authority, on an as requested basis, any information the Authority may request to determine the feasibility of the continuation of the Demonstration Pilot Project. Should either applicant fail to comply with these standards at any time, the Authority may terminate the Demonstration Pilot Project.

G. The Authority's decision to grant a request to participate in the Demonstration Pilot Project does not constitute a Certificate of Need, or any entitlement to the facilities to provide these services beyond the terms of the pilot. During the pilot, the Authority will closely monitor the success of the program and will evaluate whether it is appropriate to allow this arrangement to continue in West Virginia. The Authority may consult with the Department of Health and Human Resources in evaluating the success of this program.

CERTIFICATE OF SERVICE

I, Thomas G. Casto, do hereby certify that I have served the foregoing *Reply Brief and Response Brief Filed on Behalf of Stonewall Jackson Memorial Hospital, Company* by delivering a true and exact copy thereof this 29th day of September 2022, to:

James W. Thomas
Jackson Kelly PLLC
500 Lee Street, Suite 1600
Charleston, WV 25301
Via email and U.S. mail

Allen B. Campbell, General Counsel
Health Care Authority
100 Dee Drive
Charleston, West Virginia 25311
Via email and U.S. mail

Thomas G. Casto (W.Va. Bar No. 676)
Lewis Glasser PLLC
300 Summers Street, Suite 700
Charleston, West Virginia 25301
(304) 345-2000 – telephone
(304) 343-7999 – facsimile
tcasto@lewisglasser.com