WEST VIRGINIA

HEALTH CARE AUTHORITY

In re: Raleigh General Hospital,
Applicant.

CON File #21-1-12253-H

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ceased funding the various state agencies known as State Health Planning and Development Agencies and in late 1986, repealed the former provisions of 42 U.S.C. § 300k, *et seq*.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.

II. ISSUES

The general issue to be decided is whether the Applicant is subject to CON review and, if so, whether the Authority shall issue a CON for the Applicant's proposed new health service.

III. PROJECT DESCRIPTION

Raleigh General Hospital (RGH) is a 300 bed general acute care hospital located in Beckley, West Virginia. RGH serves residents of Raleigh, Fayette, Summers, and Wyoming counties and the surrounding area. It is owned and operated by Raleigh General Hospital, LLC. RGH's ultimate parent company is LifePoint Health(R) (LifePoint). LifePoint and its affiliates operate acute care hospitals, physician practices, post-acute care services, outpatient services, and wellness and prevention programs.

RGH proposes the provision of cardiac surgery. RGH currently provides general acute care services and specialty services, including diagnostic and therapeutic cardiac catheterization (cardiac cath) services. RGH asserts the addition of cardiac surgery services is the next logical step for RGH's cardiac program.

RGH has a long history of providing cardiac services to the residents of Raleigh County and the surrounding area. RGH has provided therapeutic cardiac cath services since 2009 and has provided diagnostic cardiac cath services since 1987. RGH

performs over 1,000 diagnostic cardiac cath procedures per year and approximately 1,000 therapeutic cardiac caths per year. RGH has a wide range of other cardiac diagnostic and therapeutic cardiac services. RGH states it prides itself on its extensive cardiac outreach and community education services to the citizens of its service area.

The proposed project will allow RGH to provide more accessible cardiac surgery services to the residents of the service area. RGH will work with another LifePoint hospital that is an experienced provider of invasive cardiac services, to develop the proposed services. RGH's goal is to provide high quality cardiac surgery services to the residents of the service area.

The cardiac surgery program will be incorporated into the hospital's cardiology program and directed by a cardiovascular surgeon certified by the American Board of Thoracic Surgery. The director will serve as liaison between the cardiology program, the clinical departments of the hospital, administration, the community and primary care providers.

The objectives of the project include:

- To improve the accessibility and availability of cardiac surgery services to residents of southern West Virginia.
- To reduce cardiac morbidity and mortality in the service area.
- To decrease the number of West Virginia residents who seek cardiac surgery in out of service area hospitals.

- To develop a complete cardiac care diagnostic and treatment facility at RGH.

The components of the project include:

- RGH acquires the needed equipment;
- RGH employs the cardiac surgeons and other staff needed for the proposed cardiac surgery services;
- RGH develops policies and trains staff: and
- RGH begins providing cardiac surgery services.

The capital expenditure associated with the project is $1,150,000.00.

IV. PROCEDURAL HISTORY

On September 17, 2021, the Authority received the Letter of Intent from RGH (Exhibit 1). On September 17, 2021, the Authority acknowledged receipt of the Letter of Intent (Exhibit 2). On September 27, 2021, the Authority received the Application and the appropriate filing fee (Exhibit 3). On September 27, 2021, the Authority acknowledged receipt of the Application and appropriate filing fee (Exhibit 4). On September 29, 2021, the Authority requested additional information via Email (Exhibit 5). On September 29, 2021, the Authority received, via Email, the requested information (Exhibit 6). On September 30, 2021, the Authority, via Email, requested confirmation of Income Statement (Exhibit 7). On September 30, 2021, the Authority received, via Email, the confirmation of the Income Statement (Exhibit 8). On September 30, 2021,

the Application was declared complete (Exhibit 9). On October 1, 2021, the Authority issued the Notice of Review (Exhibit 10).

On October 8, 2021, the Authority received the Notice of Appearance and Request for Affected Party status on behalf of Appalachian Regional Healthcare, Inc. d/b/a Beckley ARH Hospital (Exhibit 11). On October 12, 2021, the Authority acknowledged the Notice of Appearance and Request for Affected Party status on behalf of Appalachian Regional Healthcare, Inc. d/b/a Beckley ARH Hospital (Exhibit 12).

On October 18, 2021, the Authority received a Letter of Support for RGH's development of cardiac surgery services from Senator Rollan Roberts (Exhibit 13). On October 18, 2021, the Authority acknowledged receipt of the Letter of Support from Senator Rollan Roberts (Exhibit 14).

On October 22, 2021, the Authority received the Notice of Appearance, Request for Affected Party Status and a Request for Administrative Hearing on behalf of Charleston Area Medical Center (CAMC) (Exhibit 15). On October 22, 2021, the Authority acknowledged receipt of the Notice of Appearance, Request for Affected Party Status and Request for Administrative Hearing on behalf of CAMC (Exhibit 16).

On October 29, 2021, the Authority received a Request for Administrative

Hearing on behalf of Appalachian Regional Healthcare, Inc. d/b/a Beckley ARH Hospital (Exhibit 17). On October 29, 2021, the Authority acknowledged the Request for Administrative Hearing on behalf of Appalachian Regional Healthcare, Inc. d/b/a Beckley ARH Hospital (Exhibit 18).

On November 16, 2021, the Authority issued the Notice of Prehearing Conference and Administrative Hearing (Exhibit 19) and the Hearing Order (Exhibit 20).

On December 3, 2021, the Authority received the Notice of Appearance of Rachel D. Ludwig on behalf of RGH (Exhibit 21).

On December 7, 2021, the Authority issued an Amended Notice of Prehearing Conference and Administrative Hearing (Exhibit 22) and an Amended Hearing Order (Exhibit 23).

On January 5, 2022, the Authority received Replacement Pages (Exhibit 24).

On January 12, 2022, the Authority received Raleigh General Hospital's Motion to Dismiss Appalachian Regional Healthcare, Inc. as an Affected person (Exhibit 25).

On January 21, 2022, the Authority received Appalachian Regional Healthcare, Inc. d/b/a Beckley ARH Hospital's Motion for Discovery (Exhibit 26). Also, on January

21, 2022, the Authority received Appalachian Regional Healthcare, Inc. d/b/a Beckley ARH Hospital's Interrogatories, Requests for Production of Documents, and Requests for Admissions to RGH (Exhibit 27).

On January 24, 2022, the Authority received the Certificate of Service for Motion for Discovery on behalf of RGH for Appalachian Regional Healthcare, Inc. d/b/a Beckley ARH Hospital (Exhibit 28). Also, on January 24, 2022, the Authority received the Certificate of Service for Raleigh General Hospital, LLC's Request for Admission, Interrogatories, and Request for Production of Documents to Appalachian Regional Healthcare, Inc. d/b/a Beckley ARH Hospital (Exhibit 29).

On January 24, 2022, the Authority received the Certificate of Service for Motion for Discovery on behalf of RGH to CAMC (Exhibit 30). Also, on January 24, 2022, the Authority received the Certificate of Service for Raleigh General Hospital LLC's Requests for Admission, Interrogatories, and Requests for Production of Documents to CAMC (Exhibit 31). On January 27, 2022, the Authority received the Certificate of Service for CAMC's Request for Admission, Interrogatories, Requests for Admission and Requests for Production of Documents to RGH (Exhibit 32).

On February 1, 2022, the Authority received Appalachian Regional Healthcare, Inc. d/b/a Beckley ARH Hospital's Response to RGH's Motion to Dismiss Appalachian Regional Healthcare, Inc. as an Affected Person (Exhibit 33). On February 22, 2022, the

Authority received RGH's Reply to Appalachian Regional Healthcare, Inc. d/b/a Beckley ARH Hospital's Response to RGH's Motion to Dismiss (Exhibit 34).

On February 25, 2022, the Authority received the Certificate of Service for Raleigh General Hospital, LLC's Answers and Responses to CAMC's Request for Admission, Interrogatories and Requests for Production of Documents (Exhibit 35). On February 28, 2022, the Authority received the Certificate of Service for CAMC's Answers and to RGH's Requests for Admission, Interrogatories, and Requests for Production of Responses Documents (Exhibit 36).

On March 1, 2022, the Authority received the Certificate of Service for Raleigh General Hospital LLC's Answers and Responses to Appalachian Regional Healthcare, Inc. d/b/a Beckley ARH Hospital's Interrogatories, Requests for Production of Documents, and Requests for Admission (Exhibit 37). Also, on March 1, 2022, the Authority received the Certificate of Service for Raleigh General Hospital LLC's Answers and Responses to CAMC's Requests for Admission, Interrogatories and Requests for Production of Documents (Exhibit 38).

On March 3, 2022, the Authority received the Certificate of Service for Appalachian Regional Healthcare, Inc. d/b/a Beckley ARH Hospital's Answers and Responses to Raleigh General Hospital, LLC's Interrogatories, Requests for Production of Documents, and Requests for Admissions to Appalachian Regional Healthcare, Inc.

d/b/a Beckley ARH Hospital (Exhibit 39).

On March 7, 2022, the Authority received the Certificate of Services for CAMC's Supplemental Answers and Responses to RGH's Requests for Admission Interrogatories, and Requests for Production of Documents (Exhibit 40).

On March 7, 2022, the Authority received CAMC's Motion to Deny Application (Exhibit 41). Also on March 7, 2022, the Authority received Appalachian Regional Healthcare, Inc. d/b/a Beckley ARH Hospital's Motion to Compel RGH to Supplement its Discovery Response (Exhibit 42).

On March 7, 2022, the Authority received a letter from Jill Cranston, Counsel for Appalachian Regional Healthcare, Inc. d/b/a Beckley ARH Hospital, Requesting Subpoenas for Simon Ratliff and William "Lee" Brown (Exhibit 43). On March 8, 2022, the Authority issued a letter to Jill Cranston, Counsel for Appalachian Regional Healthcare, Inc. d/b/a Beckley ARH Hospital, enclosing Subpoenas for Simon Ratliff and William "Lee" Brown (Exhibit 44).

On March 10, 2022, the Authority issued an Order Granting Motion to Dismiss (Exhibit 45).

On March 14, 2022, the Authority received Raleigh General Hospital LLC's

Response in Opposition to CAMC's Motion to Deny Application (Exhibit 46). Also, on March 14, 2022, the Authority received Raleigh General Hospital, LLC's Witness List, Summary of Proposed Anticipated Testimony and Documents Intended to be Submitted (Exhibit 47).

On March 14, 2022, the Authority received CAMC's Witness List, Summary of Proposed Anticipated Testimony and Documents Intended to be Submitted (Exhibit 48).

On March 17, 2022, the Authority received Appalachian Regional Healthcare, Inc. d/b/a Beckley ARH Hospital's Objection to Order Granting Motion to Dismiss (Exhibit 49).

On April 21, 2022, the Authority received the Pre-Hearing Transcript (Exhibit 50). On May 6, 2022, the Authority received the Hearing Transcript Day 1 (Exhibit 51) and Hearing Transcript Day 2 (Exhibit 52).

On June 6, 2022, the Authority received the Brief on Behalf of RGH (Exhibit 53). On July 18, 2022, the Authority received the Response Brief filed on behalf of CAMC (Exhibit 54).

On July 28, 2022, the Authority received the Reply Brief on Behalf of Raleigh General Hospital, LLC (Exhibit 55). Also, on July 28, 2022, the Authority received the

Proposed Decision on Behalf of Raleigh General Hospital, LLC (Exhibit 56).

On July 29, 2022, the Authority received the Proposed Decision on behalf of CAMC (Exhibit 57).

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).

The applicable review criteria for this project contained in W. Va. State Health Plan are the Cardiac Surgery standards approved by the Governor on May 3, 2007. These Standards are set forth in bold below and the Applicant's responses follow:

CARDIAC SURGERY

I. **PREAMBLE** - Omitted.

II. **DEFINITIONS** - Omitted.

III. **CURRENT INVENTORY** - Omitted.

Definition of the Proposed Study Area

RGH submits that it proposes providing cardiac surgery services in Raleigh County, West Virginia, which is the county of proposal. RGH's study area includes Raleigh County and the following counties that are significantly impacted: Fayette, Greenbrier, McDowell, Monroe, Summers, and Wyoming counties in West Virginia.

RGH submits that according to the West Virginia State Health Plan standards for Cardiac Surgery (approved by the Governor on May 3, 2007), "For applications proposing the initiation of Cardiac Surgery Services or a new Cardiac Surgery Unit, the service area for the proposal consists of the county of proposal and any county significantly impacted." RGH further submits that a significantly impacted county is defined as a county where at least 25% of the residents rely on or will rely on the diagnostic cardiac cath services in the county of proposal or a county which generates at least 10% of the Applicant's diagnostic cardiac cath patient load.

RGH submits that using the report provided by the Authority, included as Exhibit E-1), Raleigh County providers of diagnostic cardiac cath services maintained a market share in excess of 25% for diagnostic cardiac cath services in Fayette, Greenbrier,

McDowell, Monroe, Raleigh, Summers and Wyoming counties in West Virginia in 2019.

This is presented in the tables below:

Raleigh County
25/10 Report - 2019
Source: 2019 UB92 Data from the WVHCA
Diagnostic Cath Procedures Only
2019 Discharges - County of Origin coming to Raleigh County

	County	Total	Raleigh	Pct.
WV	Raleigh	969	775	80.0%
WV	Wyoming	292	200	68.5%
WV	Summers	115	73	63.5%
WV	Fayette	493	259	52.5%
WV	McDowell	125	84	67.2%
WV	Monroe	37	18	48.6%
WV	Greenbrier	184	73	39.7%
WV	Mercer	186	40	21.3%
WV	Nicholas	155	23	14.8%
WV	Pocahontas	27	5	18.5%
WV	Webster	68	7	10.3%
WV	Mingo	93	1	1.1%
WV	Braxton	71	1	1.4%
WV	Boone	214	5	2.3%
WV	Logan	310	5	1.6%

(Exhibit 3: Application, Section E, Exhibit E-2, p.1)

2019 Discharges - Raleigh General Hospital

25/10 Report
Source: 2019 UB92 Data from the WVHCA
Diagnostic Cath Procedures Only
2019 Raleigh General Hospital - Patient Origin

	County	RGH	Pct.
WV	Raleigh	636	45.8%
WV	Fayette	223	16.0%
WV	Wyoming	175	12.5%
WV	McDowell	83	6.0%
WV	Greenbrier	72	5.2%
WV	Summers	61	4.4%
WV	All Others	140	10.1%
	TOTAL	1,390	100.0%

(Exhibit 3: Application, Section E, Exhibit E-2, p.2)

RGH submits that the population of the proposed study area is presented in the table below:

Raleigh General Hospital
Service Area Population
Source: WVRRI March 2017 Projections

County	2021	2025	2026
Fayette	43,409	42,723	42,484
Greenbrier	35,193	34,725	34,580
McDowell	17,493	16,462	16,279
Monroe	13,323	13,149	13,075
Raleigh	76,099	75,335	75,128
Summers	12,718	12,584	12,517
Wyoming	20,781	20,164	19,983
TOTAL	219,014	215,142	214,046

(Exhibit 3: Application, Section E, Exhibit E-3, p.1)

CAMC states that the county of proposal is Raleigh County. The rest of the study area consists of six other surrounding counties including Monroe County. Monroe County is included, according to RGH, because at least 25% of its residents rely on the diagnostic cardiac cath services in Raleigh County. CAMC further states that it disagrees with the inclusion of Monroe County. (Ex. 54, CAMC Response Brief, p. 5).

CAMC asserts that there are two facets to this issue. First, is the legal issue, which is whether Monroe County is a significantly impacted county and is properly included in the study area as defined in the Standards. As stated above, a "significantly impacted county is a county" where at least 25% of its residents rely on or will rely on the diagnostic cardiac cath services in the county of proposal. See Standards, Section IV (C). CAMC further asserts the Standards state "25% of the residents," not 25% of the residents who seek care in the state of West Virginia. (Ex. 54, CAMC Response Brief, p.5).

CAMC states that in the Application, RGH calculates that Monroe qualifies as a 25/20 county because more than 25% of the residents of the County obtain diagnostic cardiac cath services in Raleigh County hospitals. However, CAMC states the problem with the calculation is that RGH only used data from West Virginia hospitals, meaning that it has calculated that 25% of the residents of Monroe County who seek diagnostic

cardiac cath services in West Virginia hospitals seek those services in Raleigh County. CAMC submits that the problem with this calculation is that based on data obtained from the State of Virginia, Virginia Health Information, it ignores the fact that approximately 52.5% of the citizens of Monroe County leave the state to get diagnostic cardiac cath services. (Ex. 48, Attachment 9). Thus, by including Monroe County in the study area, RGH is ignoring more than half of the patients from that County that obtain diagnostic cardiac cath services. CAMC states that to properly establish the study area, RGH must consider the total number of residents who access diagnostic cardiac cath services, including those who access them in other states. Otherwise, the specific language of the Standards that states that "25% of the residents" that access the services makes a county is included is amended to mean that only 25% of the residents who access the services in West Virginia facilities are included. CAMC asserts neither RGH nor the Authority can amend or alter the language or the plain meaning of that language in the Standards. The only way Monroe County can be included in the study area is for the Authority to alter or amend that plain language. (Ex. 54, pp 5-6).

CAMC states that the Standard is clear and not ambiguous. It provides that if 25% of the residents of a county access services at hospitals in another county that county is in the study area. In this case 25% of the residents of Monroe County do not access diagnostic cardiac cath services in Raleigh County. Therefore, Monroe County is not in the study area. (Ex. 54, CAMC Response Brief, pp 6-7).

CAMC states that the second part of the issue is the practical side. Whether purposeful or not, failing to include the Virginia data in this matter materially skews the need analysis. If only West Virginia hospitals are included in the calculations, then more than 25% of the residents of Monroe County rely on the diagnostic cardiac cath services in Raleigh County. (Ex. 3, App. Rep. Ex. E-2). However, when looking at the bigger, and more accurate, picture, when Virginia hospitals are included in the calculation, less than 25% of the residents of Monroe County rely on diagnostic cardiac cath services in Raleigh County. (Ex. 48, Attachment 9) More importantly, the loss of Monroe County from the RGH study area is fatal to the need projection. (Ex. 54. CAMC Response Brief, pg. 7).

Still, CAMC admits the definition of the 25/10 study area does not say explicitly applicants must use "Virginia data or North Carolina data or any out-of-state data." (Ex. 52,Tr. II, pp. 229:11-13, Ex.9 to Ex. 48(CAMC_000252)). Ultimately, CAMC suggests that this is the correct approach because "[i]t gives a more complete picture." (Ex. 52 Tr. II, pp. 451:6-10, Ex. 54, CAMC Response Brief, pp.7).

RGH responds that the 25/10 calculation, as defined in the Standards, expressly contemplates the use of out-of-state data under certain circumstances. The Standards require the use of authoritative out-of-state data when applicants include out-of-state counties in their service area. RGH further submits that the Standards explicitly specify

when authoritative out-of-state data must be consulted and demonstrate that such data is not otherwise required to the study area calculation.

RGH submits that its 25/10 calculation is consistent with prior approved applications – including applications filed by CAMC. RGH further submits that, David Jarrett–CAMC's health planning expert and CON application author–admitted that his own CAMC applications have not included out-of-state data to calculate entirely in-state study areas, even when border counties are included in the study area, as in its Application. (Ex. 52, Tr. II, pp. 471:17-472:19; 473:8-474:1). The Authority approved these applications.

RGH submits that it adhered to the written Standards, as outlined in Section IV(C), by calculating its exclusively in-state service area based on in-state data. The study area was calculated in the same way. (Ex. 51, Tr. I, pp. 84:24 -85:4). As a result, the study area calculation properly includes the above-mentioned counties of Fayette, Greenbrier, McDowell, Monroe, Raleigh, Summers, and Wyoming Counties. (Ex. 55, RGH Reply Brief, pp. 10-11).

RGH submits that applications are not always required to perform the use rate calculation. Instead, the use rate calculation was previously provided by the Authority. (Ex. 51, Tr.1, pp. 74:1-6). In the Application, RGH submits that its use rate calculation reflects West Virginia resident discharges for cardiac surgery procedures - specifically

diagnosis-related groups (DRG) 216-221, 228-229 and 231-236- for services provided in West Virginia, Kentucky, Maryland, Pennsylvania, Virginia, and Ohio, in part. Ohio data is unavailable - with the exception of Medicare recipients - and thereby excludes (1) all individuals age 15 through 44 and (2) the vast majority of individuals aged 45-64, and underreports individuals over the age of 65. (Ex. 3, Application, Section E, Exhibit E-4 to Ex.3). Thus, Ms. Raymona Kinneberg, President, RKSB Health Care Consulting, concluded "the Ohio data is an understatement of the number of West Virginia residents that . . . obtained cardiac surgery in Ohio." (Ex. 51, Tr. 1, pp. 69:14-16).

The Authority finds that there is no implicit requirement to use out-of-state data to calculate in-state study areas. The Standards do not say applicants should not use out-of-state data. Nevertheless, the absence of a prohibition does not create an embedded requirement to include such data. If the Standards always required the inclusion of out-of-state data, the identification of certain study areas where out-of-state data must be consulted would be meaningless. Therefore, RGH's 25/10 calculation adheres to the written Standards and Monroe County is properly included in RGH's study area.

IV. NEED METHODOLOGY

A. Applicants proposing to initiate a Cardiac Surgery Unit or existing providers of Cardiac Surgery proposing an additional Cardiac Surgery Unit must demonstrate:

1. **That at least 1,000 Diagnostic Cardiac Catheterization cases have been performed by the applicant in the preceding 12 months. If it is a Joint Application, at least 1,000 Diagnostic Cardiac Catheterization cases must have been performed in the preceding 12 months, in total, by the Joint Applicants. In calculating the 1,000 Cardiac Catheterization cases, Joint Applicants may count all of the Cardiac Catheterization cases which they performed in their study areas, as defined in C of this Section, if the county of the proposed Cardiac Surgery Unit is contiguous to the county of the other Joint Applicant's facility. If the counties are not contiguous, as described herein, the Joint Applicant which will be the site of the proposed Unit may count the Cardiac Catheterization cases it has performed and the Cardiac Catheterization cases performed by the other Joint Applicant in the study area, as defined in C of this Section, of the proposed Unit; or**

RGH submits that for the 12 months ending August 31, 2021, it performed 1,084 diagnostic cardiac cath cases, in excess of 1,000 cases. RGH further submits that the above cardiac cath cases do not include any diagnostic cardiac caths performed in conjunction with or prior to a therapeutic catheterization, resulting in a conservative estimate of its diagnostic cardiac cath volume.

Based upon the evidence presented in the application and during the Administrative Hearing, the Authority accepts RGH's utilization for the number of diagnostic cardiac caths performed. Furthermore, the Authority finds that CAMC did not dispute RGH's cardiac cath volume.

2. **That at least 1,000 Diagnostic Cardiac Catheterization cases are projected to be performed annually by 36 months after initiation of Cardiac Surgery services. In projecting Cardiac Catheterization procedures, the Joint Applicants may only include the counties in their study area as defined in C of this Section; and,**

Not applicable as RGH submits it performed in excess of 1,000 diagnostic cardiac cath cases in the previous twelve months.

3. **That using the most recent three-year average West Virginia Cardiac Surgery Use Rate by age cohort as defined by the Authority, as applied to the population of the applicant's or Joint Applicants' study area, at least 250 Cardiac Surgeries will be performed by the new Unit annually by 36 months after initiation of the services. Applicants may also submit projections based on the most recent version of the National or Southern Use Rates by age cohorts as defined by the National Center for Health Statistics.**

RGH submits that the West Virginia Resident Open Heart use rate calculation is shown by age cohort in Exhibit E-4. The West Virginia use rate includes West Virginia residents obtaining services in West Virginia, Kentucky, Maryland, Pennsylvania and Virginia. RGH further submits that it also includes West Virginia Medicare beneficiaries receiving services in Ohio as a total number was not available. Subsequent to the determination of the study area, and the determination of the population within this defined study area, as previously discussed, the Cardiac Surgery standards require the applicant to adjust the study area population for out-migration and in-migration.

West Virginia Resident Open Heart Use Rate

1.Number of Discharges by state (DGs 216-221, 228-229, and 231-236)

A. 2017	0-14	15-44	45-64	Over 65	Totals
Ohio[1]	-	-	11	67	78

[1] CMS Medicare Standard Analytical File

Virginia[2]	-	2	26	31	59
Kentucky[3]	-	8	22	33	63
Pennsylvania[4]	7	6	34	45	92
Maryland[5]	-	-	28	43	71
West Virginia[6]	36	133	886	1,149	2,204
Grand Total	43	149	1,007	1,368	2,567

B. 2018	0-14	15-44	45-64	Over 65	Totals
Ohio	-	-	21	71	92
Virginia	-	1	14	20	35
Kentucky	-	10	33	27	70
Pennsylvania	9	3	21	57	90
Maryland	-	+	18	30	48
West Virginia	36	166	938	1,268	2,408
Grand Total	45	180	1,045	1,473	2,743

C. 2019	0-14	15-44	45-64	Over 65	Totals
Ohio	-	-	-	56	56
Virginia	-	1	13	18	32
Kentucky	-	7	24	32	
Pennsylvania	6	4	28	49	87
Maryland	-	-	13	30	43
West Virginia	41	176	1,086	1,445	2,748

[2] Virginia Health Information
[3] Kentucky Health Facility and Services Data
[4] Pennsylvania Health Care Cost Containment Council
[5] hMetrix
[6] WVRRI March 2017 Population Estimates

Grand Total	47	188	1,164	1,630	3,029

2. West Virginia Population Data[7]	0-14	14-45	45-64	Over 65	Totals
2017	308,516	667,569	507,532	352,244	1,835,861
2018	306,333	663,029	503,415	360,484	1,833,261
2019	304,149	658,490	499,297	368,724	1,830,660

3. Use Rate Per Thousand	0-14	14-45	45-64	Over 65	Totals
2017	0.139	0.223	1.984	3.884	1.398
2018	0.147	0.271	2.076	4.086	1.496
2019	0.155	0.286	2.331	4.421	1.655
Average	0.147	0.260	2.130	4.130	1.516

(Exhibit 3: Application, Replacement Section E, Replacement Exhibit E-4)

The Out-migration Adjustment

The study area population must be reduced by the percentage of study area residents who seek or will seek Cardiac Catheterization services outside the study area.

Applicants are required to compute the adjusted population on an age-cohort specific basis by applying the percentage of residents who seek or will seek Cardiac Catheterization services outside the study area.

RGH submits it is generally accepted for clinical reasons and for reasons of patient preference, the providers of cardiac cath services that do not have cardiac cath

[7] WVRRI March 2017 Population Estimates

surgery capabilities will capture fewer cardiac cath patients than those providers who have cardiac surgery capabilities. Clearly, the availability of Cardiac Surgery services affects the migration patterns of patients. Therefore, the historical migration patterns in Raleigh County will not accurately predict the percentage of residents who will obtain cardiac services once a cardiac surgery unit is developed in the county. RGH further submits that this market share adjustment is supported by historically applied and approved market share adjustments that account for the expected increase in a provider's cardiac offerings following the initiation of cardiac surgery services. (Ex. 51, Tr. I, pp. 75:8-22).

RGH submits that the out-migration adjustment was performed by analyzing the total patient origin by county for cardiac catheterization procedures. A market share percentage is calculated for patients coming to Raleigh County. RGH further submits that the inverse number of patients coming to Raleigh County is the out-migration.

RGH submits that it then adjusted the market share for each county, decreasing the out-migration by ten percent for inpatient services only. (Ex. 51, Tr.I, pp. 74:17-75:22). RGH further submits that this adjustment is not ten percent of the inpatient out-migration, but instead, a reduction of ten percent of the percent of inpatients out-migrating.

RGH submits that the question, therefore, is how will historical migration patterns

for cardiac catheterization be affected by the development of a cardiac surgery program in Raleigh County. RGH further submits that, for purposes of the need projection contained in this application, it is assumed that the historical market share for cardiac cath will increase by 10% in the service area subsequent to the development of a cardiac surgery program at the hospital. For example, if the market share of a county is 62%, that makes the out-migration rate 38%. An increase of market share by 10% will increase market share to 68.2% and decrease out-migration to 31.8%.

RGH submits, using the above assumption, Exhibit-5, that is presented in the table below, contains a calculation of the out-migration adjustment using all cardiac caths[8]. Exhibit E-6 applies this factor to the population of the service area. The total adjusted population of the service area projected for FY 2025 is 152,354.

Service Area Cardiac Cath Outmigration

source: WV Health Care Authority Cardiac Cath Procedures (Exhibit -1) for Diagnostic
WVDHHR UB92 Database DRGs 246-251

	Patient Origin	Coming to Raleigh Co.	Market Share Percentage	2019 Cardiac Cath Outmigration	OHS Market Share 10% Inc.	2019 Outmigration	Adj. Card. Cath Coming to Raleigh County
Fayette	659	362	54.9%	45.1%	60.4%	39.6%	398.2
Greenbrier	245	107	43.7%	56.3%	48.0%	52.0%	117.7
McDowell	180	124	68.9%	31.1%	75.8%	24.2%	136.4
Monroe	47	21	48.9%	51.1%	53.8%	49.26%	25.3
Raleigh	1,289	1,032	80.1%	19.9%	88.1%	11.9%	1,135.2
Summers	155	98	63.2%	36.8%	69.5%	30.5%	107.8

[8] Diagnostic cardiac cath numbers are from Exhibit E-1. Therapeutic cardiac cath numbers are from the Authority's UB -92 database using MS-DRGs 246 through 251.

Wyoming	388	266	68.6%	31.4%	75.4%	24.6%	292.8

(Exhibit 24, Replacement Pages, Exhibit E, Replacement Page E-5)

West Virginia Resident Open Heart Projections without In-Migration

Service Area Counties - 2025

	0-14	15-44	45-64	65 +	Totals	2019 Cardiac Cath Outmigration	0-14	15-44	45-64	65+	Totals
Fayette	6,965	13,716	11,563	10,479	42,723	39.6%	4,209	8,288	6,987	6,332	25,815
Greenbrier	5,419	11,392	9,079,	8,835	34,725	52.0%	2,603	5,473	4,362,	4,244	16,682
McDowell	2,521	5,643	4,325	3,973	16,462	24.2%	1,910	4,276	3,277	3,011	12,475
Monroe	2,083	3,856	3,696	3,514	13,149	46.2%	1,121	2,076	1,990	1,892	7,078
Raleigh	13,021	26,671	18,231	17,412	75,335	11.9%	11,462	23,489	16,056	15,334	66,346
Summers	1,728	4,034	3,547	3,275	12,584	30.5%	1,202	2,806	2,467	2,278	8,752
Wyoming	3,317	6,722	5,176	4,949	20,164	24.6%,	2,501	5,069	3,903	3,732	15,206
	35,054	72,034	55 617	52,417	215,142		25,014	51,476	39,041	36,823	152,354

	0-14	15-44	45-65	65+	Total
Use Rate	0.147	0.260	2.130	4.130	1.516

Projected OHS Cases - Using Cardiac Cath

	0-14	15-44	45-64	65+	Totals	Raleigh Adjusted Card Cath Cases	Proj. OHS Cases
Fayette	-	2.2	14.9	26.2	43	398.2	43
Greenbrier	-	1.4	9.3	17.5	28	117.7	28
McDowell	-	1.1	7.0	12.4	21	136.4	21
Monroe	-	0.5	4.2	7.8	13	25.3	13
Raleigh	-	6.1	34.2	63.3	104	1,135.2	104

Summers	-	0.7	5.3	9.4	15	107.8	15
Wyoming		1.3	8.3	15.4	25	292.6	25
Cases	-	13.3	83.2	152.0	249	2,213	249

(Exhibit 24, Replacement Pages, Exhibit E, Replacement Exhibit E-6)

RGH submits that this market share adjustment is clinically supported by expected volume increases in its cardiac offerings following the initiation of cardiac surgery services. RGH further submits that the University of Virginia Medical Center cardiovascular surgeon, Dr. Kenan Yount, testified that on-site cardiac surgery expands a provider's existing services by enhancing "what you can offer in terms of therapeutic catheterization if you have surgical backup for a patient. It also allows you to take on more services [that] will be useful if you have surgical backup." (Ex. 51, Tr. I, pp. 196:11-16). In addition, Dr. Yount recognized that patient preference undergirds the observed volume increases experienced by cardiac programs after initiating cardiac surgery, as "patients see it as they have a center that is able to provide more complex cardiac care." (Ex. 51, Tr. I, pp. 196:17-197:3)

CAMC states that RGH's justification for this 10% decrease in out-migration is based on two past CON cases that also projected a decrease. (Ex. 51, Tr. I, pp. 76-77). However, these two cases do not apply the facts at hand. CAMC further states that the previous two matters cited involved open heart surgery applications by two hospitals in Parkersburg and by Bluefield Regional Medical Center. None of these hospitals had a

high volume diagnostic cardiac catheterization program and none even provided therapeutic catheterization services. (Ex. 52, Tr. II, p. 455). CAMC states that finding that those hospitals would have an immediate increase in their volume, with a corresponding decrease in out-migration, is not speculation given the addition of entirely new services that were not previously offered in any form. Finally, CAMC states that RGH already provides both diagnostic and therapeutic cath services and does so at a high volume. Projecting more volume, with less out-migration, based upon the previous cases is not feasible. Mr. Jarrett testified in the two previous cases,

> I believe the theory was that you would be adding a whole new service line with interventional cardiac cath. Both of those programs — both of those applications at the time, they had to show that they would be able to perform a lot more cardiac cath procedures and justify the number of open-heart procedures. So they had large bumps in grabbing the new service. In this case, Raleigh General already performs elective therapeutic caths and PCIs. So I don't think there's going to be that kind of bump. (Ex. 52 Tr. II, p. 455).

RGH submits that CAMC argues that Monroe County is improperly included in the service area, recalculating its out-migration without Monroe County. (Ex. 9 to Ex. 48(CAM_000254)). CAMC's recalculation also excludes RGH's market share adjustment. (Id). Specifically, it characterizes past applicants' market share adjustment as "large bumps" that captured "grabbing the new service." (Ex. 54, Tr. II, pp. 455:10-17). Finally, RGH submits that CAMC concludes that it will not experience "that kind of bump," meaning the bump past applicants applied, as RGH already performs therapeutic catheterizations. (Ex. 53, Tr. II, CAMC Brief, pp. 455:18-20).

RGH submits that the market share adjustment it applied is not the same or as significant as the adjustment applied by either of the previous cardiac surgery joint applicants –CAMC and St. Joseph's Hospital's or CAMC and Bluefield Regional Medical Center. RGH asserts that both joint applicants applied a market share adjustment in addition to one or more base assumptions. (Ex.53, RGH Brief, pp. 13-14). RGH further submits that it has presented evidence that the CAMC Bluefield joint application assumed all diagnostic catheterizations that were: (1) performed at Bluefield, (2) performed at CAMC as their partner, and (3) Clinch Valley, Virginia would in-migrate to their program, and then added ten percent to their market share. (Ex. 51, Tr. I, pp. 77:15-21). RGH concludes that its own market share adjustment is modest in comparison: both made without additional assumptions and excluding all procedures done on an outpatient basis. (Ex. 53, RGH Brief, p.14). For this reason, RGH further concludes that its slight market share adjustment is reasonable and aligns with the anticipated increase in its cardiac offerings and current catheterization volume.

Based on the evidence presented, the Authority finds that the market share adjustment, as applied, is consistent with past precedent and clinical experience. As previously concluded, RGH properly included Monroe County within its service area. Accordingly, the Authority rejects CAMC's calculation and finds RGH has properly calculated its out-migration adjustment.

Subsequent to the calculation of the adjusted population, applicants must

compute the number of Cardiac Surgery cases they will perform on residents of the study area by applying the use rates specified in Section IV.A.3. of these Standards to the age-cohort adjusted population. Applicants are not permitted to include the pediatric population (0-14 age cohort) in the projection of need unless they can submit substantive evidence of their ability to serve this population.

RGH submits that the projection of need adjusted for out-migration for all cardiac cath cases is presented in Exhibit E-6 using the 2017-2019 average West Virginia use rate as specified in the standards. The pediatric population is not included in this calculator.

RGH submits that, applying the out-migration to the diagnostic catheterization UB data, the number of projected cardiac surgery cases under the primary need methodology is 249 (without adjusting for in-migration). (Ex. 24, Repl. Ex.E-6 to Ex. 24; Ex. 51, Tr. I, pp. 78:5-8).

The In-migration Adjustment

It is recognized that an applicant will draw residents from outside its defined study area. Accordingly, an applicant is permitted to include residents who migrate into the applicant's program based on the number of Diagnostic Cardiac Catheterizations that have been historically performed on residents from outside the study area. This in-migration rate must be computed using the Authority's UB-92 data for the most recent three-year period. The average in-migration rate for these three years must be utilized.

The in-migration adjustment must be applied subsequently to the calculation of the number of Cardiac Surgery cases that will be performed on residents of the study area.

RGH submits that the in-migration adjustment is computed in Exhibit 7, which is presented in the table below, using the Authority's UB-92 diagnostic cardiac catheterization data for the period 2017-2019. The in-migration rate is 7.5% for diagnostic cardiac caths. (Ex. 24, Repl. Ex.E-7A to Ex. 24, Ex. 51, Tr. I, pp. 79:1-2).

RGH submits that the projection of need is also contained in Exhibit E-7A using the 2017-2019 average West Virginia use rate as specified in the standards and adjusting for cardiac cath out-migration and diagnostic cardiac cath in-migration. The total projected open heart surgery cases are 269, excluding the pediatric population.

West Virginia Resident Open Heart Projection with In-Migration

Projected OHS Cases - using Cardiac Cath

	0-14	15-44	45-64	65+	Totals	Raleigh Adj. Card Cath Cases	Proj. OHS Cases
Fayette	-	2.2	14.9	26.2	43	398.2	43
Greenbrier	-	1.4	9.3	17.5	28	117.7	28
McDowell	-	1.1	7.0	12.4	21	136.4	21
Monroe	-	0.5	4.2	7.8	13	25.3	13
Raleigh	-	6.1	34.2	63.3	104	1,135.2	104
Summers	-	0.7	5.3	9.4	15	107.8	15
Wyoming	-	1.3	8.3	15.4	25	292.6	25
Cases		13.3	83.2	152	249	2,213	249

(Exhibit 24, Replacement Pages, Exhibit E, Replacement Exhibit E-7)

In-Migration Rate	7.50%
In-Migration Cases	179

Total Raleigh Cardiac Cath Cases	2,392
Projected OHS Cases that are In-Migrating	20
TOTAL Projected OHS Cases	269

Based upon the evidence, the Authority finds that RGH's in-migration adjustment adheres to the Standards.

B. Since Cardiac Surgery is a centralized service, applicants proposing Cardiac Surgery services must also provide evidence that all existing West Virginia Cardiac Surgery Units within two hours normal driving time of the proposed Cardiac Surgery Unit have performed at least 500 Cardiac Surgeries during the preceding 12 month period and that the initiation of new Cardiac Surgery services by the applicant will not cause any West Virginia providers of Cardiac Surgery within two hours normal driving time of the proposed Cardiac Unit which are currently performing at least 500 Cardiac Surgeries annually to fall below this procedure level.

RGH submits that the West Virginia hospitals providing cardiac surgery within two hours driving time of RGH are CAMC and St. Mary's Medical Center (SMMC). RGH further submits that CAMC performed 730 cardiac surgeries and SMMC performed 829 in FY 2020 according to their 2020 Uniform Reports on file with the Authority, both above 500 cases. CAMC performed 788 cardiac surgeries and SMMC performed 744 in FY 2019 according to their 2019 Uniform Reports on file with the Authority.

RGH submits that, as shown in Exhibit E-8, 202 of CAMC's and 29 of SMMC's cardiac surgeries were performed on residents of the proposed service area. Even if it were assumed that all of the surgeries projected to be performed at the proposed unit from the service area counties were to result in a corresponding reduction in CAMC's or

SMMC's volume (which is not consistent with this application), neither hospital's volume would drop below 500 annual Cardiac Surgeries. RGH finally submits that, therefore, the development of the proposed services will not cause CAMC's or SMMC's total Cardiac Surgery volume to fall below 500 surgeries annually.

Based upon the evidence, the Authority finds that RGH has correctly addressed the Standard.

C. For applicants proposing the initiation of Cardiac Surgery services or a new Cardiac Surgery Unit, the study area for the proposal consists of the county of proposal and any county significantly impacted. The county of proposal is the county in which the proposed Cardiac Surgery Unit will be located. The study area may include counties outside West Virginia. The population projections for out-of-state counties must be based on authoritative sources. In addition, using authoritative sources, applicants shall document the location and utilization of all Cardiac Surgery Units located in the out-of-state counties of the study area as well as the out-migration of residents for Cardiac Catheterization services to out-of-state providers. A significantly impacted county is a county:

1. **Wherein at least 25% of the residents rely or will rely on the Diagnostic Cardiac Catheterization services in the county of proposal; or**

2. **A county that generates at least 10% of the applicant's or Joint Applicants' Diagnostic Cardiac Catheterization patient load.**

In the event that the study area for an individual applicant differs from that of the facility where the proposed Cardiac Surgery Unit will be located, the study area of the proposed Cardiac Surgery Unit will govern. Joint Applicants may combine their study areas if the county in which the proposed Cardiac Surgery Unit will be located is contiguous to the county of the other Joint Applicant's facility. If the counties are not contiguous, as described herein, Joint Applicants may use only the population of the counties which are shared by the Joint Applicants in their study areas and the population of the counties which comprise the study area where the Cardiac Surgery Unit will be located.

The proposed service area has previously been addressed.

D. In projecting need for Cardiac Surgeries, applicants must subtract the actual number of surgeries performed on residents of the study area by Cardiac Surgery providers in the study area.

RGH submits that there are no cardiac surgery providers in the study area.

E. Preference shall be given to Joint Applications to provide Cardiac Surgery services. Each site or Unit must demonstrate need, under IV.

Not applicable.

F. Notwithstanding any provision of these Standards, no new Cardiac Surgery Unit, as defined in these Standards, shall be approved in a county in which a Cardiac Surgery Unit is currently located.

RGH submits that there is currently no Cardiac Surgery Unit in Raleigh County.

DISTINGUISHING CRITERIA

Applicants may distinguish themselves by demonstrating broad-based community support for their provision of Cardiac Surgery, including support from referring physicians, patients and acute care facilities within their service areas.

RGH submits that the proposed project has broad-based community support, including support from referring physicians, patients, and members of the community. Support, as indicated in the letters of support including as Exhibit P-1, includes but is not limited to physicians, elected officials, and members of the community. The

physician letters of support are representative of the widespread support amongst physicians on RGH's staff, rather than submission of letters from all members of RGH's medical staff.

Another distinguishing characteristic is the provision of charity care, which is defined as the provision of uncompensated care to indigent people and does not include accounts written off as bad debts, contractual adjustments or third-party adjustments.

RGH submits that it serves patients needing emergency and medically necessary services without regard to the patient's ability to pay. In the case of cardiac surgery, all patients needing this service will be served. As indicated in its Charity Care policy, included as Exhibit F-1, RGH's provides a 100% charity care discount to indigent and low-income persons with incomes up 200% of the federal poverty level. The same policy will apply to patients served under the proposed cardiac surgery and angioplasty services. Finally, RGh submits that it provided $1,772,180.00 in charity care in FY 2019 and $774,771.00 in FY 2020. Charity care in FY 2020 was impacted by COVID-19.

While the need methodology found in Section IV of the Standards must be met as a condition precedent to approval, the Authority will examine the applications with the goal of promoting geographic access to Cardiac Surgery to all West Virginians.

RGH submits the proposed project will improve access to open heart services for the residents of the service area. RGH further submits it will be the only provider of

cardiac surgery in southern West Virginia. The six existing cardiac surgery providers are located in Huntington, Charleston and northern West Virginia.

Finally, applicants may distinguish themselves by demonstrating their provision of community outreach and education services which are targeted to reduce the health status indicators of obesity, smoking, and sedentary lifestyle, with the goal of reducing the incidence of heart disease.

RGH submits that it routinely and regularly provides community outreach and education services targeted at healthy living and recognition of risks and symptoms of heart attacks and strokes, with the goal of reducing the incidence of heart disease. Examples of these community outreach include : (1) Services and activities provided to the community; (2) Education provided to healthcare professionals both outside and within RGH; and (3) Education provided to the community.

The Alternative Need Methodology

RGH submitted an alternative need methodology in the Application. The basis of the alternative need methodology centered around the total number of therapeutic cardiac caths RGH performed. The Authority finds there is no provision in the Standards allowing it to consider an alternative methodology. Without such a provision, the Authority finds it has no authority to review and rule on such a methodology.

V. QUALITY

The applicant shall demonstrate compliance with each of the following:

A. The applicant must maintain a fully staffed and equipped Cardiac Surgery Intensive Care Unit.

RGH submits that it will have an eight (8) bed CVICU. RGH further submits that it will use eight beds, already available within the currently licensed 32 CCU beds. The unit will be adequately staffed and equipped. The staffing plan included in Section L was developed in consultation with nursing and surgeons who had experience with cardiac surgery at another hospital. The equipment list is included as Exhibit C-1.

B. Staffing of the proposed Cardiac Surgery Unit must meet appropriate guidelines as indicated by the American College of Cardiology (ACC), American Heart Association (AHA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

RGH submits that it developed its staffing plan for the proposed cardiac surgery unit in keeping with the guidelines of the ACC, the AHA, and The Joint Commission (TJC) formerly known as JCAHO. RGH further submits that the cardiac surgery CCU will be staffed in part by providers already engaged, as well as certain of the 33.6 FTEs outlined in the staffing model. (Ex. 24, Repl. p. L-1). Finally, RGH submits that the proposed staffing model includes two cardiovascular surgeons, four registered nurses (RNs) First Assists, four additional operating room (OR) RNs, 16.6 CCU RNs, and 7 technicians. (Ex. 3, Appl., Exhibit N-2 to Ex. 3).

RGH submits that, in addition to the outlined FTEs, it has existing professionals in place to support its cardiac surgery program. (Exhibit 53, RGH Brief, p.33). Those professionals include a cardiology-trained physician's assistant (PA), anesthesiologists, nephrologists, vascular surgeons, pulmonologists (which are critical care trained), an additional critical care trained physician, and office staff, including the schedulers. (Ex. 51, Tr. I, pp. 30:24-31:2; Ex. 52, Tr. II, pp. 486:15-487:12,488:8–489:3, 489:5–19). RGH further submits that it has gathered a team of professionals experienced in administering and supporting cardiac surgery programs, including its chief nursing officer (CNO) and chief operating officer (COO). (Ex. 51, Tr. I, pp. 30:18–31:8).

CAMC asserts that RGH's staffing model is deficient for failing to include a number of positions, including anesthesiologists, critical care doctors, office staff and PAs. (Ex. 52, Tr. II, pp. 303:13-21, 334:8-335:11).

Based upon the evidence, the Authority finds that RGH's proposed staffing model, together with its existing and available staff, forms a fully staffed cardiac surgery program. The Authority notes the deficiencies raised by CAMC are satisfied by RGH's existing staff. Accordingly, the Authority concludes that RGH presented sufficient evidence that current staff, together with the proposed FTEs, will fully staff its cardiac surgery program.

The applicant shall document that it will be able to recruit adequate staff necessary for the operation of a Cardiac Surgery program including, but not limited to, the recruitment of cardiologists, cardiac surgeons, cardiac

anesthesiologists, nephrologists, pulmonologists, intensivists, operating room nurses and pump perfusionists.

RGH submits that it currently has on staff cardiologists, nephrologists, pulmonologists, intensivists, and operating room nurses. RGH will recruit additional staff through its physician recruiter on site and support from the physician recruitment division at LifePoint corporate headquarters. RGH further submits it may contract with a national cardiac consulting group for assistance in recruitment of cardiac surgeons and, if needed, other staff necessary to provide cardiac surgery and staff the CVICU. Finally, RGH submits that it will provide perfusionists through a contracted provider.

RGH submits that it does long range planning for physician recruitment, retention and succession planning. Finally, RGH submits that it develops a physician recruitment plan every year for the recruitment of physicians as part of its annual strategic planning process.

The cost of recruiting the necessary health professionals shall be included in the demonstration of financial feasibility, as required in Section VII of these Standards.

RGH submits that provisions for staff recruitment and education have been included in pre-opening expenses. In an attempt to account for unexpected pre-opening costs and the costs of physician recruitment, a total of $500,000.00 of

pre-opening costs have been included in the financial projection. The financial projection also includes provision for ongoing staff recruitment and training.

The applicant shall also provide information regarding its recruitment of health professionals for the past three years.

RGH submits it adopts an annual recruitment plan for both staff and physicians. RGH further submits that it recruited 104 physicians and mid-level practitioners from FY 2018 through FY 2020.

C. Utilization review and quality assurance programs shall be maintained.

RGH submits that it maintains utilization and quality assurance programs for all of its services. RGH will implement this program with appropriate utilization review and quality assurance programs. RGH's 2021 Performance Improvement Plan - Patient Safety and Clinical Quality is included as Exhibit I-1. RGH further submits that it will establish quality indicators for its cardiac surgery programs with the assistance of the existing LifePoint hospitals that operate a cardiac surgery program.

In addition, RGH anticipates that the utilization review and quality assurance program will include, at a minimum:

- development of critical pathways;
- peer review;

- chart review with 100% chart review on open heart surgeries;
- outcomes management
- oversight by a clinical specialist;
- data registry; and
- benchmarking

RGH submits that these anticipated quality assurance programs will join its current cardiology-related quality initiatives, like cardiac navigators. Cardiac navigators, or staff members tasked with post-discharge cardiac care, contact pharmacies to ensure they have all prescribed medications upon patient discharge, verify that the medications are covered by insurance and follow-up appointments are booked. (Ex. 51, RGH Brief, pp. 233:3-16). Finally, RGH submits that its proposed utilization review and quality assurance programs join ongoing initiatives designed to provide quality, effective cardiology services to its patients.

D. The applicant shall be a participant in the ACC/National Cardiovascular Data Registry (NCDR) database.

RGH submits that it participates in ACC and NCDR database.

E. The applicant must be accredited by the JCAHO.

RGH submits it is accredited by TJC. This project will be implemented in full compliance with TJC accreditation requirements.

F. There shall be at least two Cardiac surgeons who perform Cardiac Surgeries at the Unit. The surgeons who perform Cardiac Surgery at the proposed Unit must each perform a minimum of 120 Cardiac Surgeries annually by 36 months after initiation of services.

RGH submits that it will recruit two cardiac surgeons. As established by the primary need calculation above, 36 months after initiation of services, it projects it will provide 269 cardiac surgeries. (Ex. 24, Repl., Ex. E-7A to Ex 24); Ex. 51, Tr. I, pp. 79:3-6).The cardiac surgeons will perform a minimum of 120 cardiac surgeries annually by 36 months after the initiation of services.

VI. CONTINUUM OF CARE

Applicants proposing Cardiac Surgery services shall have in place and make available to all patients appropriate programs and personnel to provide for all levels of post Cardiac Surgery care.

RGH submits that it has been the regional provider of cardiac cath services since 1987. RGH further submits that for the two years FY 2019 and FY 2020, it performed an average of 1,080 therapeutic cath cases annually and an average of 1,236 diagnostic cardiac cath cases annually. RGH currently provides a complete range of diagnostic cardiac cath services and a whole range of cardiac therapeutic services. This project will allow RGH to complete the continuum of care for cardiac services through the provision of cardiac surgery services. Finally, RGH submits that it will work with another LifePoint hospital currently providing cardiac surgery services to develop its cardiac surgery program.

RGH submits that CAMC raises RGH's omission of a critical care physician within its proposed FTEs, noting critical care doctors are necessary to "monitor and care for patients in the critical post-surgery period." (Ex. 54, CAMC Response Brief, pp. 26). RGH further submits that CAMC does not dispute the program's continuity of care from patient diagnosis and treatment through recovery.

In response, RGH notes that the existing and available staff include three critical care trained doctors – pulmonologists–and an additional critical care trained physician, a general surgeon (Ex. 51, Tr. I, pp. 488:20–489:13).

Based upon the evidence, the Authority finds that RGH is well-positioned to provide patients with all levels of post-cardiac surgery care, given its existing staff and increased local continuity of care.

VII. COST

Applicants shall demonstrate the financial feasibility of the proposed Cardiac Surgery services by presenting projections which show that revenues will equal expenses by the end of the third year of operation. Applicants must also demonstrate that the capital costs of the project are consistent with the current Authority rate setting methodology. Applicants 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, as defined by the Authority. Applicants must provide a charity care policy, which shall include its provision of uncompensated care to indigent people, and does not include accounts written off as bad debts, contractual adjustments or third-party adjustments.

RGH submits that as shown in the table below, revenues will exceed expenses in the third year of operation. Rate setting has been abolished through legislation and no longer applies. Finally RGH submits that it provides services to any patient in need of services regardless of ability to pay.

Raleigh General OHS CON PRO FORMA
Dollars in Thousands

	Year 1	Year 2	Year 3
OHC Cases	135	188	269
Gross Revenue	$21,045	$29,875	$43,562
Revenue Deductions			
Contractual Allowances	16,489	23,140	34,141
Bad Debts	421	593	871
Charity	210	299	436
Total Revenue Deductions	17,120	24,306	35,448
Net Revenue	3,924	5,568	8,114
Expenses			
Salaries & Benefits	2,323	2,903	3,812
Supplies	638	917	1,356
Implants	310	445	658
Drugs	398	573	847
Perfusion Expense	471	487	503
Depreciation and Amortization	251	251	251
Total Expenses	4,390	5,576	7,427
Net Income	$(466)	$(8)	$687

(Exhibit 24, Replacement Pages, Exhibit N, Replacement Exhibit N-2)

RGH submits that its financial projections demonstrate conservatism, bolstering the pro formas' ultimate conclusion that the program is financially feasible. (Ex. 53, RGH Brief, p.44). According to RGH, the pro forma adopts a preference to understate, rather than overstate, anticipated revenue from the proposed project. RGH further submits that it identifies numerous dimensions of conservatism, including the pro formas (1) exclusion of charges under DRGs 228 and 229 though they have included them; (2) adoption of a 19 percent collection rate when CAMC reported a collection rate between 21 and 29 percent; (3) application of an inflation rate below current market trends, and significantly below CAMC's reported inflation rate, to estimate revenue; (4) utilization of an $8,600.00 contribution margin per case, below contribution margins of $27,602.00 for 2020 and $29,775.00 for fiscal year 2021; and (5) the omission of anticipated revenue increases in catheterization and other cardiac services as a direct result of on-site cardiac surgery services. (Ex. 53, RGH Brief, pp. 44-48).

CAMC states that there are two sides to the financial projection. First is the revenue side. The initial, but not the most important, issue with the revenue side is that revenue is based solely on the volume projection. If the volume projection is high the revenue projection is correspondingly high. Normally, if volume and the resulting revenues decrease, adjustment can be made in expenses to maintain profitability. CAMC submits that the problem with this service and this program is that the major expenses – salaries and benefits – are essentially fixed and would not correlate with any dip in revenue. (Ex. 54, CAMC Response Brief, p.21).

The other side of the pro forma is the expense side. CAMC notes the issues there include underestimating salary expenses, neglecting required employees, neglecting to include costs of locum tenens employees, neglecting to include sign on bonuses, and most importantly, wildly overestimating the payor mix. From drastically underestimating the cost of hiring cardiac surgeons to arguing over whether other employees are needed, the pro forma reflects the deficiency in the program. (Ex. 54, CAMC Response Brief, p. 21).

CAMC notes that the following issues regarding the financial pro forma:

a. Cardiac Surgeon Salaries - the salary expense is undervalued. The costs of engaging two cardiac surgeons reflected in the pro forma is $1,000,000.00 total, including salary and benefits for both and without any apparent accounting for recruiting fees. Each surgeon will cost RGH approximately $500,000.00. If the 10% benefit package is removed from the figure, the salary of the cardiac surgeons would be $450,000.00. CAMC states that it has presented testimony that the surgeon's employment costs are vastly understated. Specifically, CAMC's expert testified that the expected competitive salary for a cardiac surgeon in the area is $700,000.00 to $1,000,000.00 or more. (Ex. 52, Tr. II, p. 392). CAMC further states that in response, RGH alleges that its cardiac surgeon witness testified that the salary costs of surgeons at the University of Virginia Medical Center are between $350,000.00 and

$1,000,000.00. (Ex 51, Tr. I, p. 216). RGH states that their projected salary falls within this range. (Ex. 51, Tr. I, p. 437). CAMC further submits that there are three problems with RGH's testimony. The first issue is that the figures quoted by Dr. Yount were only inclusive of salary, not salary and benefits. The second issue is that the range Dr. Yount quoted shows a range based on experience, $350,000.00 being a new surgeon or the least experienced, or otherwise qualified. Realistically, at least one of the two projected surgeons will need to have enough experience to essentially start and run a new cardiac surgery program without oversight. Given that requirement, at least one of the two surgeons will require a higher salary, pushing the second surgeon even below the low range offered by RGH's expert. Likewise, who will oversee the lesser qualified surgeon. (Ex. 54 CAMC Response Brief, p.22). The third issue is that RGH is not an academic center comparable to the University of Virginia. In fact, RGH has no teaching program and does not have the prestige of an academic medical center as well as the salary for teaching that would make up for the lower than market surgery salaries. RGH is a smaller hospital located in Beckley, West Virginia and will recruit in the same general market as CAMC, without the benefit of CAMC's larger program, budget and teaching hospital affiliations. Given these factors, the salary costs for a surgeon as testified to by Jeff Cook, Vice President for Ambulatory Services at CAMC, between $750,000.00 and $1,000,000.00 (Ex. 52, Tr.,

p.392) are most assuredly conservative for RGH's market and recruitment potential.

b. Other Medical Staff Salaries, Benefits and Costs – CAMC states that RGH failed to consider a number of matters regarding the remaining costs related to the medical staff required for such a program. (Ex. 54, CAMC Response Brief, pp. 24-25).

c. Office Expenses – CAMC submits that RGH failed to consider the cost of an office and office supplies in its pro forma. RGH proposes no new office staff or even an office for the surgery program. As with the PA, the cardiac surgery program will be sharing employees and offices with the cardiology program.

d. Critical Care Physician or Intensivist Salary – CAMC states RGH projected a total profit in year 3 of $686,000.00. (Ex. 3, Application, Section N, Repl. Ex. N-2). However, that projected profit is almost entirely consumed by the underestimates of the surgeon costs. However, the program and the pro forma lack necessary physicians outside of the cardiac surgeons. CAMC further states that it called three physician witnesses, including a cardiac surgeon. All testified that critical care physicians or intensivists are necessary to the program. They monitor and care for patients in the critical post-surgery period. The costs associated with hiring such a physician

were estimated to be $400,000.00 per year, salary only. (Ex. 52, Tr. II, p. 396). RGH's witness Dr. Yount, also testified about the need for these physicians (Ex. 51, Tr. 1, pp. 219-220), as well as others such as nephrologists and pulmonologists. (Ex. 51, Tr. I, p. 220).

e. Payor Mix – CAMC states that the issue of the payor mix that forms the basis of the revenue projection is misstated. Kip Rice, Corporate Director of Budget Reimbursement and Cost Accounting at CAMC, testified regarding the payor mix of open-heart surgery performed at CAMC on residents from the study area. (Ex. 51, Tr. II, pp. 429-432). The mix of those patients was different from the payor mix in the pro forma. The payor mix is also different from RGH's historic payor mix. Mr. Rice testified that the overall revenue figure projected by RGH is not a reasonable number "[b]ased on the payor mix from those seven counties that CAMC saw." (Ex. 52. Tr. II, p. 432). CAMC further states that Mr. Rice testified that in his opinion RGH's payor mix projecting 8% of the cases being Medicaid was "a little low..." (Ex. 52, Tr. II, p. 429). Dr. Polity, an RGH witness, testified that the percentage of overall cardiac patients on Medicaid transferred out of RGH was much higher, "at least 40, 30 percent..." (Ex. 51, Tr. I, p. 246). CAMC states that Dr. Polity's figure was more of a guess and was obviously high. However, it was not as

inaccurate as RGH's projection of 8% Medicaid contained in the pro forma. (Ex. 54, CAMC Response Brief, p. 31).

f. The project is not financially feasible – CAMC states that the mistakes and omissions from the pro forma financial projections in Replacement Exhibit Exhibit N-2 are too numerous and too impactful to ignore. The costs associated with surgeons and other needed physicians and physician extenders are underestimated or not taken into account. Recruiting costs and sign on bonuses are not accounted for. The costs associated with hiring locum tenens surgeons and other providers are not accounted for even though two surgeons are needed to operate the program. (Ex. 52, Tr. II, p. 216). CAMC finally states, RGH only projected a profit of $687,000.00 with its proposed pro forma. The problems include:

1. Underestimating surgeons costs by at least $500,000.00.
2. Not considering critical care intensivist costs of $400,000.00.
3. No considering the costs of locum tenens surgeons which is, at the very least $400,000.00.
4. Not considering locum tenens costs for any other physicians, including the sole anesthesiologist that is planned.
5. Not accounting for the approximate $100,000.00 cost of a PA by trying to somehow fit one PA into two separate programs.
6. Not accounting for more than $400,000.00 in sign-on bonuses for the 206 registered nurses proposed to be hired.
7. Using a payor mix that has no relationship to the actual history of RGH's hospital or the actual data provided by CAMC.

CAMC states that the underestimated costs and deletion of costs amount to more than $1,460,000.00 in costs that were not included in the expense side of the pro forma when the total profit for the third year was estimated at $687,000.00. Even half of that is more than the projected profit. CAMC further states that this is evidence of a proposal that has not reasonably demonstrated that it will be financially feasible. (Ex. 52, Tr. II, pp. 435-436; Ex. 54, CAMC Response Brief, pp. 33-34;).

RGH submits that the evidence presented establishes the reasonableness of the cardiovascular surgeons projected salaries. RGH's cardiovascular surgeon expert testified that the salary range within his cardiac surgery department was between $350,000.00 to $1,0000,000.00. (Ex. 51, Tr. I, pp. 2216:7-8). The low end of this range compensates a cardiovascular surgeon with five years of experience and subspeciality expertise. (Ex. 52, Tr. I, pp, 185:15-20).

RGH contends that all remaining costs identified by CAMC represent non-incremental costs properly omitted from its pro formas. (Ex. 53, RGH Brief, p. 48). RGH asserts that non-incremental costs must be excluded in financial feasibility analyses. (Id) RGH argues and CAMC financial expert agrees – that costs associated with existing office space, office staffing, critical care services, and PA have no role in the pro formas. (Ex. 51, Tr. I, pp. 175:1 - 176:5, Ex. 52, Tr. II, pp. 437:4-438:10)

Based upon the evidence, the Authority concludes that the proposed project is financially feasible. RGH's pro formas appropriately exclude non-incremental costs in assessing financial feasibility. As a result, revenues will equal (and are projected to exceed) expenses by the third year of operation.

VIII. ACCESSIBILITY

Applicants proposing Cardiac Surgery services shall demonstrate the following:

A. The existence of a scheduling priority system based on patients' medical need without regard to the source of referral or payment.

RGH submits that it has a long history of providing care to patients regardless of source of referral or payment source. As discussed in Section F, RGH operates on non-discriminatory bases without regard to age, race, creed, ethinicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation and gender identity or expression, national origin or source of payment of care. RGH finally submits that scheduling is done based on physician determination of patient's medical necessity. CAMC does not contest the existence of an appropriate scheduling priority system

B. Accessibility for the disabled in compliance with applicable state and federal laws.

RGH submits that it complies fully with state and federal laws regarding accessibility to the disabled, including the Americans with Disabilities Act. CAMC does not contest RGH's accessibility for individuals with disabilities under applicable state and federal laws.

The provision of Cardiac Surgery services 24 hours per day, seven days per week.

RGH submits that Cardiac Surgery services will be provided 24 hours per day, seven days a week.

IX. WITHDRAWAL OF CERTIFICATE OF NEED

The applicant's failure to perform 250 Cardiac Surgeries annually by 36 months after initiation of the services shall result in the Authority's review of the Certificate of Need. The Authority may take any action available under the law, including withdrawal of the Certificate of Need.

RGH submits that, as shown in Section E and N, it projects that it will perform in excess of 250 surgeries per year by the end of the third year of operation.

Based upon the evidence presented, the Authority finds that the Applicant has adequately addressed and is consistent with the Standards pertinent to the proposed project. Additionally, the Authority determines that, as evidenced in the financial projections, the project is financially feasible.

Other Required Findings:

In addition to the Authority finding that the project is needed and consistent with the State Health Plan under W. Va. Code § 16-2D-12(a), the Authority must make other required findings under W. Va. Code § 16-2D-12(b) and (c).

First, under W. Va. Code § 16-2D-12(b)(1), the Authority must find that superior alternatives to the services in terms of cost, efficiency and appropriateness do not exist and the development of alternatives is not practicable. RGH submits that two alternatives were considered; (1) to maintain the status quo; and (2) to develop a cardiac surgery program. With regard to the first alternative of maintaining the status quo, RGH submits that the proposed project relates to the development of cardiac surgery services. Under the status quo, these services would not be developed, and residents of the service area would continue to travel out of the service area to obtain cardiac surgery services.

With regard to the second alternative, RGH submits that this option was set aside with the approval in August 2008 of the revised Cardiac Catheterization standards which allowed the provision of therapeutic cardiac cath services at RGH without cardiac surgery. At that time, RGH deemed it better to proceed with a program that would immediately benefit the residents of Raleigh County and the surrounding area in southern West Virginia rather than delay provision of the therapeutic cardiac cath

services by a potential lengthy CON process similar to the one encountered in RGH's 1992 CON application application for cardiac surgery services that was denied in 1995 approximately three years after the original submission. RGH has now provided therapeutic cardiac cath services since 2009, or approximately 12 years. RGH meets the state health plan standards needs assessment for cardiac surgery through analyzing the traditional diagnostic cardiac cath metrics and through analyzing therapeutic cardiac cath metrics and is not able to proceed with its application for a CON for cardiac surgery.

CAMC states that despite RGH's repeated questions about there being no open-heart providers in Southern West Virginia, it has served the residents of the study area for decades. All the planning CAMC has done for its cardiac services program take those residents into account as presented in testimony from Dr. Glen Crotty, Chief Operating Officer at CAMC and David Jarrett, Planning Analyst at CAMC. (Ex. 52, Tr. II, pp. 262-263, 464-465). CAMC further states that the result of the proposed project reflects that RGH proposes to take the routine cases while referring difficult complicated ones to CAMC and other providers. This is a problem for both the patients and CAMC. RGH takes the "easy" cases while referring the complicated cases out.

CAMC states that the damage will not be limited to the cases it will receive from RGH. Dr. Glen Crotty, Chief Operating Officer, testified about the impact this program will have on CAMC's open heart surgery program. Dr. Crotty has been a practicing

physician in the area since 1982. Since 1988 he has been involved in the CAMC administration as Chief Medical Officer and then as Chief Operating Officer. Throughout that time, he has seen the open-heart surgery program grow and change. (Ex. 52, Tr. II, pp. 266-267). Most importantly, the RGH proposal is not without consequences to the patients in the area either. It will have an impact on CAMC's program. CAMC's program will not be devastated. It will not close. But the program will be adversely affected impacted and changed, all to the detriment of the patients.

RGH submits that its proposal is superior in terms of cost, efficiency, and appropriateness to the alternative, maintaining the status quo. In terms of cost, RGH submits that its proposal represents a superior alternative to the status quo, as a potentially lower cost option for patients and insurers. RGH further submits that evidence identifying CAMC's contribution margin and net revenues per cardiac surgery cases are exceptionally high, resulting in one of the most significant differences between its proposal and CAMC's existing cardiac surgery program. (Ex. 51, Tr. I, pp. 149:20-23, 150:2-5).

RGH submits that additional cardiac surgery costs disproportionately fall on study area patients, as patients incur travel expenses, including gas and lodging, to undergo surgery and complete follow-up appointments over an hour away. These additional costs are consequential, posing a significant barrier to some patients. (Ex. 51, Tr. 1, pp. 192:24-193:18). The development of cost-effective, local cardiac surgery services

removes financial barriers to southern West Virginia patients and provides additional, more accessible options to consumers.

RGH submits that, in terms of efficiency, its proposal provides local accessible cardiac surgery services in lieu of the status quo's prolonged transfer process. Residents of southern West Virginia currently travel approximately 60 miles to Charleston or 100 miles to Huntington to receive cardiac surgery services, or even farther to other in-state or out-of-state facilities (Ex. 51, Tr. 1, 17:16-18:5). Study area patients from Summers or Greenbrier County must travel two or three-plus hours to receive cardiac surgery services from the closest in-state provider CAMC (Ex. 52, Tr. II, pp. 352:21-24).

Based upon the evidence, the Authority finds that superior alternatives do not exist. RGH has presented sufficient evidence that its proposal presents a local, cost-effective option superior to the status quo. Although CAMC endeavors to mitigate lodging expenses for certain qualifying low-income patients, study area patients as a whole still bear increased costs to access cardiac care under the status quo. In terms of efficiency, the evidence demonstrates that some study area patients must travel two to three-plus hours to access care under the status quo. Travel times of this magnitude form an impediment to care. In addition, while some wait times may be unavoidable, travel-related wait times can be eliminated by increased geographic access to care. Finally, in terms of appropriateness, continuity of care from diagnosis to surgery to

aftercare presents a superior alternative to the status quo.

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 it does not dispute the appropriate and efficient use of the existing services. (Ex. 53, RGH Brief, p. 29). However, RGH submits that, despite the appropriate and efficient use of the existing services, an unmet need remains for local, accessible cardiac surgery services for southern West Virginia residents. Based upon the evidence, the Authority finds that the six existing cardiac surgery providers in this state-located in Charleston, Huntington, Morgantown, Parkersburg, and Wheeling are operating in an appropriate and efficient manner. (Ex. 51, Tr. I, pp. 88:3-18).

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 no new construction is required for the proposed project. 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 there are no providers of cardiac surgery services in the service area. Residents of the service area must travel to obtain cardiac surgery services. Finally, RGH submits that the proposed project will allow residents of the service area to obtain this life saving service without traveling outside the service area.

CAMC contends that patients do not currently experience serious problems in obtaining care and will not experience serious problems absent its proposal. CAMC's cardiothoracic surgeon concluded "the travel time's not an impediment or affect patient care." (Ex. 52, Tr. II, pp. 327:8-13). CAMC characterized patients' desire for convenient access to health care services like Cleveland Clinic as "not realistic." (Ex. 52, Tr. II, pp.327:6-13). Instead, CAMC suggests that granting the proposal may create serious issues because, "if [RGH's program] takes away volume, then the larger centers can't have the specialists. (Ex. 52, Tr. II, pp. 328:16-20).

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. The Authority further finds that RGH presented sufficient evidence that patients must travel and bear associated costs, manage family involvement and follow-up care, and potentially change providers for local post-surgery care.

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 will serve all persons in need of the medically necessary services it provides without regard to source of payment. RGH further submits that it obtains financial data to determine if the patient meets the requirements to be classified as in need of financial assistance. Charity care is based on the family income in relation to the federal poverty guidelines. As noted in its Patient Rights and Responsibilities policy, included as Exhibit E-2, impartial "access to care and treatment that is medically indicated regardless of age, race, creed, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression, national origin or sourceof payment for care." 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 ***Raleigh General Hospital*** for the provision of cardiac surgery. 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 ***$1,150,000.00***. 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. 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 ***$1,150,000.00*** may be subject to review.

APPEALS

Appeal from this Decision shall be made, within thirty (30) days after the date of this Decision, to the West Virginia Intermediate Court of Appeals at www.courtswv.gov, pursuant to the provisions governing the judicial review of contested administrative cases in § 29A-5-1 *et seq.* of this code.

Done this 12th day of September, 2022.

Robert Gray, Chairman

Darrell Cummings /RJB
Darrell Cummings, Board Member

Sandy Dunn /RJB
Sandy Dunn, Board Member

Charlene Farrell /RJB
Charlene Farrell, Board Member

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Dennis Garrison, Director, Consumer Advocacy Division
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GCDF/TEA

CON Case File #21-1-12253-H