IN THE INTERMEDIATE COURT OF APPEALS OF WEST VIRGINIA

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CHARLESTON AREA MEDICAL CENTER, INC.,
RESPONDENT BELOW, PETITIONER

vs. No. 22-ICA-169

RALEIGH GENERAL HOSPITAL,
APPLICANT BELOW, RESPONDENT

and

THE WEST VIRGINIA HEALTH CARE AUTHORITY,
RESPONDENT

Petitioner Charleston Area Medical Center's Brief

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ASSIGNMENTS OF ERROR

1. The Decision issued by the Health Care Authority (hereinafter "HCA" or "Authority")(Designated Record, hereinafter "(D.R." 0003-67) does not have proper findings of fact or conclusions of law and therefore, it is not in the proper form. As such, it is inconsistent with the requirements of W.Va. Code § 29A-5-3 and the Supreme Court of Appeals of West Virginia's holding in *Citizens Bank of Weirton v. West Virginia Board of Banking & Financial Institutions*, 160 W.Va. 220, 233 S.E.2d 719 (1977). As a result, the HCA's Decision is made in violation of statutory provisions, is made upon unlawful procedures, and is arbitrary or capricious, characterized by an abuse of discretion. W.Va. Code § 29A-5-4(g).

2. HCA's entire decision is deficient as no member of the HCA Board was present during the two days of the hearing, the HCA Board made no independent analysis of the witness testimony and the evidence introduced at the hearing as reflected by the HCA's Decision, and the HCA does not make proper findings of fact and conclusions of law. As a result, HCA's Decision is made in violation of statutory provisions, is made in excess of the statutory authority, is made upon unlawful procedures, is affected by other errors of law, is clearly wrong in view of the reliable, probative, and substantial evidence on the whole record, and is arbitrary or capricious, characterized by an abuse of discretion. W.Va. Code § 29A-5-4(g).

3. HCA's Decision, as it relates to the need for services as defined in W. Va. Code 16-2D-12(a)(1) and Section IV of the State Health Plan Standards on Need Methodology for Cardiac Surgery (hereinafter "Standards")[1], is deficient as it: (a) contains no analysis of the facts

[1] In Syllabus Point 5, *Amedisys West Virginia, LLC v. Personal Touch Home Care of West Virginia, Inc.,* 245 W.Va. 398, 859 S.E.2d 341 (2021), the Supreme Court recognized that the Standards from the State Health Plan were promulgated by the HCA pursuant to statute and approved by the Governor and the Legislature in W.Va. Code § 16-2D-6(g). In *Amedisys,* the Home Health Services Standards were at issue a part of the State Health Plan. In this case, a different set of standards, those for Cardiac Surgery are at

presented; (b) fails to apply the plain language of the Standards, that require that the only counties to be included in the study area population upon which the need calculation is made, are those "wherein at least 25% of the residents rely or will rely on the Diagnostic Cardiac Catheterization services in the county of proposal;" (c) allows out-of-state data to be presented in one calculation and does not require it in another, when neither explicitly require or exclude it, leading to a patently and objectively false finding that 25% of the resident of Monroe County obtain their care in Raleigh County; and, (d) allows a projected expansion of market share based upon past decisions, without explaining why those past decisions are applicable or consistent, when there was evidence, not analyzed, that they were not. As a result, HCA's Decision is made in violation of statutory provisions, is clearly wrong in view of the reliable, probative, and substantial evidence on the whole record, and is arbitrary and capricious, characterized by an abuse of discretion. W.Va. Code § 29A-5-4(g).

4. HCA's Decision, as it relates to the financial feasibility of services as required in W. Va. Code 16-2D-12(a)(2) and defined in Section VII of the Standards, is deficient as it: (a) contains no analysis of the facts presented; (b) fails to properly assess the financial feasibility of the services as Section VII of the Standards; (c) fails to assess or analyze the issues listed on pages 46-50 of HCA's Decision (D.R. 0048-52); (d) fails to address the payor mix evidence presented by Charleston Area Medical Center, Inc. (hereinafter "CAMC,") including the fallacy of the proposed percentage mix of payors which will have a significant impact on program revenues; (e) fails to address the discovery issue where Raleigh General Hospital (hereinafter "RGH") certified it was hiring a specialized physician in response to an Interrogatory posed by CAMC, never amended the response, and presented a witness who testified counter to the response; (f) fails to

issue. They may be found on the HCA's web site, under the CON Standards tab at https://hca.wv.gov/certificateofneed/Documents/CON_Standards/CardiacSurStd2007.pdf

analyze how existing full time employees not associated with the proposed program will be employed as part of the proposed program and will remain in their present position and add additional responsibilities, without increasing costs associated with the program; (g) fails to analyze the impact of not including the cost of employing *locum tenens* physicians to replace the physicians and surgeons in the financial projections, when the surgeons and other physicians are on vacation, when such vacations are included in the employment contracts and the presence of two cardiac surgeons and other physicians is required to operate the program twenty-four hours a day and seven days a week; (h) fails to properly assess the projected salary of the cardiac surgeons proposed to be hired, by comparing the salaries proposed to those paid by an academic medical center, without adequately describing the evidence as such; and, (i) misstates and fails to properly assess and analyze the issue of non-incremental costs in the cost projection. As a result, HCA's Decision is made in violation of statutory provisions, is clearly wrong in view of the reliable, probative, and substantial evidence on the whole record, and is arbitrary and capricious, characterized by an abuse of discretion. W.Va. Code § 29A-5-4(g).

5. HCA's Decision, as it relates to the requirements of W.Va. Code § 16-2D-12(a)(2) and the Standards, is deficient as it: (a) fails to properly assess the financial feasibility of the services as Section VII of the Standards; (b) fails to properly assess the need for the services as Section IV of the Standards requires; (c) fails to properly assess the quality of the proposed program as Section V of the Standards requires; and, (d) fails to properly assess the accessibility of the proposed program as Section VIII of the Standards requires. As a result, HCA's Decision is made in violation of statutory provisions, is clearly wrong in view of the reliable, probative, and substantial evidence on the whole record, and is arbitrary and capricious, characterized by an abuse of discretion. W.Va. Code § 29A-5-4(g).

6. HCA's Decision, as it relates to requirements of W.Va. Code § 16-2D-12(b)(1)(b) is deficient as it: (a) fails to assess the staffing of the program by not considering the *locum tenens* costs for any of the personnel they propose to engage, including the cost of *locum tenens* coverage for physicians and cardiac surgeons that is not contained in the expenses of the program; (b) fails to assess that present full time staff (for example: physician's assistants, anesthesiologist, nephrologist, pulmonologist) are being used in a new program without any analysis of how they will do so, while still being employed full time in other areas; and, (c) fails to assess the evidence presented by CAMC that accessibility will be decreased by granting the proposal because, "if [RGH's program] takes away volume, then the larger centers can't have the specialists." (D.R. 0061 and 1916). As a result, HCA's Decision is made in violation of statutory provisions, is clearly wrong in view of the reliable, probative, and substantial evidence on the whole record, and is arbitrary and capricious, characterized by an abuse of discretion. W.Va. Code § 29A-5-4(g).

STATEMENT OF THE CASE

On or about September 27, 2021, Respondent RGH filed an Application seeking a Certificate of Need (hereinafter "CON") to develop a cardiac or open-heart surgery program at its facility in Beckley, Raleigh County. (D.R. 0085-256). The application was filed pursuant to the terms of W. Va. Code §§ 16-2D-1 *et. seq.* and was filed with the HCA. *Id*. Respondent RGH claimed that there was a need for more cardiac or open-heart surgery in Southern West Virginia. In order to prevail on a CON under the applicable Cardiac Surgery Standards, Respondent RGH was required to establish as follows:

1) Under Section IV, Need Methodology – that a proper need for the proposed Cardiac Surgery program may be established under the parameters and requirements of this Section.

2) Under Section V, Quality – that the applicant must maintain a fully staffed and equipped Cardiac Surgery Intensive Care Unit; staffing meets appropriate guidelines

set by the American College of Cardiology and other groups; and meet other requirements set forth in the Section.

3) Under Section VI, Continuum of Care – that the applicant shall have in place programs and personnel to provide for all levels of post Cardiac Surgery Care.

4) Under Section VII, Cost – that the applicant shall demonstrate the financial feasibility of the proposed Cardiac Surgery services; and meet other requirements set forth in the Section.

5) Under Section VII, Accessibility – the existence of a scheduling priority system based on patients' medical need with regard to payment; accessibility for the disabled; and the ability to provide Cardiac Surgery services 24 hours per day, seven days per week.

Petitioner CAMC requested "affected person" status in the application process pursuant to the terms of W. Va. Code § 16-2D- 2(1)(E).[2] (D.R. 0339-340). CAMC also requested that the HCA hold a public hearing pursuant to the terms of W. Va. Code § 16-2D-13(g). *Id.* The case proceeded over the next few months, culminating in a two-day hearing on March 21 and 22, 2022. (D.R. 1536-2201). The transcript reflects that B. Allen Campbell, a Senior Assistant Attorney General assigned to represent the HCA, served as the Hearing Examiner during the two days of hearings.[3] The transcript further reflects that no member of the HCA Board attended either day of the hearing. *Id.*

On September 12, 2022, HCA's Decision was issued granting the CON to Respondent RGH finding that it could develop and offer open heart surgery services at RGH. (D.R. 0003-67). Significantly, HCA's Decision is not in proper form as it fails to include proper findings of fact

[2] An "affected person" is a term defined in CON proceedings under W.Va. Code § 16-2D-2 and it includes health care facilities such as CAMC.

[3] It should be noted that, even though Mr. Campbell is listed on the transcript as a hearing examiner, he did not issue a decision and, based upon information and belief, he played no direct role in rendering the HCA's Decision in this case. The procedure followed by the HCA in rendering a decision is very different from that utilized by the West Virginia Board of Medicine wherein, a hearing examiner first renders a decision with findings of fact and conclusions of law that is then reviewed by the entire Board. See e.g. *Hasan v. West Virginia Board of Medicine,* 242 W.Va. 283, 835 S.E.2d 147 (2019). The HCA alone has rendered a decision in this case without ever hearing any of the evidence at the hearing.

and conclusions of law related to the evidence adduced at the two-day hearing. Further, as more fully discussed herein, HCA's Decision fails to analyze the evidence introduced by Petitioner CAMC and Respondent RGH at the hearing and therefore, the HCA did not properly determine whether RGH's CON Application should have been granted. Petitioner CAMC timely filed its Notice of Appeal with this Court on October 11, 2022, that sets forth the errors that it raised. This Brief now more fully discusses each of those errors. For these reasons, as more fully discussed herein, this Court must reverse HCA's Decision granting Respondent RGH a CON for cardiac or open-heart surgery.

SUMMARY OF ARGUMENT

This appeal involves a very simple issue for this Court, should HCA's Decision granting Respondent RGH a CON for cardiac or open-heart surgery, that was rendered without it hearing any evidence and without it making proper findings of fact and conclusions of law, be summarily reversed? This appeal is important because, as discussed more fully herein, if Respondent RGH is allowed a CON to perform cardiac or open-heart surgery, that has the potential to reduce the number of cardiac or open-heart surgeries performed at Petitioner CAMC's Hospital, which will decrease access to specialty cardiac surgery services presently offered to the public by CAMC, thus increasing the risk that cardiac surgery services will suffer in Southern West Virginia and not be improved. (D.R. 1915-1920).

As further discussed herein, this Court must address several deficiencies in the HCA's Decision including whether the decision and the reasoning behind it comply with the requirements for granting a CON set forth in W.Va. Code §§ 16-2D-1 *et seq.*, the West Virginia State Health Plan Standards for Cardiac Surgery, and the West Virginia Administrative Procedures Act (hereinafter "APA"), W.Va. Code § 29A-5-3. As will be discussed herein, the HCA's Decision

failed to comply with the statutory requirements of W. Va. Code § 29A-5-3 as interpreted by the Supreme Court in *Citizens Bank of Weirton v. West Virginia Board of Banking & Financial Institutions*, 160 W.Va. 220, 233 S.E.2d 719 (1977). The HCA's Decision is not in proper form as it does not discuss, analyze, or make proper findings of fact or conclusions of law on the bulk of the testimony offered by CAMC at the two-day hearing.

The arguments and evidence offered by CAMC are listed in the HCA's Decision, but never analyzed and no specific reasoning is given in HCA's Decision for the rejection of CAMC's arguments and evidence that the Cardiac Surgery Standards were not met by RGH. This failure is further complicated by the fact that no members of the HCA Board, the HCA's decision-making body, were present at the hearing to hear the evidence offered in order to make a decision based in fact. Accordingly, CAMC asks the Court to reverse HCA's Decision finding that it is made in violation of statutory provisions, is clearly wrong in view of the reliable, probative, and substantial evidence on the whole record, and is arbitrary and capricious, characterized by an abuse of discretion.

STATEMENT REGARDING ORAL ARGUMENT AND DECISION

Pursuant to Rule 18(a) of the West Virginia Rules of Appellate Procedure, oral argument is necessary in this appeal to aid the Court's decision. Accordingly, CAMC requests oral argument and defers to the Court to determine whether the oral argument should be held pursuant to Rule 19 or 20 of the West Virginia Rules of Appellate Procedure.

STANDARD OF REVIEW

Appeal to this Court from a final decision of the HCA is authorized by W. Va. Code § 16-2D-16a(a)(2) which provides as follows:

> An appeal of a final decision in a certificate of need review, issued by the authority after June 30, 2022, shall be made to the West Virginia Intermediate Court of Appeals, pursuant to the provisions governing the judicial review of contested administrative cases in §29A-5-1 et seq. of this code.

In *Amedisys West Virginia, LLC v. Personal Touch Home Care of West Virginia, Inc.,* 245 W.Va. 398, 859 S.E.2d 341 (2021), the Supreme Court recently set forth the standard of review for HCA's decisions in the following four syllabus points:

> 4. "Upon judicial review of a contested case under the West Virginia Administrative Procedure Act, Chapter 29A, Article 5, Section 4(g), the circuit court may affirm the order or decision of the agency or remand the case for further proceedings. The circuit court shall reverse, vacate or modify the order or decision of the agency if the substantial rights of the petitioner or petitioners have been prejudiced because the administrative findings, inferences, conclusions, decisions or order are: '(1) In violation of constitutional or statutory provisions; or (2) In excess of the statutory authority or jurisdiction of the agency; or (3) Made upon unlawful procedures; or (4) Affected by other error of law, or (5) Clearly wrong in view of the reliable, probative and substantial evidence on the whole record; or (6) Arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.' Syllabus point 2, *Shepherdstown Volunteer Fire Department v. West Virginia Human Rights Commission*, 172 W.Va. 627, 309 S.E.2d 342 (1983)." Syllabus, *Berlow v. West Virginia Board of Medicine*, 193 W.Va. 666, 458 S.E.2d 469 (1995).' Syl. Pt. 1, *Modi v. West Virginia Bd. Of Medicine*, 195 W.Va. 230, … 465 S.E.2d 230 … (1995)." Syl. Pt. 1*, W. Va. Med. Imaging & Radiation Therapy Tech. Bd. Of Exam'rs v. Harrison*, 227 W. Va. 438, 711 S.E.2d 260 (2011).
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> 3. "'If legislative intent is not clear, a reviewing court may not simply impose its own construction of the statute in reviewing a legislative rule. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute. A valid legislative rule is entitled to substantial deference by the reviewing court. As a properly promulgated legislative rule, the rule can be ignored only if the agency has exceeded its constitutional or statutory authority or is arbitrary or capricious. W. Va. Code,

> 29A-4-2 (1982).' Syl. Pt. 4, *Appalachian Power Co. v. State Tax Dep't of W. Va.,* 195 W. Va. 573, 466 S.E.2d 424 (1995)." Syl. Pt. 6, *Murray Energy Corp. v. Steager*, 241 W. Va. 629, 827 S.E.2d 417 (2019).
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> 4. "'Interpreting a statute or an administrative rule or regulation presents a purely legal question subject to *de novo* review.' Syl. Pt. 1, *Appalachian Power Co. v. State Tax Dep't of W. Va.*, 195 W. Va. 573, 466 S.E.2d 424 (1995)." Syl. Pt. 2, *Steager v. Consol. Energy, Inc.*, 242 W. Va. 209, 832 S.E.2d 135 (2019).

This Court should apply this standard of review in this case and determine as a matter of law that HCA's Decision in this matter is not in proper form as it fails to include proper findings of fact and conclusions of law and it contains many other plain legal errors and therefore, it should be summarily reversed as a matter of law.

ARGUMENT

I. THIS COURT MUST REVERSE THE HCA'S DECISION BECAUSE IT FAILS TO INCLUDE PROPER FINDINGS OF FACT AND CONCLUSIONS OF LAW AND IT IS THEREFORE NOT IN PROPER FORM.

The HCA's Decision is not in proper form as it fails to include proper findings of fact and conclusions of law as required by the APA, W.Va. Code § 29A-5-3. This code provision requires:

> **Every final order or decision rendered by any agency in a contested case shall be in writing or stated in the record and shall be accompanied by findings of fact and conclusions of law.** Prior to the rendering of any final order or decision, any party may propose findings of fact and conclusions of law. If proposed, all other parties shall be given an opportunity to except to such proposed findings and conclusions, and the final order or decision shall include a ruling on each proposed finding. **Findings of fact, if set forth in statutory language, shall be accompanied by a concise and explicit statement of the underlying facts supporting the findings.** A copy of the order or decision and accompanying findings and conclusions shall be served upon each party and his attorney of record, if any, in person or by registered or certified mail. (emphasis added).

In *Citizens Bank of Weirton v. West Virginia Board of Banking & Financial Institutions*, 160 W.Va. 220, 230-31, 233 S.E.2d 719, 727 (1977), the Supreme Court interpreted W. Va. Code § 29A-5-3 and it ruled that

> However, in every contested case, W. Va. Code, 29A-5-3 (1964) **contemplates a decision in which the agency sets forth the underlying evidentiary facts which lead the agency to its conclusion, along with an explanation of the methodology by which any complex scientific, statistical, or economic evidence was evaluated**. In this regard, if the conclusion is predicated upon a change of agency policy from former practice, there should be an explanation of the reasons for such change. Whenever an agency may be permitted to state its findings of fact in bare statutory language, the decision may be rendered by a clerk or secretary who has been given the agency's conclusion, *i.e.*, in this case, 'application granted,' and assigned the task of filling in the appropriate form. This is not the rational thought process contemplated by the Administrative Procedures Act. (emphasis added).

HCA's Decision in this case fails to follow either the provisions of the APA or the requirements set forth by the Supreme Court in *Citizens Bank of Weirton.* Further, the Supreme Court has acknowledged "[a]n administrative agency's 'order must contain findings of facts, rather than conclusory statements, so as to withstand judicial scrutiny.'" *Consumer Advocate Div. of Pub. Serv. Comm'n v. Pub. Serv. Comm'n*, 182 W. Va. 152, 157, 386 S.E.2d 650, 655 (1989) (quoting Syl. pt. 3, in part, *Mountain Trucking Co. v. Public Service Commission*, 158 W. Va. 958, 216 S.E.2d 566 (1975)). Accordingly, the Supreme Court in *Muscatell v. Cline*, 196 W. Va. 588, 590, 474 S.E.2d 518, 520 (1996) articulated the following standard for the proper form of administrative decisions:

> "With respect to decisions of administrative agencies following from findings of fact and conclusions of law proposed by opposing parties, that the agency must rule on the issues raised by the opposing parties **with sufficient clarity to assure a reviewing court that all those findings have been considered and dealt with, not overlooked or concealed.** In requiring an order by an

> agency in a contested case to be accompanied by findings of fact and conclusions of law, **the law contemplates a reasoned, articulate decision which sets forth the underlying evidentiary facts** which lead the agency to its conclusion." (emphasis added).

The Supreme Court has reversed administrative agency decisions on numerous occasions when the agency failed to make proper findings of fact and conclusions of law. *See e.g. Modi v. West Virginia Board of Medicine,* 195 W.Va. 230, 465 S.E.2d 230 (1995)(The Board failed to follow the Hearing Examiner's decision with findings of fact and conclusions of law and the Supreme Court reversed, finding the Board failed to make proper findings of fact and conclusions of law under *Citizens Bank of Weirton, supra.,* when it changed the Hearing Examiner's decision); *St. Mary's Hospital v State Health Planning & Development Agency, et al.,* 178 W.Va. 792, 364 S.E.2d 805 (1987) (The SHPDA was a prior agency that considered Certificates of Need for health care facilities and the Supreme Court reversed its decision, finding the SHPDA failed to make proper findings of fact and conclusions of law under *Citizens Bank of Weirton, supra.*); and, *Jones v. Mullen,* 166 W.Va. 538, 276 S.E.2d 214 (1981) (The Circuit Court reversed the decision of the Banking Commissioner to deny a charter when the findings of fact were clearly wrong and the Supreme Court upheld the Circuit Court, finding that the Banking Commissioner failed to make proper findings of fact and conclusions of law under *Citizens Bank of Weirton, supra.*)

HCA's Decision lists issues and arguments raised by CAMC but it never addresses them nor does it make any specific findings of fact or conclusions of law with regard to these issues and arguments. HCA's Decision lacks specific findings of fact on key issues, such as the need for the project and the financial feasibility of it, both required to be proven by RGH. The conclusions of law are akin to the "application granted" language rejected by the Supreme Court in *Citizens Bank of Weirton, supra.*

For example, financial feasibility is an important factor that RGH must establish under the Standards, Section VII. HCA's Decision lists several factors raised by CAMC related to financial feasibility under the Standards, but it never discusses them again nor does it rule upon them or conclude that RGH has introduced sufficient evidence to establish financial feasibility for the CON. HCA's Decision just concludes that RGH's CON Application conforms to the requirements set forth in Section VII of the Standards. (D.R. 54). CAMC presented considerable evidence at the hearing regarding the financial feasibility issues including: 1) RGH's overstated the payor mix, which would have an adverse impact on revenues; 2) RGH failed to provide an accounting for the costs of *locum tenens* coverage for the physicians in the proposed Cardiac Surgical program; and, 3) RGH underestimated the costs associated with many of the physicians and nurses proposed in the program. (D.R. 0048). Those issues are key to RGH's CON Application, as the projected profit for the program in year three was only $687,000. None of these financial feasibility issues were discussed or ruled upon in HCA's Decision.

The same can be said for many other issues raised at the hearing but ignored in HCA's Decision. There were issues regarding the adverse impact on the CAMC program raised but not discussed. (D.R.1855). Most importantly, there were issues how this program will have an adverse impact on the patients in the RGH service area and beyond by causing the loss of specialty services. (D.R. 1915-1920). The Supreme Court has ruled that the provisions of W.Va. Code § 29A-5-3 "contemplates a decision in which the agency sets forth the underlying evidentiary facts which lead the agency to its conclusion, along with an explanation of the methodology by which any complex scientific, statistical, or economic evidence was evaluated." *Citizens Bank of Weirton*, 160 W. Va. at 230, 233 S.E.2d at 727. HCA's Decision can best be described as a listing of evidence without any discussion of it leading to a ruling that is not explained. As a result, HCA's

Decision is made in violation of statutory provisions, is made upon unlawful procedures, and is arbitrary or capricious, characterized by an abuse of discretion and it should be reversed by this Court under W.Va. Code § 29A-5-4(g).

II. THIS COURT MUST REVERSE THE HCA'S DECISION BECAUSE NO MEMBER OF THE HCA BOARD ATTENDED THE HEARING AND THEREFORE, IT WAS NOT ABLE TO RENDER A PROPER DECISION BASED ON THE EVIDENCE PRESENTED AT THE HEARING.

W. Va. Code § 16-29B-12(a) requires that "[t]he board shall conduct such hearings as it deems necessary for the performance of its functions and shall hold hearings when required by the provisions of this chapter or upon a written demand by a person aggrieved by any act or failure to act by the board regulation or order of the board..." In this matter, as reflected in the transcript, no member of the HCA Board was present during the two days of the hearing. (D.R. 1536-37, 1838-39). Even a brief review of HCA's Decision demonstrates that the HCA Board members had little knowledge of the testimony of the witnesses for both parties. For example, CAMC presented a cardiac surgeon to testify regarding the provision of open-heart services, the problems with a small facility like RGH providing those services, and the impact the RGH program would have on the overall provision of specialty services in Southern West Virginia. (D.R. 1815-1820). The surgeon's testimony was never mentioned at all in HCA's Decision and it certainly was not analyzed or refuted.

RGH was applying to provide open heart surgery services in Southern West Virginia and an open-heart surgeon was called by CAMC to testify and discuss the provision of those services. This CAMC witness was not offered as background or as a witness on a minor issue in the case. He was offered as a fact and expert witness on the bedrock issue in the case, whether an open-heart surgery program at RGH could be staffed, could be successful and would not have an adverse

impact on the overall cardiac services in the area. No HCA Board member was present when this critical adverse testimony was presented and based upon the total absence of discussion of this key testimony in HCA's Decision, apparently no HCA Board member even read the transcript of the hearing to at least consider this important testimony.

This is not the only issue and witness that was ignored in HCA's Decision as evidenced by the total lack of discussion or analysis of the evidence presented by CAMC. In the sections of HCA's Decision discussing the need for the project and financial feasibility, the HCA lists CAMC arguments but never discusses them or makes formal rulings on the evidence, even though the issues were clearly denied by the granting of the CON. A financial witness was presented but, again, no HCA Board member was present, and his testimony is barely mentioned in HCA's Decision and it is not analyzed or discussed. The issues raised by CAMC are simply listed, not analyzed or even discussed. (D.R. 0048-52).

W.Va. Code § 16-29B-12(e) provides that "[a]fter any hearing, after due deliberation, and in consideration of all the testimony, the evidence and the total record made, the board shall render a decision in writing. The written decision shall be accompanied by findings of fact and conclusions of law as specified in section three, article five, chapter twenty-nine-a of this code…" For the HCA Board to properly deliberate and consider all the testimony, an HCA Board member should have attended the hearing and listened to the testimony, or at the very least, carefully reviewed the hearing transcript. The complete lack of even a cursory mention of the cardiac surgeon's testimony is clear evidence that the HCA Board didn't even perform the least of its duties. *Garris v Governing Bd. of the State Reinsurance Facility*, 333 S.C. 432, 511 S.E.2d 48 (1998) (holding that "The persons legally responsible for an administrative agency's decision must be informed and unbiased, must hear the case, and must in fact make the decision." *Flav-o-Rich,*

Inc. v. NLRB, 531 F.2d 358, 362 (6th Cir. 1976*); KFC Nat'l Mgt. Corp. v. NLRB*, 497 F.2d 298, 304 (2d Cir. 1974).

The provisions of W.Va. Code § 16-29B-12(e) require that "[a]fter any hearing, after due deliberation, and in consideration of all the testimony, the evidence and the total record made, the board shall render a decision in writing. The written decision shall be accompanied by findings of fact and conclusions of law as specified in section three, article five, chapter twenty-nine-a of this code…" The HCA Board failed to attend the hearing and clearly failed to put itself in a position to seriously deliberate and consider all the testimony and evidence presented at the hearing. That failure to comply with the minimum requirement of the law is reflected in HCA's Decision when the HCA offers no proper findings of fact and conclusions of law. As a result, HCA's Decision is made in violation of statutory provisions, is made in excess of the statutory authority, is made upon unlawful procedures, is affected by other errors of law, is clearly wrong in view of the reliable, probative, and substantial evidence on the whole record, and is arbitrary or capricious, characterized by an abuse of discretion and it must be reversed by this Court under W.Va. Code § 29A-5-4(g).

III. THIS COURT MUST REVERSE THE HCA'S DECISION BECAUSE IT FAILS TO INCLUDE PROPER FINDINGS OF FACT AND CONCLUSIONS OF LAW TO ESTABLISH THAT RESPONDENT RGH PRESENTED SUFFICIENT EVIDENCE TO MEET THE STATE HEALTH PLAN STANDARDS ON NEED METHODOLOGY.

W. Va. Code § 16-2D-12(a)(1) provides that "[a] certificate of need may only be issued if the proposed health service is [f]ound to be needed…." The required method that must be used by an applicant for a CON to establish need is contained in Section IV of the Standards There are a number of deficiencies in HCA's Decision regarding the finding that the proposed RGH Cardiac

Surgery project is needed. The major deficiency involves the HCA's interpretation of the Section in the Standards that sets forth the method of establishing the "study area" for the services.

The method that must be used to prove that the services are needed, and thus that the application is consistent with the terms of W.Va. Code § 16-2D-12(a)(1) is outlined in Section IV of the Standards. It is a population-based methodology. In other words, a base population is established and a use rate, the number of people per 100,000 that will need open heart surgery is applied to the base population. That base population is then the "study area" that is established as required in Section IV of the Standards. If the resulting number shows that more than 250 people in the study area will need open heart surgery, there is a presumed need for the service.

Thus, the establishment of the "study area" is the key to the entire method. The more population in the study area, the higher the projection of need will be. Section IV of the Standards contains the required way to establish the "study area." There are two parts of the requirements, but only one of the two is at issue in this case.[4] Section IV of the Standards provides that to be included in the study area a county must be one "wherein at least **25% of the residents** rely or will rely on the Diagnostic Cardiac Catheterization services in the county of proposal." The plain language of this requirement makes clear that only a county where 25% of all the resident who will obtain diagnostic cardiac catheterization services will obtain those services in Raleigh County, the county of proposal here, can be included in the "study area."

[4] Under Section IV of the Standards, there are two separate calculations that are made to establish the "study area." The first calculation includes counties "[w]herein at least 25% of the residents rely or will rely on the Diagnostic Cardiac Catheterization services in the county of proposal." The second calculation includes counties "that generates at least 10% of the applicant's or Joint Applicants' Diagnostic Cardiac Catheterization patient load." Only the first calculation applies to this matter.

The evidence in the record demonstrates that one county RGH included in the service area, Monroe County, does not qualify if the clear language of the Standard is applied. (D.R. 1597-98; 1628-29). More than 50% of the residents of Monroe County, who obtain diagnostic cardiac catheterization services, obtain those services in Virginia hospitals. (D.R. 1629). If that 50% is excluded from the calculation, then Monroe County is in the service area. *Id.* However, excluding that 50% gives a totally false picture of the need for RGH's CON Application. The reason a 25% county is included is because it is deemed to be significantly impacted by the application and, as a result, the entire population of the county is included in the population base described above. That is why the plain meaning of the definition in the Standards must be applied and all the population of a county must be included in the 25% calculation.

First, if more than half of the population who access a service go out of state to obtain that service, that fact should not be ignored as it is in HCA's Decision. Second, Section IV of the Standards has language that plainly states that a county is included in the study area if "at least **25% of the residents** rely or will rely" on providers in the county of proposal. In this case, if you include all residents of Monroe County, including those going out of State, 25% of the residents of Monroe County do not rely on Raleigh County to get diagnostic cardiac catheterization services unless the fiction of ignoring where half of the population get those services is upheld. (D.R. 1629).

"A reasonable construction at this step is one that 'harmonizes with the plain language of the statute, its origin, and its purpose.'" *EEOC v. Seafarers Int'l Union*, 394 F.3d 197, 205 (4th Cir. 2005) (citing *Bankers Life & Cas. Co. v. United States*, 142 F.3d 973, 981 (7th Cir. 1998) (quoting *Bell Fed. Sav. & Loan Ass'n v. Comm'r*, 40 F.3d 224, 227 (7th Cir. 1994)); *See also Birchfield-Modad v. W. Va. Consol. Pub. Ret. Bd.,* 2022 W. Va. LEXIS 685 at *10-11 (Nov. 3, 2022) (upholding the Court's long history of using the plain meaning when a statute is

unambiguous); *Syl. pts. 2-3 Crockett v. Andrews*, 153 W. Va. 714, 718-719, 172 S.E.2d 384, 387 (1970) (holding an unambiguous statute is given its plain meaning and "interpretation is impermissible").[5] Petitioner CAMC argues that HCA's Decision does not apply the plain meaning of Section IV of the Standards and on that basis, this Court must reverse the decision.

RGH and the HCA's response to this CAMC argument is essentially that out-of-state data is hard to obtain and has not been utilized by applicants in the past, including CAMC. First, from first-hand experience, the data is not hard to obtain. CAMC obtained it to submit into the record of this case. RGH obtained out-of-state data, including data from Virginia, to calculate the use rate. It is simply not credible that RGH obtained one set of data about open heart surgery services performed on West Virginia residents at Virginia facilities and found obtaining data about diagnostic cardiac catheterization procedures on that same set of people too difficult. Second, a witness for CAMC clearly explained why out-of-state data was not used on some CAMC applications in the past. "It was not available." (D.R. 1610). However, this data is now available and readily and easily obtainable as revealed by the evidence presented by CAMC at the hearing. (D.R. 2607, 1399-1405).

The reason this issue is important is that if Monroe County is properly excluded from the study area for RGH's proposed Cardiac Surgery project, RGH's Application fails. The HCA's ruling on this issue does not address the plain language in the Section IV of the Standards. The HCA argues that the language in Section IV of the Standards does not state that out-of-state data is to be used, because there is no specific language requiring the use of such data. The problem with that HCA interpretation is that, as noted, the plain language of the Section IV of the Standards

[5] As previously noted, In Syllabus Point 5, *Amedisys West Virginia, LLC, supra*, the Supreme Court recognized that the Standards from the State Health Plan were promulgated by the HCA pursuant to statute and approved by the Governor and the Legislature in W.Va. Code § 16-2D-6(g). Therefore, the State Health Plan is the equivalent of a statute and should be analyzed as such.

does not state that to be included in the "study area," a county must be one wherein at least 25% of the residents who obtain diagnostic catheterization services in "West Virginia" hospitals rely or will rely on the Diagnostic Cardiac Catheterization services in the county of proposal. Monroe County, where more than 50% of the people who obtain such cardiac services, obtain them in "Virginia" facilities points out the folly of this interpretation by HCA. The entire county is included in the "study area" when only half of the county accesses services in West Virginia.

The HCA went on to rule that:

> 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. (D.R. 0021).

With due respect to HCA, this "ruling" is nonsensical. Including readily available out of state data in this matter makes clear that only counties wherein at least **25% of the residents** rely or will rely on the Diagnostic Cardiac Catheterization services in the county of proposal are included. Not including such data allows a county that does not comply to be included. That is far from meaningless. It is meaningful as it complies with the plain language of Section IV of the Standards and accurately predicts which counties will likely produce patients for the services. Further, RGH's calculation does not adhere to Section IV of the Standards as written. It adheres to the Standards as the HCA has "amended" them, not interpreted them. An administrative agency cannot "amend" or interpret the plain language of a statute. It can only apply it. The plain language of Section IV of the Standards is that a county is to be included in the study area only if 25% of the residents in that county access the services in the county of proposal. Twenty five percent of the residents of Monroe County do not access diagnostic cardiac catheterization services in Raleigh

County and therefore, under the plain meaning of Section IV of the Standards, it should not be included in the "study area."

The Supreme Court has recognized when an agency's interpretation of their own regulations is inconsistent with a clear statute or when the interpretation is beyond the Legislature's intent, no deference is awarded to the agency. *Griffith v. Frontier W. Va., Inc.*, 228 W. Va. 277, 287, 719 S.E.2d 747, 757 (2011). *See also Consumer Advocate Div. of Pub. Serv. Comm'n*, 182 W. Va. at 156, 386 S.E.2d at 654 (1989) (recognizing that an administrative agency interpreting "A statute, or an administrative rule, may not, under the guise of 'interpretation,' be modified, revised, amended or rewritten." *State v. General Daniel Morgan Post No. 548*, 144 W. Va. 137, 145, 107 S.E.2d 353, 358 (1959)). HCA must follow the plain meaning of Section IV of the Standards and the procedures laid out in W. Va. Code § 16-2D-6.

When the other deficiencies in the calculation are added into the need factor, the calculation only gets worse. Those deficiencies include an improperly calculated percentage decrease to the number of people from the study area who are projected to leave the "study area" to obtain cardiac surgery services. It also includes an improperly calculated use rate for cardiac surgery. The use rate is applied to the population of the "study area" to project how many people need cardiac surgery. As with the study area population, the higher the use rate, the higher the resulting population of need for the services. The calculation used by RGH used data that included procedures that were not cardiac surgery procedures. RGH also included procedures in the use rate that it admittedly has no plan to perform. Those errors, along with the Monroe County "study area" population mistake falsely increased the number of cardiac surgery procedures RGH projected it would perform. (D.R. 1651).

HCA's Decision results in clear error under Section IV of the Standards pertaining to Need Methodology. Because RGH failed to properly prove that the service is needed, RGH's Application is not consistent with the provisions and requirements set forth in W. Va. Code § 16-2D-12(a)(1). The HCA erred in accepting the deficient calculation of need and in not considering or ruling upon CAMC's clear evidence that need was not met. As a result, HCA's Decision is made in violation of statutory provisions, is clearly wrong in view of the reliable, probative, and substantial evidence on the whole record, and is arbitrary and capricious, characterized by an abuse of discretion under W. Va. Code § 29A-5-4(g). HCA's Decision should be reversed.

IV. THIS COURT MUST REVERSE THE HCA'S DECISION BECAUSE IT FAILS TO INCLUDE PROPER FINDINGS OF FACT AND CONCLUSIONS OF LAW TO ESTABLISH THAT RESPONDENT RGH PRESENTED SUFFICIENT EVIDENCE TO MEET THE STATE HEALTH PLAN STANDARDS ON FINANCIAL FEASIBILITY.

The deficiencies in HCA's Decision discussed above are also present in the HCA's finding that the process is financially feasible. The requirement that the proposal be proven to be financially feasible, and the definition of that term are found in Section VII of the Standards on Cost, that requires "[a]pplicants 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." The statutory requirement on this issue is contained in W. Va. Code 16-2D-12(a)(2), which provides that a CON cannot be approved unless the proposal is consistent with the State Health Plan.

The problems with the HCA's findings on this issue are many. They include: 1) the failure to discuss or analyze evidence presented by CAMC; 2) the failure to properly assess the evidence; and, 3) the failure to address a major discovery violation. Specifically, the HCA listed the deficiencies alleged by CAMC in HCA's Decision but failed to analyze or even address them.

(D.R. 0048-52). Listing evidence is not an analysis of that evidence, setting forth the underlying evidentiary facts which lead the agency to its conclusion, along with an explanation of the methodology by which economic evidence was evaluated. It is simply a list without more.

The profit that RGH projected for the program in the third year was $687,000. (D.R. 1671). CAMC alleged multiple failures in the projections, even a few of which would cause the program to fall below profitability and thus, fail to be consistent with Section VII of the Standards. Those allegations included a major overstatement of the payor mix for the patients in the program. (D.R. 1606). The payor mix is RGH's projection of class or source of insurance coverage for the patients in the program. It includes the percentage of people who would have Medicare, Medicaid, Public Employees Insurance Agency coverage ("PEIA"), private insurance coverage and others. The reason the percentages are important is that the difference between the payment received by RGH on an open-heart surgery from private insurance and Medicaid is a substantial one. A small percentage change in those percentages can have an immense impact on the project revenues of the program.

There were simple mistakes on the face of the payor mix projection that were evident without looking deeper, including the fact that there was no provision for PEIA insurance coverage, as if there are no government employees in the study area who would be accessing the services at RGH. (D.R. 2018-19. The reason the exclusion of PEIA from the payor mix is important is because it is the lowest payor, below even Medicaid. (D.R. 2019). The inclusion of PEIA would have a negative impact on the projected revenues of the program. Similarly, the overestimation of other payors, like Medicare and private insurance, the highest payors in the mix would highly impact the actual revenues by creating false projections. The percentages projected for Medicare and private insurance were not supported by RGH's past payment data available to the HCA in its

own files and were directly contradicted by evidence of actual open-heart surgery patients from the study area that was presented by CAMC. (D.R. 2017-20). The actual data would have skewed RGH's data to the point of reducing the projected revenue enough to severely impact the profit margin, without even examining the expense side of the projection, but that is not addressed in HCA's Decision. As with other important issues, it was listed but never discussed in HCA's Decision. As before, a list is not a discussion or a proper conclusion that RGH met the Standards in Section VII on Cost. It is not a serious deliberation and consideration of all the testimony and evidence adduced at the hearing.

Unfortunately, the problems with HCA's Decision on this issue do not end with the lack of discussion and analysis on the revenue side of the projection. The lack of discussion and analysis on the expense side is just as bad, if not worse. The problems there start with RGH's assertion in discovery. In response to Interrogatory No. 33, which asked, in part, whether RGH had a critical care intensivist on staff or had plans to engage one, RGH response was that it would engage one "if this CON Application is approved." (D.R. 1164). In rebuttal testimony, RGH's CEO testified inconsistently with this response. (D.R. 2080-81). West Virginia Rules of Civil Procedure, Rule 26(e)(2) requires a party to supplement discovery responses that it knows are incorrect when made or were correct when made but are no longer correct. It is unclear which of the requirements apply, but at the very least, RGH became aware that its response to Interrogatory No. 33 was no longer true some time before RGH's CEO testified that it was not true. Yet it made no attempt to amend the response prior to the hearing, instead it ambushed CAMC at the hearing. The HCA's hearing examiner noted in the hearing that the response "certainly implies though that [RGH is] going to hire one to do the program." (D.R. 2080). The costs for that physician, $400,000 per year plus

benefits (D.R. 1983), were not included in the financial projection. (D.R. 2009). The cost of hiring an intensivist would have crippled RGH's cost projection.

This leads to a "valid concern that the discovery is misleading." (D.R. 2080-81). The hearing examiner stated on the record that the parties were to "address that in your findings and conclusions and we'll address it in the decision." (D.R. 2081). The issue was not addressed or ruled upon in HCA's Decision, even though it involved at least a $400,000 omission from the costs of the program.

The Supreme Court is *Frazier v. Null*, 874 S.E.2d 252, 262, 2022 W. Va. LEXIS 278 *23-24 (April 15, 2022) opined "a well-established reversible error" is:

> Where there is a direct conflict in the critical evidence upon which an agency proposes to act, the agency may not elect one version of the evidence over the conflicting version **unless the conflict is resolved by a reasoned and articulate decision, weighing and explaining the choices made and rendering its decision capable of review by an appellate court.** (citing *Muscatell,* at Syl. Pt. 6 (emphasis added).

HCA's failure to address the costs associated with the hiring of a necessary physician is an error. The failure to address the fact that RGH changed a discovery response in rebuttal testimony only compounds the error. The failure to address these issues individually and collectively was in error. More importantly, the financial impact of these issues was enough to cause the program to lose money in the third year of operation, in violation of the requirement in Section VII of the Standards on Cost and thus RGH's Application was not consistent with the State Health Plan as required by W.Va. Code § 16-2D-12(a)(2).

Those are not the only issues and evidence that were not considered and discussed. The HCA found that many of the expenses that CAMC argued were not included in the financial projection were incremental expenses already incurred by RGH that should not be included in a

new projection. This finding misinterprets what an incremental cost is by not discussing or analyzing how an existing full-time employee, like a Physician's Assistant or an anesthesiologist, not associated with the proposed program, can be employed as part of the proposed program, and yet remain in their present full-time position. RGH argued and the HCA found, that adding additional responsibilities to a full-time employee, without increasing costs associated with the program, are incremental costs and should not be included without discussing how a full-time employee can perform more services for another program while maintaining his or her present full-time employment. This applies to many employees, including those mentioned above. The costs of adding a Physician's Assistant would be approximately $100,000 per year plus benefits. (D.R. 1987). Even RGH's own cardiac surgery witness admitted that a Physician Assistant is a necessary part of an open-heart program. (D.R. 2009). Nevertheless, the costs were not included in RGH's proposal.

The financial projection also did not include the costs of *locum tenens* physician coverage. This is a significant cost that was completely ignored by RGH. An open-heart program must have two physicians to operate. (D.R. 1930-33). The employment contracts for the cardiac surgeons will provide for six weeks of vacation for each. (D.R. 1578). That is twelve weeks that must be covered or the program will have to be closed. Closure would adversely impact revenues. Not closing and hiring a locum tenens physician would entail incurring the costs of hiring such an employee. Those costs for hiring a locum tenens cardiac surgeon, between $3,500 and $5,000 per day (D.R. 1988) were not included in any financial projections. That means that even using the low-end cost of $3,500 per day, an expense of $210,000 was not included in RGH's financial projection. The HCA's Decision never mentioned this omission and its analysis of the failure to include those costs

is non-existent. Those locum tenens costs would also apply to other key employees but were not included.

The same can be said for other expenses that were questioned by CAMC, but not discussed or analyzed in HCA's Decision. Among those expenses that were questioned include the low projected salary and benefit costs associated with the cardiac surgeons, the costs of hiring nurses with a $20,000 sign on bonuses advertised by RGH. (D.R. 1580). None of these costs were included in RGH's financial projection and none were considered or analyzed in HCA's Decision. Three of the major costs not included, the $400,000 per year for an intensivist, the $210,000 per year in *locum tenens* costs, the $100,000 per year for a Physician's Assistant, individually and collectively result in the program losing money. With the addition of the wild understatement of the costs for cardiac surgeons totaling at least $400,000 (D.R. 1980), the lack of including the advertised $20,000 sign on bonuses for 20.6 nurses totaling more than $400,000, and the overstatement of the payor mix for the services as well as various other employees who are necessary for an open-heart program but not included, the program doesn't come close to having revenues that will equal expenses by the end of the third year of operation as required by the Standards. Yet, the HCA simply did not discuss, analyze, or rule on these matters except to note that "RGH's pro formas appropriately exclude non-incremental costs in assessing financial feasibility." (D.R. 0054). Simply listing CAMC's arguments and evidence without discussing it or ruling on it is not the analysis that the legislature requires in W.Va. Code § 29A-5-3 or that the Supreme Court requires under *Citizens Bank of Weirton, supra*.

The problem with the lack of any analysis is two-fold. First, the combination of the impact of the reduced revenues for the program if the payor mix is consistent with the actual data the HCA had available in the decision-making process and the increased expenses clearly establishes that

the program will operate at a loss. In fact, it clearly establishes that it will have a large loss. That alone causes the application to be inconsistent with the State Health Plan, Section VII pertaining to Cost and in violation of the requirement of W.Va. Code 16-2D-12(a)(2). Second, the lack of any analysis of these critical issues means the HCA's finding that the project is consistent with the State Health Plan, is financially feasible and, that revenues will equal expenses in the third-year has no factual support other than the financial projection in RGH's Application. Totally accepting RGH's Application and ignoring the evidence introduced by CAMC in the record is not consistent with the HCA's duties to issue "a decision in which the agency sets forth the underlying evidentiary facts which lead the agency to its conclusion, along with an explanation of the methodology by which any complex scientific, statistical, or economic evidence was evaluated …" *Citizens Bank of Weirton*, 160 W. Va. at 230, 233 S.E.2d at 727. Blindly accepting RGH's Application is not analysis and due consideration. As a result, HCA's Decision is made in violation of statutory provisions, is clearly wrong in view of the reliable, probative, and substantial evidence on the whole record, and is arbitrary and capricious, characterized by an abuse of discretion and it must be reversed under W.Va. Code § 29A-5-4(g).

V. THIS COURT MUST REVERSE THE HCA'S DECISION BECAUSE IT FAILS TO INCLUDE PROPER FINDINGS OF FACT AND CONCLUSIONS OF LAW TO ESTABLISH THAT RESPONDENT RGH PRESENTED SUFFICIENT EVIDENCE TO MEET THE STATE HEALTH PLAN.

W. Va. Code § 16-2D-12(a)(2) provides that a CON may only be issued if the proposed health service is consistent with the State Health Plan. As noted, the applicable provisions of the State Health Plan are the Cardiac Surgery Standards approved by the Governor on May 3, 2007. Section IV of the Standards requires that an applicant for a cardiac surgery CON must demonstrate that the program will perform at least 250 cardiac surgeries annually by 36 months after initiation

of the services. (D.R. 1603). As discussed in detail above, RGH did not provide sufficient evidence to meet Section IV of the Standards and the HCA's finding that it would do so is flawed for multiple reasons. Section VII of the Standards requires that an applicant must show that revenues will equal expenses by the end of the third year of operation. As discussed in detail above, RGH did not do so and the HCA's finding that it would do so is flawed for multiple reasons. Section VIII of the Standards requires that the provision of cardiac surgery services must be available twenty-four hours per day, seven days per week. By not including *locum tenens* costs for cardiac surgeons, much less the many other providers necessary to run such a program in the financial projections, RGH is admitting that the services will not be available twenty-four hours per day, seven days per week.

RGH failed to demonstrate all these matters and the HCA failed to properly discuss, analyze, and rule on all of them. As a result, RGH's Application was not consistent with the State Health Plan and it should not have been approved. The HCA's failure to properly deal with all these issues is clear error. As a result, HCA's Decision is made in violation of statutory provisions, is clearly wrong in view of the reliable, probative, and substantial evidence on the whole record, and is arbitrary and capricious, characterized by an abuse of discretion and it must be reversed under W.Va. Code § 29A-5-4(g).

VI. THIS COURT MUST REVERSE THE HCA'S DECISION BECAUSE IT FAILS TO INCLUDE PROPER FINDINGS OF FACT AND CONCLUSIONS OF LAW TO ESTABLISH THAT RESPONDENT RGH PRESENTED SUFFICIENT EVIDENCE TO MEET NO SUPERIOR ALTERNATIVES AVAILABLE REQUIREMENTS UNDER W. VA. CODE § 16-2D-12(b)(1)(b).

W. Va. Code § 16-2D-12(b)(1)(b) provides that "[t]he authority may not grant a certificate of need unless, after consideration of the appropriateness of the use of existing facilities within this state providing services similar to those being proposed, the authority makes each of the

following findings in writing: (1) That superior alternatives to the services in terms of cost, efficiency and appropriateness do not exist within this state and the development of alternatives is not practicable." The application and HCA's Decision fail in multiple ways to be consistent with this requirement.

The issues related to costs, efficiency and appropriateness have been discussed above. The application and, as a result, HCA's Decision fail to assess the staffing of the program that was proposed by RGH. This includes not budgeting for or considering the *locum tenens* costs for any of the personnel they propose to engage, including the cost of *locum tenens* coverage for physicians and cardiac surgeons that is not contained in the expenses of the program. (D.R. 1579,1697-1698). RGH's alternative to having to pay the high costs involved with providing coverage so a cardiac surgeon could take a vacation was to argue that they didn't need vacation. (D.R. 1587). That is certainly not the superior alternative in terms of cost and appropriateness. RGH's Application and HCA's Decision fail to assess this fact. In an attempt to rescue the deficient financial projections, RGH proposed and the HCA accepted the assertion that present full-time staff (for example: physician's assistants, a single cardiac anesthesiologist, nephrologist, pulmonologist) that are now providing full-time health care services to patients, will also provide full time health care services in the open-heart surgery program without any analysis of how they will do so, while still being full time in other areas. Again, that is not the superior alternative in terms of cost and appropriateness.

The most important failure in this regard is the failure to assess or even address in HCA's Decision the evidence presented by CAMC that accessibility will be decreased by granting the proposal because, "if [RGH's program] takes away volume, then the larger centers can't have the specialists. (D.R. 1916). This testimony was listed in HCA's Decision (D.R. 0061), but not

discussed, analyzed, or ruled upon. Again, listing evidence is not discussing it. Listing evidence is not analyzing it. Listing evidence is not ruling on it as part of the HCA's duties imposed by W.Va. Code § 29A-5-3. As a result, HCA's Decision is made in violation of statutory provisions, is clearly wrong in view of the reliable, probative, and substantial evidence on the whole record, and is arbitrary and capricious, characterized by an abuse of discretion and it should be reversed under W. Va. Code § 29A-5-4(g).

CONCLUSION

Based on the foregoing discussion, this Court should follow the APA standards under W. Va. Code § 29A-5-4(g) and *Citizens Bank of Weirton, supra* and reverse the HCA's Decision and deny RGH's CON Application that allows it to engage in open heart surgery. In the alternative, this Court should remand this matter to HCA with instructions that HCA must conduct a new hearing, with HCA Board members in attendance, and require it to consider each issue discussed herein. This Court should award such further relief as the interests of justice require.

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IN THE INTERMEDIATE COURT OF APPEALS OF WEST VIRGINIA

CHARLESTON AREA MEDICAL CENTER, INC.,
RESPONDENT BELOW, PETITIONER

vs. No. 22-ICA-169

RALEIGH GENERAL HOSPITAL,
APPLICANT BELOW, RESPONDENT

and

THE WEST VIRGINIA HEALTH CARE AUTHORITY,
RESPONDENT

CERTIFICATE OF SERVICE

I, Thomas G. Casto, do hereby certify that on January 12, 2023, I have caused service of the foregoing *Petitioner Charleston Area Medical Center Brief* to be made electronically upon the following counsel of record:

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