WEST VIRGINIA

HEALTH CARE AUTHORITY

In re: Roane General Hospital,
Applicant.

CON File #21-5-12124-P

DECISION

I. JURISDICTION

From 1977 until September 30, 1986, West Virginia participated in the federally funded health planning functions provided for by the National Health Planning and Resources Development Act of 1974. After October 1, 1986, Congress ceased funding the various state agencies known as State Health Planning and Development Agencies and in late 1986, repealed the former provisions of 42 U.S.C. § 300k, *et seq.* However, West Virginia has continued with its state health planning and development functions. Pursuant to W. Va. Code § 16-2D-1, *et seq.*, the state's Certificate of Need (CON) program was created and jurisdiction over that program is vested in the West Virginia Health Care Authority (hereinafter sometimes referred to as the "Authority").

The CON law in West Virginia, W. Va. Code § 16-2D-1, *et seq.*, provides that any proposed new health service as defined therein, shall be subject to review by the Authority prior to the offering or development of the service. The law became effective July 8, 1977.

- RGH enters into an option to lease real property;
- RGH conducts due diligence regarding the real property;
- RGH leases the property;
- RGH acquires a modular building to use for the RHC;
- RGH installs and builds out the building for the RHC;
- RGH acquires equipment for the RHC;
- RGH relocates to the new site; and
- RGH begins operating the RHC at the new site.

The capital expenditure associated with the proposed project is $439,720.00.

IV. PROCEDURAL HISTORY

The Letter of Intent was received on July 12, 2021 (Exhibit 1). On July 12, 2021, the Authority acknowledged receipt of the same (Exhibit 2).

On July 22, 2021, the CON application and appropriate filing fee were received (Exhibit 3). On July 22, 2021, the Authority acknowledged receipt of the same (Exhibit 4). The application was declared complete on July 30, 2021 (Exhibit 5), and the Notice of Review was issued on August 2, 2021 (Exhibit 6).

On August 26, 2021, the Authority received the Notice of Appearance, Request

for Affected Party Status, and Request for Administrative Hearing on Behalf of Minnie Hamilton Health Care Center, Inc. d/b/a Minnie Hamilton Health System (MHHC) (Exhibit 7). On August 26, 2021, the Authority acknowledged receipt of the Notice of Appearance, Request for Affected Party Status, and Request for Administrative Hearing on Behalf of MHHC (Exhibit 8).

On August 27, 2021, the Authority received the Notice of Appearance on Behalf of RGH (Exhibit 9)

On September 14, 2021, the Authority issued the Hearing Order (Exhibit 10) and the Notice of Prehearing Conference and Administrative Hearing (Exhibit 11).

On October 6, 2021, RGH submitted Replacement Pages (Exhibit 12).

On October 20, 2021 the Authority received the Certificate of Service for RGH's Requests for Admission, Interrogatories, and Request for Production of Documents (Exhibit 13). On October 21, 2021, the Authority received the Certificate of Service for Interrogatories, Requests for Production of Documents, and Requests for Admission to RGH (Exhibit 14).

On November 17, 2021, the Authority received the Certificate of Service for Responses to RGH's Requests for Admission, Interrogatories, and Requests for

Production of Documents to MHHC (Exhibit 15).

On November 18, 2021, the Authority received the Certificate of Service for RGH's Answers to Interrogatories, Requests for Production of Documents, and Requests for Admission (Exhibit 16).

On December 1, 2021, the Authority received the Certificate of Service for Supplemental Responses to RGH's Requests for Admission, Interrogatories, and Requests for Production of Documents to MHHC (Exhibit 17).

On December 1, 2021, the Authority received MHHC.'s Motion to Compel (Exhibit 18). On December 6, 2021, the Authority received RGH's Response to MHHC's Motion to Compel (Exhibit 19).

On December 7, 2021, the Authority received Supplemental Answers to Requests for Production of Documents on Behalf of RGH (Exhibit 20). On December 7, 2021, the Authority received the List of Witnesses and Exhibits on Behalf of RGH (Exhibit 21). On December 7, 2021, the Authority received MHHC's Witness and Exhibit List (Exhibit 22).

On December 9, 2021, the Authority received MHHC's Amended Witness and Exhibit List (Exhibit 23).

On January 10, 2022, the Authority received the Prehearing Transcript (Exhibit 24). On January 11, 2022, the Authority received the Hearing Transcript (Exhibit 25).

On January 28, 2022, the Authority received the Brief of Behalf of RGH (Exhibit 26).

On February 28, 2022, the Authority received the Opposition Brief of MHHC (Exhibit 27).

On March 15, 2022, the Authority received the Reply Brief (Exhibit 28) and Proposed Decision on Behalf of RGH (Exhibit 29).

On March 15, 2022, the Authority received the Proposed Decision on behalf of MHHC (Exhibit 30).

V. ANALYSIS OF CRITERIA AND FINDINGS OF FACT

West Virginia Code § 16-2D-12(a) states that a Certificate of Need may only be issued if the proposed new health service is:

1. Found to be needed, and
2. Consistent with the State Health Plan, unless there are emergency circumstances that pose a threat to public health.

The two findings above are independent of one another; that is, both must be met and the absence of one of the above requires the Authority to deny the application. *See Princeton Community Hospital v. State Health Planning and Development Agency,* 174 W. Va. 558, 328 S.E.2d 164 (1985).

Definition of the Proposed Service Area:

RGH submits that the proposed service area is the zip code for Arnoldsburg (25234) and two adjacent/nearby zip codes, Orma (25268) and Chloe (25235), all in Calhoun County. RGH submits that the population of the proposed service area is presented in the table below:

Service Area Population

Zip Code	2021	2026
Arnoldsburg (25234)	1,151	1,127
Chloe (25235)	792	775
Orma (25268)	792	775
Total	2,735	2,677

Source: WVRRI March 2017 Population Projections
(Exhibit 3: Application, Section E, p.1.)

The applicable review criteria for this project are contained in W. Va. State Health Plan (SHP) Ambulatory Care Center Standards approved by the Governor on October 5, 1992. The Standards are set forth in bold below and the Applicant's responses

follow:

AMBULATORY CARE CENTERS

I. **DEFINITIONS** - Omitted.

II. **GENERAL STANDARDS**

The following standards apply to all ambulatory care centers. Standards which apply specifically to a particular type of ambulatory care center are listed in Section III of this standard and supplement the general standards, unless otherwise noted.

A. Need Methodology

For ambulatory care centers for which no specific need methodology is set forth in Section III, below, the following general need methodology shall be used. If a need methodology is specified for a particular type of ambulatory care facility in Section III of this standard, the general need methodology will apply only to those portions of the need methodology which are not specified.

All certificate of need applicants shall demonstrate, with specificity, that there is an unmet need for the proposed ambulatory care services, that the proposed services will not have a negative impact on the community by significantly limiting the availability and viability of other services or providers, and that the proposed services are the most cost effective alternative.

The applicant shall delineate the service area by documenting the expected areas around the ambulatory care facility from which the center is expected to draw patients. The applicant may submit testimony or documentation on the expected service area, based upon national data or statistics, or upon projections generally relied upon by professionals engaged in health planning or the development of health services.

RGH submits that, as previously discussed, the proposed service area is the zip code for Arnoldsburg (25234) and two adjacent/nearby zip codes, Orma (25268) and Chloe (25235), all in Calhoun County. Ms. Raymona A. Kinneberg, President of RKSB Health Care Consulting, conducted a zip code analysis of the unique patients served by RGH's existing on-campus RHCs from October 2019 to September 2020. (Ex. 25, pp. 19-22 and Ex. 21, Attachment J) Ms. Kinneberg testified that a targeted zip code analysis (as opposed to a general, county wide analysis) is her usual and preferred method to delineate service areas for purposes of primary care related CON applications. (Ex. 25, pp. 23-24) RGH further submits that this zip code analysis revealed that the top 75% of the patients served by the RHCs on its campus resided in eight (8) unique zip codes, all located in Roane or Calhoun counties. (Ex. 25, p. 21 and Ex. 21, Attachment J) Since the project is intended to be a satellite outpatient primary and specialty care clinic that is intended to bring care close to home for this satellite population, the service area does not include any Roane County zip codes. (Ex. 25, pp. 156,163) RGH also submits that three (3) zip codes, within this 75% threshold and not located in Roane County, for Arnoldsburg (25234), Orma (25268), and Chloe (25235), were selected to encompass the service area. (Ex. 25, pp. 20-22 and Ex. 21, Attachment J) Finally, Mr. Douglas E. Bentz, Chief Executive Officer of RGH, testified that relocating an on-campus RHC to the service area furthers its patient-centric mission. (Ex. 25, pp. 155-156)

MHHC contends that RGH's interpolation of the raw population data to calculate the projected service area on a zip code-specific basis for years 2021 and 2026 (Ex. 25, p. 22) results in the application being deficient. MHHC further contends that RGH was required to project the population of its service area for the intervening years, not just the initial year proposed (2021) and five years later (2026).

MHHC countered RGH's population projections and suggested that Ms. Kinneberg's testimony on this subject was inconsistent. Ms. Kinneberg used an internet source, unitedstateszipcodes.org, to obtain the population data despite stating in the application that the Authority was the source of the population data. (Ex. 3, Section E, p. 1 and Ex 25, pp. 69-70) MHHC further contends that although an applicant is permitted to propose using other, non-Authority data, the data source must be stated, as well as the rationale for using it, and RGH's expert supplied neither. (Ex. 3, Section E, p.1) Ms. Kinneberg was unable to recall when she previously used zip code-based population data for a need methodology as opposed to a full county's population data or how recently she did so, and was also unable to recall what areas, counties, or zip codes were subject to such an application. (Ex. 25, p. 83) MHHC finally contends that the questionable origins and accuracy of the population data casts doubt on the entirety of the unmet need projected in the application.

The Authority finds that after careful review and consideration of the facts, evidence, and arguments of both parties, that the service area was properly calculated in accordance with the SHP Standards. The SHP Standards state in relevant part that:

> the applicant shall delineate the service area by documenting the expected areas around the ambulatory care facility from which the center is expected to draw patients

Therefore, the Ambulatory Care Center Standards do not impose a county-wide service area requirement. The Authority recently approved a primary care-related CON application which encompassed a single zip code service area as recently as February 14, 2022. *In re: WMC Physician Practices, LLC*, CON File No. 21-11-12322-P (February 14, 2022). The Authority has approved various other CON applications with zip code-specific service areas throughout the years. *See In re: Camden-Clark Physician Corporation*, CON File No. 19-5-11626-P (July 20, 2019), involving a three (3) zip code service area in southern Wood County, West Virginia; and, *Wheeling Hospital*, CON File No. 03-11-7662-P (October 1, 2003), involving a single zip code service area encompassing Wellsburg, West Virginia and the immediate surrounding area.

The Authority further finds that Applicants are required to formulate a service area "from which the center is expected to draw patients." (Ambulatory Care Centers Standards, Section II.A). The three (3) zip codes which encompass the service area were the top three (3), non-Roane County, zip codes of patients served by RGH at its

on-campus RHC's, pursuant to RGH's zip code analysis. (Ex. 25, pp. 20-22 and Ex. 21, Attachment J). These three (3) zip codes, in turn, rationally and objectively reflect "the expected areas around the ambulatory care facility from which the center is expected to draw patients." As a corollary the application's service area was formulated in conformance with the Ambulatory Care Centers Standards Need Methodology.

The applicant shall document expected utilization for the services to be provided by the facility for the population within the service area. As used in this section, "expected utilization", in addition to the expected demand for the service, may be expressed as the number of providers typically required to serve any given population, or as the number of persons in a population that are typically served by a single provider. Where a population is known to have specific characteristics, such as age or disease rates, that affect utilization, then those characteristics may be taken into consideration.

Primary Care

RGH submits that a study commissioned by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) to develop revised guidelines for criteria for establishing Medically Underserved Areas (MUAs) and Health Professional Shortage Areas (HPSA) sets the "preferred ratio of 1,500 people per full-time primary care physician as a central-tendency standard of adequate access."[1] The same study goes on to recommend setting the threshold for a medically

[1] Ricketts, Thomas C., Ph.D. et al "Designating Places and Populations as Medically Underserved: a Proposal for a New Approach." Journal of Health Care for the Poor and Underserved 18 (2007): 567-589. 10 June 2008 <bhpr.hrsa.gov/shortage/designatingMUs.htm>. p.573.

underserved area as a physician to population ratio of 1:3,000.[2] In addition, the study states:

- Primary care physicians include family medicine, pediatric, obstetrics/gynecology, and internal medicine.[3]
- FTE numbers may be adjusted to agree with actual availability[4]:
    - Physicians (MDs and DOs) count as 1 FTE..
    - Mid-Levels (NPs, PAs, and CNMs) count as 0.5 FTE
    - MD and DO interns and residents count as 0.1 FTE

RGH submits that it utilized three (3) separate approaches to demonstrate that a need exists in the service area for the project's provision of primary care services. The first methodology is based on a study previously discussed (hereafter the Ricketts Study). (Ex. 3, Section E, Replacement Page 3)[5] Ms. Kinneberg testified that the Ricketts Study is commonly utilized by health planners to establish the need for primary care services for CON application purposes. (Ex. 25, p. 24-25)

RGH submits that the Ricketts Study set the preferred ratio of 1,500 people to one full-time primary care physician[6] as a central-tendency standard of adequate

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[2] Ibid.

[3] Ibid.

[4] Ibid. p.575

[5] Calhoun County is designated by HRSA as a MUA for primary care services, and as a HPSA for primary care providers (Ex. 21, Attachments F-G); (Ex. 25, at pp. 28-29)

[6] The Ricketts Study generally counts a full-time physician as 1.0 FTE, a full-time mid-level provider as 0.5 FTE, and a full-time intern/resident as .1 FTE.

access, and sets the threshold for a MUA at a physician-to-population ratio of 3,000 people per full-time primary care physician. (Ex. 3, Section E, Replacement Page 3) Applying these ratios to the calculated population of the service area, RGH further submits that there is a need for 1.82 primary care physician FTEs in the service area to meet the ideal ratio, and there is a need for 0.91 primary care physician FTEs in order for the service area to not be designated as an MUA.

RGH submits that the second methodology is based on a study from HRSA's National Center for Health Workforce Analysis (the National Center Study). (Ex. 3. Replacement Page 6) The National Center Study projects an update depiction of need for primary care practitioners[7] in the year 2020. The National Center Study started with the 2010 average ratio of 98 primary care practitioners (including physicians, physician assistants, and nurse practitioner) per 100,000 population and updated this figure for 2020 based on a projected increase in the need for primary care practitioners - driven by an increase in the aging population, increased coverage under the Affordable Care Act, and general population growth.

Recognizing that the service area population has not experienced the same population growth as the the national average, but that the need for primary care practitioners in the service area will nevertheless increase due to an increase in the

[7] The National Center Study counted full-time mid-level practitioners as 0.75 FTEs.

aging population and increased coverage under the Affordable Care Act, RGH submits that it conservatized the National Center Study's projected growth vis-a-vis the need for primary care practitioners to 4%-7% for the service area.[8] (Ex. 21, Attachment I and Ex. 25, pp. 31-32, 38-39) RGH further submits that using the 98 primary care practitioners per 100,000 population ratio identified in the National Center Study, it calculated that there was a need for 2.68 primary care practitioner FTEs in the service area in 2010. (Ex.3, Section E, Replacement Page 6) Applying the conservatized growth in the need percentage of 4%-7% to the number, RGH calculated a need exists for 2.79 to 2.87 primary care practitioner FTEs in the service area.

RGH submits that the third methodology contained in the application to establish need for primary care services is based on the historical unique service area patient utilization of its on-campus RHCs. (Ex. 3, Section E, Replacement Page 5) Specifically, RGH identifies that its on-campus RHCs served 1,901 unique patients from the service area in FY 2019 and 1,264 in FY 2020. (Ex. 3, Section E, Replacement Page 5 and Ex. 25, pp. 30-31)[9] Finally, since the project encompasses the relocation of an existing RHC to the service area, RGH identifies that these service area utilization figures inherently signify that a need for the project exists.

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[8] The National Center Study projected an increase in the need for primary care practitioners at a rate of 14% to 17%. Hence RGH identified that the projected increase of 4% to 7% is far more conservative than the National Center Study"s projected increase in the need for primary care practitioners.

[9] RGH identified that the decrease in patient utilization for 2020 was due to the COVID-19 pandemic, and based on 2021 data, it projects that patient utilization will return to pre-pandemic numbers.

Cardiology

RGH submits that according to the 2020 Physician Specialty Data Book, which provides a ratio of the availability of specialty physicians per a given population, there is approximately one cardiologist (non-interventional) to 14,717 population.[10] (Ex. 3, Section E, Replacement Pages 3-4 and Ex. 25, p. 33) Ms. Kinneberg testified that health planners commonly utilize the Physician Specialty Data Book to calculate the need for specialty purposes for CON applications. (Ex. 25, p. 33)[11] Given the population of the service area, there is a need for 0.186 FTE cardiologists to meet the needs of the service area. RGH further submits that it plans to have a cardiologist at the Arnoldsburg location one day a month and a cardiology mid-level another day a month, both the equivalent of less than 0.05 FTEs, considerably less than the need.

General Surgeon

According to the 2020 Physician Specialty Data Book, there is approximately one general surgeon to 12,965 population.[12] Given the population of the service area, there is a need for approximately 0.21 FTE general surgeons to meet the needs of the service area. RGH submits that it plans to have a general surgeon at the Arnoldsburg location

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[10] Center for Workforce Studies. Association of American Medical Colleges. "2020 Physician Specialty Data Book." 2020. Table 1.2. Number of People per Active Physicians by Specialty, 2019. https://www.aamc.org/what-we-do/mission-areas/health-care/workforce-studies/interactive-data/number-people-active-physician-specialty-2019. Accessed September 27, 2021.

[11] Ms.Kinneberg also testified that the Physician Specialty Data Book does not include a single ratio for the aggregate of all primary care providers. Thus it was utilized in the application to determine the need for primary care services. (Ex. 25, pp 85-86)

[12] Ibid.

one day a month, the equivalent of less than 0.05 FTEs, considerably less than the need. (Ex. 3, Section E, Replacement Pages 4-5)

RGH submits that the service area's 65-year-old-and-over population is projected to increase from 2021 to 2026. (Ex. 21, Attachment and Ex. 25, pp. 38-39) Ms. Kinneberg testified that aging populations have a higher demand for primary and specialty care services. (Ex. 25, p. 38) In addition to having an aging population, RGH identifies that the service area is exceedingly rural. (Ex. 21, Attachment M, at RGH000589) RGH further submits that the West Virginia Rural Health Plan identifies that chronic health conditions are more prevalent among rural populations, and further ranks Calhoun County among West Virginia's least healthy counties. (Ex. 21, Attachment M, at RGH000592-594 and Ex. 21, Attachment N)

MHHC presented evidence and argued that RGH's proposal to relocate its existing RHC cannot withstand critical evaluation by the Authority because the evidence upon which each of the need calculations is based is fatally flawed. MHHC cited the questionable origins and accuracy of the population data used by Ms. Kinneberg and asserts that the dubious accuracy of the information used casts enormous doubt on the entirety of the unmet need projected in the Application. (Ex. 30, p. 16)

After careful review and consideration of the facts, evidence, and arguments of both parties, the Authority determines that RGH reasonably and rationally calculated the service area population and properly established the expected utilization for the health services proposed by the application in accordance with the Ambulatory Care Centers Standards and the CON law.

The Authority finds that RGH reasonably and properly calculated the then-current and five-year projected population of the service area (2021 and 2026) based on the most recent population data which was publicly made available by the Authority and other readily obtainable, publicly available information (Ex. 3, Section E, p. 1 and Ex. 25, pp. 22-23, 69-70, 102) Aside from summarily proclaiming that it is of questionable accuracy and is unverified, MHHC failed to present any testimony or offer any evidence of record to refute the credibility of the zip code reference utilized by RGH to calculate the zip code population breakdown.

The Authority rejects MHHC's inference that the application's population analysis is flawed because the zip code reference was not specifically identified as a source in the application. The zip code reference was utilized to break down the provided population data by zip code, since zip code-specific population percentages are not provided. (Ex. 25, pp. 22-23, 69, 71, 72) Thus, the existence/identity of zip code

reference, as well as the rationale for its use to interpolate the Authority provided population data, was fully established in the record for consideration.

The Authority submits that MHHC's contention that the application improperly omitted population projections for the years 2022 through 2025 is without merit. The application complied with the instructions and documented the then-current and five-year projected population of the service area (2021 and 2026). The Authority has approved various applications which, like RGH's application, solely provides the current and future five year population projections (including the recent primary care application approved in the WMC Physician Practices, LLC decision, *In re: WMC Physician Practices, LLC*, (February 14, 2022) (setting forth population data for years 2021 and 2026); *In re: Camden-Clark Physician Corporation*, (July 20, 2019) (setting forth population data for years 2019 and 2024).

The Authority finds that the rural, aging, and unhealthy characteristics of the service area only exacerbate the need for the local patient-centered care proposed by the project. (Ex. 21, Attachments I, L, M, N) To this end, the Authority finds persuasive the West Virginia State Rural Health Plan's identification that chronic conditions are more prevalent among rural populations, and that rural elders are more likely than urban elders to have chronic conditions, have limited personal transportation, and have less access to health care services. (Ex. 21, Attachment M, at RGH000592)

Finally, the Authority finds that RGH has reasonably calculated the service area population and expected utilization for the project and has demonstrated compliance with this section of the need methodology of the Ambulatory Care Centers Standards (the Need Methodology).

After establishing expected utilization or demand, the applicant shall estimate or document the number of existing providers within the service area and the extent to which the demand is being met by existing providers located within the service area. Where expected utilization is expressed as a number of providers typically serving a given population, it shall be sufficient to show that the ratio of providers to the population in the area is below the expected number. Providers located outside the service area need not be considered, absent specific showing that a provider located outside the service area is a major provider of services to the population within the service area.

RGH submits that according to the web sites for the West Virginia Board of Medicine and the West Virginia Board of Osteopathic Medicine databases, there were no physicians or physician assistants who provided the services proposed by the application in the service area at the time the application was filed. (Ex. 3, Section E, Replacement Page 4 and Ex. 25, pp. 34-35) RGH further submits that, since MHHC's Grantsville location and RGH are located a significant distance from the service area, and since the proposed project's overarching goal is to improve local access, neither RGH nor MHHC was considered for purposes of calculating the unmet need for the project in the service area. (Ex. 25, pp. 81-82) Also, RGH submits that Ms. Kinneberg

cross-checked the results of her search with appropriate RGH personnel and attempted to confirm that no physicians or physician assistants provided primary care services in the service area. (Ex. 25, pp. 34-35)

RGH submits that its on-campus RHCs served 1,901 unique patients from the service area in FY 2019, and 1,264 in FY 2020. (Ex. 3, Section E, Replacement Page 5 and Ex. 25, pp. 30-31). RGH further submits that since the project proposes the relocation of its existing on-campus RHC primary care services to the service area, and since no existing primary care practitioners offered services of the type proposed to the general public of the service area when the application was filed, this existing primary care patient utilization data inherently reflects that the project is needed in the service area.

RGH submits that its project will include the provision of a cardiologist one day per month, and a cardiology mid-level provider another day per month. (Ex. 3, Replacement Page 5) RGH further submits that the project's combined provision of cardiology services will equate to less than 0.05 FTEs, which is considerably less than the service area's current unmet need of 0.186 FTEs. (Ex. 3, Section E, Replacement Pages 3-5) Also, RGH submits that its project will include the provision of a general surgeon's services one day per month, equating to less than 0.05 FTEs, which is far less than the service area's current unmet need of 0.21 FTEs for general surgery

services. (Ex. 3, Section E, Replacement Page 3) Finally, RGH submits that its project will not have a negative impact on the community by significantly limiting the availability and viability of other services or providers, and that the project represents the most cost-effective alternative. (Ex. 26, pp. 23-25)

MHHC contends that, as confirmed at the public hearing, Ms. Kinneberg did not survey MHHC and did not include any references to existing MHHC services despite having previously filed an exemption application on behalf of MHHC that expressly referenced the primary care available at Arnoldsburg Elementary School.[13] MHHC further contends this is a glaring omission from the application, which inaccurately states repeatedly that there are no primary care providers in the proposed service area. (Ex. 3, Section E, p. 4,5,7 and Section J, p.1)

MHHC contends that Ms. Kinneberg conceded that she did not include any utilization for the existing MHHC clinics, not just the two in Arnoldsburg, but also the hospital and primary care RHC clinics in nearby Grantsville. (Ex. 25, pp. 82-83) MHHC further contends that according to Section II (A) of the Ambulatory Care Centers Standards, when a provider outside the proposed service area is a major provider of services to the population within the service area, an applicant is required to include

[13] 13 The exemption application filed by Ms. Kinneberg on August 29, 2022, proposed behavioral health diagnostic and treatment services "in conjunction with the primary care health services" at several Calhoun and Gilmer County Schools, including Arnoldsburg Elementary School, and was approved by the Health Care Authority on September 25, 2002. See In re: Minnie Hamilton Health Center, Inc., CON File No. 02-5/7-7485-X (Sept., 25, 2002).

providers outside the service area when determining the extent to which the demand is being met by existing providers. (Ex. 3, Section E, generally; Ex. 30, p. 12) Finally, MHHC contends that RGH failed to include such providers located outside the service area. (Ex. 30, p.12)

MHHC, which has a hospital in Grantsville and several clinics in Calhoun County, including two clinics in Arnoldsburg, contends that it is a major provider of services to the population within the service area and yet, when determining the extent to which the demand is being met by existing providers, RGH ignored it entirely. In addition, Ms. Kinneberg only reviewed the Board of Medicine and Board of Osteopathic Medicine, but not the Board of Nursing because "you have to pay for and get full—a full list of APRNS." (Ex. 25, p. 84).

MHHC contends that the projected utilization of 1,900 in 2025 does not take into consideration the decline in population in the proposed service area. (Ex. 25, p. 131) MHHC further contends that RGH did not take into consideration that MHHC recently hired a former RGH employee on July 2, 2021. (Ex. 25, p. 203) The employee, a family nurse practitioner, testified that she treats patients from Arnoldsburg, Chloe, and Orma. The employee testified under oath that 90% of her patients have followed or intend to follow her from RGH to MHHC for primary care. (Ex. 25, p. 203 and Ex. 30, p.13).

After weighing the facts, evidence, and the arguments of the parties, the Authority finds that the Applicant has successfully established that existing providers are currently not meeting the expected demand for services proposed in the service area. In making this finding,the Authority recognizes the fact that the Arnoldsburg school-based health center (SBHC) does not offer services to the general public. (Ex. 21, Attachment A, p. RGH000004, RGH000010-11 and Ex. 25, p. 191) The Authority has recently affirmed its position that if a SBHC does not have CON approval to provide services to the general public, is not considered an existing provider for Ambulatory Care Centers Standards Need Methodology purposes in a CON application. *See In re: Pocahontas Memorial Hospital*, CON File No. 21-4-12029-H (November 6, 2021).

The Authority finds that MHHC attempts to distinguish the SBHC in the Pocahontas Memorial Hospital decision from the Arnoldsburg SBHC by arguing that the Arnoldsburg SBHC is not expressly limited from serving the general public. (Ex. 27, p. 8) However, MHHC admitted that the Arnoldsburg SBHC is in fact limited from serving the general public pursuant to the Safe Schools Act. (Ex. 21, Attachment A, p. RGH000010-11) Moreover, the Decision on Request for Ruling on Reviewability for MHHC's Arnoldsburg SBHC did not expressly grant it the ability to serve the general public. *See In re: Minnie Hamilton Health Care Center*, CON File No. 96-5-5484-X (February 21, 1996). Finally, the Authority finds that the utilization of a provider that

does not serve the general public should not be factored into determining the unmet need for a project which proposes to serve the general public.

The Authority submits that Ms. Kinneberg testified, and Mr. Stephen Whited, Chief Executive Officer of MHHC, admitted that the Arnoldsburg SBHC may serve students who reside outside of the service area. (Ex. 25, pp. 25, 193) This provides further justification for the exclusion of the Arnoldsburg SBHC from the Applicant's need methodology, since it is based solely on the service area population and the need for the project therein. Therefore, for these reasons the Authority finds that the Arnoldsburg SBHC was properly excluded from the application's unmet met need calculation.[14]

The Authority rejects MHHC's argument that the application improperly failed to account for the utilization of its Grantsville hospital and other Calhoun County clinics (including those not in the service area). With respect to the service area, MHHC filed a CON exemption application (nearly two months after the CON application was filed) for the development of a community-based clinic which proposes to provide primary care services in Arnoldsburg. *In re: Minnie Hamilton Health Center*, CON File No. 21-7-12162-X. However, the Authority has held that only providers who offer services

[14] The Authority also recognizes that MHHC's Arnoldsburg SBHC only provides (at most) .2 FTE mid-level primary care services weekly (and only during the Calhoun County school calendar) to Arnoldsburg Elementary School students and their household family members. (Ex 21, Attachment A, p. RGH000010); (Ex. 25, p. 191). Therefore, even if it was considered an existing provider for need methodology purposes (which it is not), MHHC's Arnoldsburg SBHC would not satisfy the unmet need for primary care services that exists in the service area, and an unmet need for the project would still exist. (Ex.3, Replacement Pages, 3-6).

when an application is filed are considered "existing providers" for purposes of determining the unmet need for the application under review. *In re: Physicians Medical Corporation*, CON File No. 98-5-6450-P, (November 18, 1998) (provision of primary care services that commenced after the CON application was filed, but before the Authority rendered a Decision, was not considered for purposes of an unmet need calculation); *See Amedisys West Virginia, LLC v. Personal Touch Home Care of W. Va., Inc.*, 245 W. Va. 398, 408, 859 S.E. 2nd 341, 351 (2021) (new home health approval information that was brought to the Authority's attention after a home health CON application was filed, but before the Authority rendered a decision, was not considered for purposes of an unmet need calculation); *In re: Camden-Clark Memorial Hospital*, CON File No. 98-5-6624-H (March 3, 2000) (new cardiac catheterization use rate information that was brought to the Authority's attention after the application was filed, but before the Authority rendered a decision, was not considered for purposes of unmet need methodology.

The Authority determines that when the RGH application was filed (and for nearly two months thereafter), MHHC did not submit the requisite filing required under the CON law for the proposal identified in its exemption application. See W. Va. Code §16-2D-11(b)(26). Since MHHC's proposed clinic was not an existing provider when the application was filed, the Authority finds that this proposed clinic was properly excluded

from the Application's unmet need calculation. Moreover, RGH sufficiently established that even if MHHC's proposed clinic was considered an existing provider of primary care services in the service area (which it is not), there is an unmet need in the service area for both the project and the MHHC exemption application proposal. (Ex. 21, Attachment D; Ex 25, pp. 46-49; and Ex. 29, p. 21)

The Authority rejects MHHC's argument that RGH improperly failed to review the Board of Nursing website to determine if any APRNs were located in the service area. Ms. Kinneberg testified that such targeted website searches for APRNs are not available, and that she cross-checked her finding that no existing APRNs were located in the service area with appropriate RGH officials. (Ex. 25, pp. 84-85) Moreover, MHHC does not identify any APRN that RGH improperly failed to consider in its unmet need calculation. (Ex. 29, p. 23)

Finally, the Authority is persuaded that the project will not significantly limit the availability and viability of existing providers. There are no existing providers which offer primary care services, cardiology services, or general surgery services to the general public in the service area. (Ex. 3, Section E, Replacement Page 5; and Ex. 25, pp. 39-40) The project's operation in the service area will therefore not limit the availability and viability of other services or providers in the service area, since no providers exist. Furthermore, the project will also not limit the availability and viability of any MHHC

providers, as evidenced by MMHC's CEO, Stephen Whited's, admission that the project will not have a significant adverse impact on MHHC. (Ex. 25, p. 201) The unmet need for the proposed services in the service area signifies that the project will not "significantly limit the availability and viability of existing providers." (Ex. 3, at Section E).

The Authority determines that the project represents the most cost-effective alternative because it will enable service area residents to receive primary and specialty care services locally. (Ex. 25, p. 157) As detailed elsewhere in this decision, the status quo requires service area residents to traverse rural terrain for 20-40 minutes each way to receive the services proposed by the project. (Ex. 25, pp.44, 157; Ex. 21, Attachment M, at RGH000589).

In summary, the Authority determines that RGH has sufficiently demonstrated that the project satisfies all requirements of the Ambulatory Care Centers Standards' Need Methodology.

All certificate of need applicants shall demonstrate, with specificity, that there is an unmet need for the proposed ambulatory care services, that the proposed services will not have a negative impact on the community by significantly limiting the availability and viability of other services or providers, and that the proposed services are the most cost effective alternative.

As previously discussed, RGH submits that there are no primary care or specialty practitioners in the service area.

B. Quality

Applicants seeking a certificate of need approval for the development of an ambulatory care center, or for a renovation project or replacement facilities, shall demonstrate compliance with applicable licensing, certification, and/or accreditation standards, or submit a substantive and detailed plan to come into compliance with applicable licensing, certification and/or accreditation requirements. All staff of the facility shall be in compliance with applicable standards.

RGH submits that the RHC that will become the Arnoldsburg RHC meets all requirements for certification as an RHC and will continue to do so following the relocation. RGH further submits that all of its practitioners, including the RHC physicians and other health care professionals, are in compliance with applicable state licensing requirements.

All ambulatory care centers shall document written plans for the development and implementation of a quality assurance program which meets acceptable standards as specified by any applicable accrediting organizations.

RGH submits that it is accredited by The Joint Commission (TJC) as shown in the certificate included as Exhibit I-1 in the application. RGH further submits that its policies are consistent with TJC requirements. Finally, RGH submits that its Utilization Management Plan is included in the application as Exhibit I-2, and its Organizational Performance Improvement Plan is included at Exhibit I-3.

All ambulatory care centers shall demonstrate:

1. suitability of physical plant, if applicable;

RGH submits that the Arnoldsburg RHC will occupy furnished office space designed specifically for the proposed service. To this end, the project facility's physical plant will be a modular furnished office space specifically designed for the project. (Ex. 3, Section C, p.1)

2. adequate staff;

RGH submits that the staff are currently employed. RGH further submits that all staff meet the qualifications for the job as outlined in its job description. RGH submits that it is uniquely familiar with the staffing demands of an RHC. (Ex. 25, pp. 161,166, 170; Ex.3, Section C, p.1; Ex. 3, Section I, p. 2; and Ex.26, p. 26)

MHHC argues that the staffing levels encompassed by the financial projection set forth at Exhibit N-2 of the application (hereafter the Financial Projection) are inadequate for the patient volume levels projected in year three of the project's operation, and may result in quality and consistency of care issues. (Ex. 27, pp. 12-13)

After careful review and consideration of the evidence, facts, and arguments of both parties, the Authority finds that RGH has sufficiently established that its project will

meet all staffing requirements of the Ambulatory Care Centers Standards. The Authority finds that MHHC's assertion is speculative, at best.

3. effective treatment environment documented by written protocol;

RGH submits that it has existing treatment protocols/clinical pathways developed for use by its practitioners. (Ex. 3, Section I, p. 2) The Authority finds that RGH has sufficiently established that its project will meet the written treatment environment protocol requirements of the Ambulatory Care Centers Standards.

4. recognition of patient rights; and

RGH submits that its Patient and Hospital Bill of Rights and Responsibilities is included in the application as Exhibit I-4. As indicated in the policy, "Every patient has rights and responsibilities." (Ex. 3, Section I, p. 2).

5. an administration/evaluation process.

RGH submits that it has its own board, which has oversight over the operations of RGH. The CEO of RGH reports to the RGH Board. (Ex. 3, Section I, p.2) The Authority finds that RGH has sufficiently established that its project will meet the

administrative/evaluation process requirements of the Ambulatory Care Centers Standards.

C. **Continuum of Care**

Ambulatory care centers will develop referral relationships and cooperative agreements with other health care providers as may be required to assure a continuum of care.

RGH submits that it is responsible for the operations of its RHC and practitioner practices. Patients have immediate access to all services at RGH including but not limited to, inpatient and outpatient hospital services. RGH further submits that the RHC will have referral relationships with the other RGH physicians and practitioners. (Ex. 3, Section I, p. 3) By offering this continuum of services to the project patients, and by cooperating with unaffiliated providers, RGH identifies that it will ensure the project patients are provided with the guidance and opportunity to coordinate further patient care. (Ex. 3, Section I, Replacement Page 3 and Ex. 25, p. 171) The Authority finds RGH has demonstrated that its project is consistent with the Ambulatory Care Centers Standards pertaining to continuity of care.

D. **Cost**

The financial feasibility of a proposed ambulatory care center must be demonstrated through three years.

RGH submits that the financial feasibility of the proposed ambulatory care center is presented in the table below:

Roane General Hospital
Arnoldsburg RHC
Financial Projection
FY 2022 - FY 2025

REVENUE	2022	2023	2024	2025
Gross Patient Revenue	$1,024,479	$1,385,095	$1,544,935	$1,566,564
Loss: Provision of contractuals and bad debts	($51,224)	($69,255)	($77,247)	($78,328)
Net Patient Service Revenue	$973,255	$1,315,840	$1,467,688	$1,488,236
Expenses				
Salaries and wages	$252,200	$261,560	$270,920	$280,280
Employee benefits	$63,050	$65,390	$67,730	$70,070
Professional fees	$15,000	$18,000	$21,000	$24,000
Utilities	$5,000	$6,000	$7,000	$8,000
Supplies and other expenses	$40,000	$30,000	$32,000	$34,000
Depreciation	$30,340	$30,340	$30,340	$30,340
Overhead allocation	$210,515	$213,713	$223,643	$233,572
Total expenses	$616,106	$625,003	$652,633	$680,263
Operating Income	$357,149	$690,837	$815,055	$807,973

(Exhibit 3: Application, Section N, Exhibit N-2)

RGH submits that the project will be profitable in its first partial year of operation, and will steadily increase in profitability during its second, third, and fourth years of operation. (Ex. 3, Section N, Ex. N-2) Specifically, RGH expects that its project will result in an operating income of $357,149.00 in its first partial year of operation, $690,837.00 in its second year, $815,055.00 in its third year, and $807,973.00 in its fourth year. (Ex. 20, p. 28)

Ms. Amy Downey, Chief Financial Officer of RGH, testified that the Financial Projection was based upon reasonable and historical utilization, expense, and revenue assumptions. (Ex. 25, pp. 109-123 and Ex. 3, Section N, Ex. N-2). Ms. Downey further testified that the Financial Projection was based upon historical utilization data of service area patients served by RHG's RHCs in 2019. (Ex. 25, pp. 110-112) Also, Ms. Downey testified that she utilized a flexible and conserative approach to this utilization calculation, and that, based on her experience and expertise in health care finance, the utilization assumptions in the Financial Projection are reasonable. (Ex. 25, pp. 113-114 and Ex. 29, p. 29)

To calculate the revenue assumptions in the Financial Projection, Ms. Downey testified that she utilized RGH's then-current average reimbursement rate, adjusted to reflect the then-current Medicare Economic Index of 1.8% (Ex. 25, p. 115) Ms. Downey further testified that, since the time the Financial Projection was created, RGH's

reimbursement rate has actually increased. Based on the aggregate of the foregoing, Ms. Downey testified that, like the utilization and revenue assumptions in the Financial Projections, the expense assumptions therein were reasonable. (Ex. 25, pp. 115-117 and Ex. 29, p. 29)

Ms. Downey testified in detail that the expense assumptions of the Financial Projection (including, but not limited to, professional fees, benefits, overhead costs, utilities, and supplies) were based on RGH's historical experience. (Ex. 25, pp. 117-122) Ms. Downey also testified that the Financial Projection accurately and conservatively reflects the project's staffing figures set forth in Section L of the Application. (Ex. 3, Section L, p.1) Therefore, Ms. Downey testified that, like the utilization and revenue assumptions in the Financial Projections, the expense assumptions therein were reasonable. (Ex. 25, p. 120)

RGH submits that the Authority must also consider that, since the project is a RHC, it will receive cost-based reimbursement for its Medicare and Medicaid patients, which will encompass approximately 80% of all patients. (Ex. 25, pp. 1, 116, 168 and Ex. 3, Section I, Replacement Page 3) RGH identifies that the cost-based reimbursement of nearly 80% of the project's patient base only further ensures that the project will be financially feasible through three (3) years, in compliance with Section II.

D. of the Ambulatory Care Centers Standards. (Ex. 25, pp. 11, 116, 168 and Ex. 3, Section N, Ex. N-2)

MHHC contends that RGH's projection has been inflated by a patient encounter rate that, in turn, has been inflated by the expenses over revenues experienced by the RHC in recent years. Ms. Downey testified that "[t]he level of expenses and the level of cost would drive that rate" in reference to RGH's increasing encounter rate that was used in the application. (Ex. 25, pp. 128-129) The effect of that inflated encounter rate, driven by past RGH expenses in Roane County, is pronounced. RGH projects profitability in excess of 36% in the first year of operation, with profit margins of 54%, 55%, and 54% in subsequent years. (Ex. 3, Section N, Ex. N-2 and Ex. 30, p. 14 Ms. Downey was asked whether any of the existing RGH clinics generate such robust profits, but claimed the profitability is "not something we would regularly look at, because it wouldn't be comparable." (Ex. 25, p. 146) Yet the financial documents reviewed at the public hearing are telling and evidence expenses well in excess of revenues for all of RGH's clinics including the RHC that RGH proposes to relocate to Arnoldsburg. MHHC's Chief Executive Officer, Mr. Whited, cast additional doubt on the current encounter rate, saying that if RHC costs do not increase but encounters do, as forecast in Exhibit N-2, then the cost per encounter will decrease and the encounter rate will drop. (Ex. 25, p. 186)

After careful review and consideration of the facts, evidence, and arguments of both parties, the Authority finds that the Financial Projection was based upon reasonable and historical utilization, expense, and revenue assumptions. (Ex 25, pp. 108-123 and Ex. 3, Section N, Ex. N-2) The Authority further finds that the Financial Projection, taken in conjunction with the project's cost-based reimbursement and the financial health of RGH, demonstrates that the project satisfies the financial feasibility requirements of the Ambulatory Care Centers Standards. (Ex. 29)

In making this finding, the Authority notes that the reimbursement rate used to formulate the Financial Projections was RGH's then-current reimbursement rate of $259.00. (Ex 25, pp. 114-115) Contrary to MHHC's assertion that this rate reflects a high-water mark, Ms. Downey testified that this rate is actually conservative, since RGH's reimbursement rate increased to $280.00 in September 2021 (after the application was filed). Ms. Downey's use of the then-current reimbursement rate (adjusted based on the Medicare Economic Index of 1.8%) to calculate the Financial Projections was a reasonable methodology to demonstrate the project's expected financial feasibility in the next three years. Furthermore, even if the project were to operate at a loss during a given period, RGH established that it would make up for any such losses through future cost-based reimbursement. (Ex. 25, p.147)

MHHC's arguments relating to the third-year utilization assumptions of the Financial Projection all fail, since the Financial Projection does not rely on attaining the patient volume levels projected to occur in year three to demonstrate the project's financial feasibility. (Ex.3, Section N, Ex. N-2; Ex. 25, p.31) For example, the Financial Projection demonstrates that the project will produce an operating income of $690,837.00 in the first full year of operation, even when operating at 70% of the patient volume capacity in year three. Hence, even if the patient volume assumptions did not increase from the truncated levels projected in year one, the project would not only be financially feasible, but would continue to be profitable by year three.

MHHC also appears to misunderstand the difference between RHC "collections" and "reimbursement," and therefore, misapprehends a fundamental and critical distinction as it relates to the project's financial feasibility. For example, MHHC argues that "the financial documents produced in discovery are telling, and present expenses well in excess of revenues for all of RGH's [RHC's]." (Ex. 27, pp. 31-32) However, Ms. Downey and Mr. Bentz squarely negated MHHC's inference that these financial documents reflect that the project will not be financially feasible. (Ex. 25, p. 169 and Ex. 25, pp.115-116, 142) Mr. Bentz testified that these financial documents encompass the margin based upon costs versus expenses, and not reimbursement versus expenses. (Ex. 25, p, 169 and Ex. 29, p. 32) Since Mr. Bentz testified that RHC reimbursement exceeds charges, the financial documents cited by MHHC are not instructive as to the

financial feasibility of the project, as they do not fairly and accurately depict the financial performance of RHG's RHCs.

Finally, the Authority determines that MHHC's arguments with respect to the assumptions of the Financial Projection are likewise unavailing. The expenses in the Financial Projection increase on a yearly basis, and MHHC did not present any expert testimony to refute Ms. Downey's opinion that such assumptions are reasonable. Moreover, Ms. Downey testified that the Financial Projection contains an overhead "catch-all" allocation in the amount of $213,713.00 for the first full year of operation. (Ex. 25, p. 122 and Ex. 3, Section N, Ex. N-2) This overhead allocation more than accounts for any of the *de minimis* expense issues raised in MHHC's Opposition Brief. (Ex. 29, p. 32).

Costs and charges for services and procedures provided in an ambulatory care center shall be comparable to the cost and charges of facilities offering comparable services, as defined by the Health Care Cost Review Authority, except where sliding fee arrangements exist based on patients' ability to pay.

RGH submits that it currently has a fee schedule with charges comparable to other providers. However, the majority of the Arnoldsburg RHC patients will be Medicare and Medicaid, which set reimbursement rates based on the cost of providing services.

The Authority finds that RGH has sufficiently established that the costs and charges for the project's services are comparable to other facilities offering comparable services, in accordance with the Ambulatory Care Centers Standards.

Applicants must demonstrate in their financial projections that all indigent persons needing the services or procedures can be served without jeopardizing the financial viability of the project.

RGH submits that it serves all patients in need of the services it provides. As noted in the assumption for the Financial Projection (included as Exhibit N-2), RHCs are cost reimbursed. (Ex. 3, Section I, p. 3 and Ex. 25, pp. 42, 123)

The Authority finds that RGH has sufficiently established in its financial projections that all indigent persons needing the project's services or procedures can be served without jeopardizing the financial viability of the project.

Applicants must demonstrate that new services, facilities and technologies will not lead to unnecessary increases in costs.

RGH submits that the proposed project is not a new service. The new location will provide space at a relatively low cost that will improve access for its patients from the service area. (Ex.3, Section I, p. 3) RGH further submits that the project will provide services in a cost effective manner and will actually reduce costs by cutting the

travel times/expenses currently required for service area residents to access primary and specialty care services. (Ex. 25, p. 157 and Ex. 21, Attachment M, at RGH 000589)

MHHC counters that the staffing proposed in the application and confirmed by Ms. Downey is woefully inadequate for the projected patient population in year three. Ms. Downey confirmed that the RHC, if relocated to Arnoldsburg, will be staffed by "1.2 of a mid level, 1.2 of an LPN, 1.2 of a registration clerk, and then a .2 of a specialty person" for a total of 3.8 total employees, but only 1.4 providers. (Ex. 25, p. 127) Although the salaries in Exhibit N-2 increase, Ms. Downey states that the increase is attributable to an adjustment in wages, not any additional providers. (Ex. 25, p. 127) In other words, the same 1.4 FTE providers expected to provide services to 1,330 patients in 2022 are expected to provide services to 1,900 in 2025, full utilization, while simultaneously growing revenue by more than $500,000.00.[15] (Ex. 25, pp. 130-131) Using RGH's "middle ground" of 2.75 visits per year (Ex. 25, p. 112) multiplied by the projected population, 1,900, RGH is expecting 5,225 visits by 1.2 providers. This far exceeds the productivity standards for an RHC, which are 4,200 annual visits for each 1.0 FTE physician and 2,100 annual visits for each 1.0 FTE mid-level.

Based upon the evidence presented in the application, witnesses during the Administrative Hearing, Briefs, and Reply Briefs, the Authority finds that RGH has

[15] 2025 net patient revenue ($1,488,236) less 2022 net patient revenue ($973,255.00) is $514,981.00. (Ex. 3, Section N, Ex. N-2)

successfully established that the project will meet all applicable Ambulatory Care Centers Standards pertaining to cost.

E. Accessibility

Facilities shall comply with all applicable state and federal laws regarding accessibility to the disabled.

RGH submits that the proposed ambulatory care facility will be in compliance with ADA. (Ex. 3, Section I, p. 4 and Ex.25, pp. 41-42)

The Authority finds that RGH has sufficiently established that the project will comply with all applicable state and federal laws regarding accessibility to the disabled, in accordance with the Ambulatory Care Centers Standards.

Preference will be given to applicants who demonstrate intent to provide services to all patients, without regard to their ability to pay.

RGH submits that it serves all patients regardless of the ability to pay. RGH further submits that its Financial Assistance and Uninsured Program policy is included in the application as Exhibit F-1. (Ex. 3, Section F, pp. 1-2; Ex. 3, Section F, Ex. F-1; and Ex. 25, pp. 42, 108-109, 116-117)

The Authority finds that RGH has sufficiently established that the project will provide services to all patients, without regard to their ability to pay, in accordance with the Ambulatory Care Centers Standards.

F. Alternatives

Alternatives to new construction should be explored and applicants must demonstrate the need for any new construction proposed for the development of an ambulatory care center.

RGH submits that, while this will be a new building, it is not new construction. Rather, it will be the build-out of a modular building placed on the site. (Ex. 3, Section I, p. 4)

Other alternatives which can assure the availability of the service at a lower or similar cost with improved accessibility shall be addressed.

RGH submits that there is no alternative to this proposal that will provide the proposed services at a lower or similar cost that will improve access. (Ex. 3, Section I, p. 4) RGH identifies that it considered several alternative options, including maintaining the status quo, as well as, utilizing other potential sites and renovation options to implement the project. (Ex. 3, Section G, p. 2) However, RGH submits that it determined the project's use of a retrofitted modular building to be the most cost-effective option to implement the project. (Ex. 3, Section I, pp. 3-4). Further, RGH

determined the project was a superior alternative to the status quo in terms of cost, efficiency, and appropriateness. (Ex. 25, p. 156)

MHHC argues that the Project is not the superior alternative to the status quo. (Ex. 27, p. 15)

After review and consideration of the facts, evidence and arguments of both parties, the Authority finds that RGH has successfully demonstrated, in accordance with the Ambulatory Care Centers Standards, that no alternatives to the project currently exist which can assure the availability of the service at a lower or similar cost with improved accessibility. In addition, the Authority has considered the facts, evidence, and arguments of the parties and determined that the project is a superior alternative to the status quo in terms of cost, efficiency, and appropriateness.

G. Other

Notwithstanding their location in an ambulatory care center, nothing in this standard shall exempt from review certain health services, major medical equipment, and/or facilities, which are subject to separate certificate of need review pursuant to West Virginia Code. These include, but are not limited to:

Computerized Tomography
Proton Emission Tomography
Magnetic Resonance Imaging
Cardiac Catheterization
Radiation Therapy
Lithotripsy

Not applicable.

000589) Assuming patients in the service area have a vehicle or other arrangements to make these lengthy trips, RGH identifies that the patient must pay the cost of fuel, mileage, and other related expenses. Also, RGH submits that, since the West Virginia State Rural Health Plan further classifies Calhoun County as an economically "distressed county", these travel costs inflict an especially grueling blow to the service area residents. (Ex. 21, Attachment M, p. RGH 000591) Moreover, the West Virginia State Rural Health Plan identifies the lack of personal and public transportation presents "substantial barriers [to] accessing healthcare" to rural West Virginians. (Ex. 21, Attachment M, pp. RGH 000598–000599) Finally, RGH submits that the project will ensure that service area residents have increased access to primary and specialty care services, and that this makes the project a superior alternative to the status quo.

MHHC contends that maintaining the status quo in both Roane and Calhoun counties is a clear superior alternative to the proposed relocation of a RHC to Arnoldsburg. Ms. Kinneberg acknowledged that Spencer, Roane County, West Virginia, is the top source of patients for the RHC. (Ex. 25, pp. 76-77) MMHC asserts this begs the question, why relocate the clinic, which currently offers specialty services to neighboring Calhoun County at all? Ms. Downey explained that the RHC has "traditionally operated and continues to operate as a specialty-provider clinic and a walk-in-clinic." (Ex. 25, pp. 133-134) She then explained that the past financial performance has no bearing on the RGH proposal to relocate, however, because the

relocated clinic will have a different patient mix and provider mix. (Ex. 25, pp. 134) RGH's Chief Executive Officer, Doug Bentz, also explained that the "staffing is going to be different because the clinic is going to be different" before ultimately explaining that "the certification or license is what is relocated." (Ex.25, pp. 159-160 and Ex. 27, p.15). MMHC argues it is plainly apparent that RGH's proposal is a new RHC disguised as a relocation in order to maintain the benefit of an enhanced encounter rate. Keeping the RHC in Spencer, Roane County, and maintaining the status quo is the superior alternative because it will ensure that patients requiring specialty services will be able to obtain those services from the existing RHC in Spencer, and will also ensure that MHHC can continue to operate without the unnecessary duplication of competing services from a third provider in Arnoldsburg. (Ex. 27, p. 15)

After careful review and consideration of the facts, evidence and arguments of both parties, the Authority finds that the project represents the superior alternative in terms of cost, efficiency, and appropriateness, and that the development of alternatives is not practicable. In making this finding, the Authority recognizes that, contrary to MHHC's assertions, the status quo does not entail two existing MHHC providers that are located in the service area which provide services to the general public. To the contrary, the only MHHC clinic which existed in Arnoldsburg when the application was filed, the Arnoldsburg SBHC, did not serve the general public. Ex. 21, Attachment A, pp. RGH00004, RGH000010-11 and Ex. 25, pp. 178-179, 191)

As documented by the West Virginia Rural State Health Plan, improved access to health care in rural areas is beneficial. (Ex. 21, Attachments M, O and Ex. 25, p. 158) The West Virginia Rural State Health Plan further identifies that the lack of personal and public transportation presents "substantial barriers [to] accessing healthcare" to rural West Virginias. (Ex. 21, Attachment M, p. RGH000598-599) The project will bring primary care and specialty care services closer to home for service area residents. Therefore, the project will reduce monetary and temporal costs associated with the status quo, since service area residents will no longer be required to find arrangements to travel a minimum of 20-40 minutes (each way) to receive primary care and specialty care services. (Ex 25, p. 157 and Ex. 21, Attachment M, p. RGH000589) The project represents a superior alternative to the status quo, and serves to improve health outcomes and the quality of care for service area residents. (Ex. 21, Attachments M, N) RGH has therefore successfully demonstrated that its project represents the superior alternative in terms of cost, efficiency, and appropriateness, and the development of alternatives is not practicable.

Second, under W. Va. Code § 16-2D-12(b)(2), the Authority must find that existing facilities providing services similar to those proposed are being used in an appropriate and efficient manner. RGH submits that there are no existing providers of similar services in the service area. Based upon the evidence, the Authority finds that this criterion is not applicable to the proposed project.

Third, under W. Va. Code § 16-2D-12(b)(3), the Authority must find that in the case of new construction, alternatives to new construction, such as modernization or sharing arrangements, have been considered and have been implemented to the maximum extent practicable. RGH submits that the project encompasses the utilization of a modular building, and no new construction is proposed. (Ex. 3, Section I, p. 4) RGH identifies that it considered other alternatives and determined that situating a modular building on the project site was the most cost-efficient and appropriate alternative to increase access to care for the service area residents. (Ex. 3, Section G, p. 2 and Ex. 3, Section I, pp. 3-4) Based upon the evidence, the Authority finds that this criterion is not applicable to the proposed project.

Fourth, under W. Va. Code § 16-2D-12(b)(4), the Authority must find that patients will experience serious problems in obtaining care of the type proposed in the absence of the proposed health service. RGH submits that the unmet need for primary and specialty care services in the service area is a practical demonstration that patients currently experience serious problems accessing such services. (Ex. 26, Initial Brief, pp. 37-38 and Ex. 3, Section E) The Authority finds that the current unmet need for primary and specialty care services in the service area, combined with cost-effectiveness, accessibility, and continuity of care benefits that will be offered to service area residents, all unite to demonstrate that serious problems will be avoided by approval of the project. Based upon the evidence, the Authority finds that patients will experience serious

problems in obtaining care of the type proposed in the absence of the proposed new service.

Finally, for each proposed new health service it approves, the Authority must make a written finding, which shall take into account the extent to which the proposed health service meets the criteria in W. Va. Code § 16-2D-12(c), regarding the needs of the medically underserved population. RGH submits that it serves all patients regardless of the ability to pay. RGH further submits that it makes its services available to all residents regardless of their financial status or ability to pay. (Ex. 3, Section I, p. 4; Ex. 3, Section F, pp. 1-2; Ex. 3, Section F, Ex. F-2 and Ex. 25, pp. 108-109, 116-117) Additionally, Ms. Downey testified that all persons with an income at or above the federal poverty level are eligible for 200% charity care on any services offered by RGH. Based upon the evidence, the Authority finds that the proposed project will be accessible to the medically underserved population.

VI. CONCLUSIONS OF LAW

1. The proposed project is reviewable under West Virginia Certificate of Need law.

2. The proposed project is needed.

3. Superior alternatives to the proposed project in terms of costs, efficiency and appropriateness do not exist.

4. Patients will continue to experience serious problems in obtaining care of the type proposed in the absence of the proposed project.

5. The project is consistent with the State Health Plan.

6. The project will serve the medically underserved population.

VII. DECISION

The West Virginia Health Care Authority ***FINDS*** the Applicant is subject to CON review and ***APPROVES*** the application submitted by ***ROANE GENERAL HOSPITAL*** for the relocation of one of its RHC's currently located on its campus to an off-campus site in Arnoldsburg, Calhoun County, West Virginia. The Decision is ***CONDITIONED*** in that the Applicant is responsible for the submission of all required financial disclosure information as set forth in W. Va. Code St. R. § 65-13-1, *et seq.* and W. Va. Code § 16-29B-24.

The capital expenditure associated with the project is ***$439,720.00***. A Certificate of Need is hereby issued in the form of this Decision.

This Certificate of Need is valid for a period of one (1) year from the date of this Decision. The Applicant shall notify the Authority immediately of any anticipated project changes, including cost increases, as outlined in W. Va. Code St. R. § 65-32-14.

At least forty-five days prior to the expiration of this Certificate of Need, the Applicant must submit a report on the progress being made toward completion of the project. At a minimum, the progress report will include the information required by W. Va. Code St. R. § 65-32-13. The progress report must contain a verification signed by

the Chief Executive Officer. If the approved project will not be completed prior to the expiration date, a written request for an extension must be submitted.

The Applicant shall incur an obligation for a capital expenditure associated with an approved project within twelve (12) months of issuance of the Certificate of Need.

Upon good cause shown, the Authority may extend the duration of a Certificate of Need for up to six (6) months. If the obligation required to be incurred by W. Va. Code St. R. § 65-32-13.6 is not incurred within eighteen (18) months of the issuance of the Certificate of Need, the Certificate automatically expires.

If the obligation is incurred within the prescribed time period, the Applicant may request a renewal of the Certificate of Need, in writing, in order to complete the project. The request shall contain a verification signed by the Chief Executive Officer. If a request for renewal of a Certificate of Need is not made before its expiration, the Certificate automatically expires.

Also, the Applicant must request a substantial compliance review, in writing, no later than forty-five days prior to licensure or the undertaking of the activity for which a Certificate of Need was issued as provided for in W.Va. Code St. R. § 65-32-16.1 and a copy of the ***final cost report*** must be filed with the Authority. The request shall contain a verification signed by the Chief Executive Officer. An increase in the capital

expenditure above the approved ***$439,720.00*** may be subject to review.

APPEALS

Appeal from this Decision may be taken in accordance with the provisions of W.Va. Code § 16-2D-16, and must be requested in writing and received by the West Virginia Health Care Authority, Office of Judges, Post Office Box 3585, Charleston, West Virginia 25328, within thirty (30) days after the date of this Decision.

Done this 29th day of April, 2022.

Robert Gray, Chairman

Darrell Cummings, Board Member

Sandy Dunn, Board Member

Charlene Farrell, Board Member

DISTRIBUTION

Raymona A. Kinneberg, President (Certified Copy)
RKSB Health Care Consulting, Inc.

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Jackson Kelly PLLC

Caleb P. Knight, Esquire (Certified Copy)
Flaherty Sensabaugh Bonasso

The Honorable Andrew "Mac" Warner
Secretary of State

Dennis Garrison, Director, Consumer Advocacy Division
West Virginia Insurance Commission

GCDF/TEA

CON Case File #21-5-12124-P

Roane General Hospital

CON File No. # 21-5-12124-P

EXHIBITS REFERENCE

Exhibit Number	Description	Document Date	Date Rec'd by Authority
1	Letter of Intent	7/12/2021	7/12/2021
2	Acknowledgement of Receipt of Letter of Intent	7/12/2021	
3	CON Application	7/22/2021	7/22/2021
4	Acknowledgement of Receipt of CON Application and Appropriate Filing Fee	7/22/2021	
5	Completeness Letter	7/30/2021	
6	Notice of Review	8/2/2021	
7	Notice of Appearance, Request for Affected Party Status and Request for Administrative Hearing on Behalf of Minnie Hamilton Health Care Center, Inc. d/b/a Minnie Hamilton Health System	8/26/2021	8/26/2021
8	Acknowlegment of Notice of Appearance, Request for Affected Party Status and Request for Administrative Hearing on Behalf of Minnie Hamilton Health Care Center, Inc. d/b/a Minnie Hamilton Health System	8/26/2021	
9	Notice of Appearance on Behalf of Hospital Development Co. d/b/a Roane General Hospital	8/27/2021	8/27/2021
10	Hearing Order	9/14/2021	
11	Notice of Prehearing Conference and Administrative Hearing	9/14/2021	
12	Replacement Pages	10/6/2021	10/6/2021

13	Certificate of Service for Roane General Hospital's Requests for Admission, Interrogatories, and Requests for Production of Documents	10/20/2021	10/20/2021
14	Certificate of Service for Interrogatories, Requests for Production of Documents and Requests for Admission to Hospital Development Co. dba Roane General Hospital	10/20/2021	10/21/2021
15	Certificate of Service for Responses to Hospital Development Co. dba Roane General Hospital's Requests for Admission, Interrogatories, and Requests for Production of Documents to Minnie Hamilton Health Care Center, Inc. dba Minnie Hamilton Health System	11/17/2021	11/17/2021
16	Certificate of Service for Roane General Hospital's Answers to Interrogatories, Requests for Production of Documents, and Requests for Admission	11/17/2021	11/18/2021
17	Certificate of Service for Supplemental Responses to Hospital Development Co. dba Roane General Hospital's Requests for Admission, Interrogatories, and Requests for Production of Documents to Minnie Hamilton Health Care Center, Inc. dba Minnie Hamilton Health System	12/1/2021	12/1/2021
18	Minnie Hamilton Health Care Center, Inc.'s Motion to Compel	12/1/2021	12/1/2021
19	Roane General Hospital's Response to Minnie Hamilton Health Center, Inc.'s Motion to Compel	12/6/2021	12/6/2021
20	Supplemental Answers to Requests for Production of Documents on Behalf of Roane General Hospital	12/7/2021	12/7/2021
21	List of Witnesses and Exhibits on Behalf of Roane General Hospital	12/7/2021	12/7/2021
22	Minnie Hamilton Health Care Center, Inc. DBA Minnie Hamilton Health System's Witness and Exhibit List	12/7/2021	12/7/2021

23	Minnie Hamilton Health Care Center, Inc. dba Minnie Hamilton Health System's Amended Witness and Exhibit List	12/9/2021	12/9/2021
24	Prehearing Transcript	12/7/2021	1/10/2022
25	Hearing Transcript	12/14/2021	1/11/2022
26	Brief On Behalf of Roane General Hospital	1/28/2022	1/28/2022
27	Opposition Brief of Minnie Hamilton Health Care Center, Inc. dba Minnie Hamilton Health System	2/28/2022	2/28/2022
28	Reply Brief on Behalf of Roane General Hospital	3/15/2022	3/15/2022
29	Proposed Decision on Behalf of Roane General Hospital	3/15/2022	3/15/2022
30	Minnie Hamilton Health Care Center, Inc. dba Minnie Hamilton Health System's Proposed Decision	3/15/2022	3/15/2022