

IX. SBH-Kingsport, LLC (Kingsport, Sullivan County) - CN1312-050D

Request by Mountain States Health Alliance to review the Administrative Law Judge's Initial Order approving the establishment of a 72 bed mental health hospital and initiation of inpatient psychiatric and substance abuse services, 28 inpatient beds for psychiatric care for children ages 5-17, 18 inpatient beds for adult psychiatric care for adults ages 18-64, 16 inpatient beds for ages 55+, and 10 adult chemical dependency beds. It would accept voluntary and involuntary admissions.

The Agency may either decline or exercise review of an Initial Order issued by an ALJ, in which event the Initial Order shall become a Final Order and go to the Davidson County Chancery Court.

If the Agency chooses to Review the Initial Order, such would occur at a later meeting, after review of the record, briefs by the parties, and oral argument. The Agency's Final Order would have to detail reasons for any findings of fact and conclusions of law that differ from the ALJ's Initial Order.

No new evidence could be considered, no matter how relevant or helpful.

The Initial Order and the parties' written arguments are attached.



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February 8, 2016

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RE: In the Matter of: SBH-Kingsport, LLC Docket No. 25.00-126908J

Enclosed is an *Initial Order* rendered in connection with the above-styled case.

Administrative Procedures Division
Tennessee Department of State

/llp
Enclosure

BEFORE THE COMMISSIONER OF THE TENNESSEE
DEPARTMENT OF HEALTH

IN THE MATTER OF:

SBH-Kingsport, LLC

DOCKET NO.: 25.00-126908J

NOTICE

ATTACHED IS AN INITIAL ORDER RENDERED BY AN ADMINISTRATIVE JUDGE WITH THE ADMINISTRATIVE PROCEDURES DIVISION.

THE INITIAL ORDER IS NOT A FINAL ORDER BUT SHALL BECOME A FINAL ORDER UNLESS:

1. THE ENROLLEE FILES A WRITTEN APPEAL, OR EITHER PARTY FILES A PETITION FOR RECONSIDERATION WITH THE ADMINISTRATIVE PROCEDURES DIVISION NO LATER THAN February 23, 2016.

YOU MUST FILE THE APPEAL, PETITION FOR RECONSIDERATION WITH THE ADMINISTRATIVE PROCEDURES DIVISION. THE ADDRESS OF THE ADMINISTRATIVE PROCEDURES DIVISION IS:

SECRETARY OF STATE
ADMINISTRATIVE PROCEDURES DIVISION
WILLIAM R. SNODGRASS TOWER
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IF YOU HAVE ANY FURTHER QUESTIONS, PLEASE CALL THE ADMINISTRATIVE PROCEDURES DIVISION, 615/741-7008 OR 741-5042, FAX 615/741-4472. PLEASE CONSULT APPENDIX A AFFIXED TO THE INITIAL ORDER FOR NOTICE OF APPEAL PROCEDURES.

**BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY**

IN THE MATTER OF:

SBH-KINGSPORT, LLC

DOCKET NO: 25.00-126908J

INITIAL ORDER

This matter came to be heard on July 27-31, 2015, before Leonard Pogue, Administrative Judge, sitting for the Tennessee Health Services and Development Agency (Agency) in Nashville, Tennessee. The Petitioner, Strategic Behavioral Health-Kingsport, LLC (SBHK), is represented by William West and Charles Grant. The Intervenor, Mountain States Health Alliance (MSHA), is represented by Brian Jackson and Travis Swearingen. The Agency was represented by James B. Christoffersen, General Counsel. This matter became ready for consideration on November 19, 2015, upon the parties' submission of proposed findings of fact and conclusions of law and rebuttal/reply briefs.

The subject of this hearing is the appeal filed by SBHK of the denial of a certificate of need (CON) to SBHK by the Agency for the establishment of a 72 bed psychiatric hospital in Kingsport, Tennessee. After consideration of the record in this matter, it is determined that the SBHK CON should be **GRANTED**. This decision is based upon the following findings of fact and conclusions of law.

FINDINGS OF FACT

I. PROCEDURAL BACKGROUND/PARTIES

1. On December 3, 2013, SBHK filed a CON application with the Agency to construct and operate a 72-bed mental health hospital in Kingsport, Tennessee at a cost of approximately \$12 million, with the initiation of psychiatric services beginning in November, 2015.

2. On June 25, 2014, the Agency considered the SBHK application. A motion to approve the CON failed by a vote of four in favor of approval and four opposed. SBHK timely perfected its petition for a contested case proceeding on the denial of its CON application. MSHA, which had opposed the SBHK CON application before the Agency, was granted permission to intervene in the contested case.

3. SBH Kingsport is an entity formed by its parent company, Strategic Behavioral Health, LLC (SBH), a privately owned Memphis based psychiatric hospital company, to build and operate the proposed psychiatric hospital. SBH has acquired, developed, and operates eight psychiatric hospitals in North Carolina, Texas, New Mexico, Colorado and Nevada. SBHK will be SBH's first psychiatric hospital in Tennessee.

4. SBHK proposes that its hospital will have the following inpatient psychiatric bed components: 18 adult psychiatric beds, 28 child and adolescent psychiatric beds, 16 geropsychiatric beds, and 10 chemical dependency beds. SBH has previously developed two facility prototypes, a 72 bed hospital and a 92 bed hospital, for use in its projects across the country.

5. MSHA is a Tennessee non-profit health care system with its principal offices in Johnson City, Tennessee and provides comprehensive medical care in 29 counties in Tennessee, Virginia, Kentucky, and North Carolina. MSHA owns and operates 13 hospitals, including

Johnson City Medical Center (JCMC), a 501 bed regional tertiary referral and Level I trauma center, Indian Path Medical Center (IPMC), a 239 bed hospital in Kingsport, and Niswonger Children's Hospital, a 69 bed children's hospital in Johnson City.

6. MSHA, through JCMS's department known as Woodridge Psychiatric Hospital (WPH), operates an 84 bed psychiatric hospital in Johnson City that has 12 child and adolescent beds, 14 geropsychiatric beds, and 58 adult psychiatric beds. WPH's beds are in five separate buildings. WPH provides chemical dependency services in some of the adult psychiatric beds.

II. SERVICE AREA

A. Project Origins

7. In the summer of 2012, SBH began evaluating 95 potential expansion markets across the United States where the company might want to construct a new psychiatric hospital. One of the 95 potential locations identified by SBH was the "Tri-Cities." The Tri-Cities service market was defined to include both Johnson City and Kingsport. To evaluate these 95 markets for need, SBH identified all psychiatric providers located in a 60-mile radius. WPH was noted as the primary provider in the Tri-Cities area and other providers in the area were identified.

8. To project need, SBH applied a 30 bed per 100,000 population formula to these markets, the same formula dictated by the State Health Plan. SBH concluded that the Tri-Cities region ranked 34th in need for new psychiatric beds and that the area ranked 2nd in the country in terms of SBH's ability to staff the facility. SBH considered other metrics in its evaluation and in the final weighted analysis, the Tri-Cities ranked 15th out of 27 potential locations for a new psychiatric hospital.

9. James Shaheen is the President and founder of SBH. In early September 2013, Mr. Shaheen chose to proceed with the project and designated Michael Garone, SBH's Director

of Development, to take charge of the project. Mr. Garone's expertise is in marketing, not health care.

10. The first area SBH collected information from was Johnson City and SBH submitted an application for economic development incentives from the Johnson City Industrial Bond Board. In early October 2013, Mr. Garone visited the Tri-Cities and met with seven people, six of whom worked in Johnson City. Soon thereafter, SBH decided to place their proposed new hospital in Kingsport instead of Johnson City. Mr. Shaheen attributed the selection of Kingsport to Sullivan County being the most populated county in upper east Tennessee, a factor critical to staffing. Mr. Garone also noted in an email at that time that SBH chose not to be in Johnson City to avoid MSHA contesting the CON application. SBH did not create documents analyzing or setting out the need for a new psychiatric hospital in Kingsport versus the case for need in Johnson City.

B. Proposed Service Area

11. SBHK describes a service area consisting of five counties: Sullivan and Hawkins Counties in Tennessee, and Wise, Scott and Lee Counties in Virginia. In this five county service area, there are 12 inpatient psychiatric beds, all for adults, at Bristol Regional Medical Center (BRMC) in Bristol, Tennessee. SBHK did not provide in its application any projections of how many patients would come from any particular county or zip code within its claimed service area and did not perform a written analysis of historical patient patterns. Mr. Shaheen and Mr. Garone were involved in the development of the CON application but SBH did not engage a health planning expert to assist in determining the service area.

12. Several weeks after filing its CON application, SBH executives made an internal presentation to representatives of the company's owner setting forth the financial rationale and

summary for the proposed project. As part of the proposal, SBH identified a catchment area consisting of 25 mile and 50 mile radii around Kingsport to demonstrate where staff and patients would come from. SBH further identified its immediate market as the area within 25 miles of the facility that included, Ridgeview Pavilion with WPH and Magnolia Ridge at or just barely beyond the 25 mile distance. SBH's proposed catchment area used for its internal business analysis is similar to the service area MSHA has argued is appropriate for CON purposes.

13. IPMC has defined its service area (based on MSHA's 2012 Social Responsibility Plan) as Sullivan County and Hawkins County in Tennessee, plus Scott, Lee, Dickenson and Wise Counties in Virginia and in MSHA'S June, 2015 Community Health Needs Assessment IPMC's primary service area was listed as western Sullivan County, Hawkins County, Wise and Scott Counties. JCMC defines its service area as being six counties: Washington, Sullivan, Unicoi, Carter, Greene and Johnson (all Tennessee).

14. In 2013 HealthSouth Rehabilitation Hospital in Kingsport received 91% of its admissions from Sullivan and Hawkins Counties in Tennessee and certain Virginia counties. Wellmont Holston Valley Medical Center (Wellmont Holston) in Kingsport, in 2013, received 86.5 % of its admissions from Sullivan and Hawkins County in Tennessee and Scott, Wise and other counties in Virginia.

15. Daniel J. Sullivan was offered by SBHK as an expert witness in the areas of Tennessee CON issues and health care planning issues. After analyzing the CON application and reviewing various comparable facilities, Mr. Sullivan concluded that SBHK's service area is a reasonable basis on which to determine the need for a new behavioral health facility located in Kingsport.

16. Mr. Sullivan noted that Wellmont Holston received only 5.7% of its patients from Washington County, Tennessee in 2013 despite the fact that it is located in Kingsport. BRMC, the only psychiatric provider in Sullivan County (12 beds), received less than one percent of its psychiatric patients from Washington County and 42.1% of its psychiatric patients were from any of the five counties (including Sullivan County) in SBHK's service area. According to Mr. Sullivan, Indian Path Pavilion, a 61 bed psychiatric hospital formerly located in Kingsport, filed a CON in a project that involved combining IPMC and Indian Path Pavilion hospital licenses and described its primary service area as Hawkins and Sullivan Counties in Tennessee, and Wise, Scott and Lee Counties in Virginia. Mr. Sullivan acknowledged that adult and child/adolescent psychiatric services are more regional in nature.

17. Mr. Sullivan found that, in reviewing and acting upon CON applications, the Agency generally has accepted CON applicants' service area definitions, even when the proposed service area excludes contiguous counties from which an applicant might draw patients. Specifically, the Agency recently approved an application by Trustpoint Hospital in Rutherford County, Tennessee to expand its inpatient psychiatric bed capacity. In its application TrustPoint defined its service area as including only two counties, Rutherford and Bedford, and excluded the contiguous counties of Davidson and Williamson. Both Davidson and Williamson counties have other large and significant hospital providers of inpatient psychiatric services and Trustpoint's application indicated that Davidson County itself was the second largest source of its admissions, yet its defined service area of Bedford and Rutherford Counties was utilized by the Agency in analyzing the need for Trustpoint's additional psychiatric beds. Also, Rolling Hills Hospital, a psychiatric hospital in Williamson County, Tennessee had its CON application

approved with Rutherford and Bedford Counties included as part of Rolling Hills service area. Williamson County is contiguous to both Rutherford County and Davidson County.

18. It was the opinion of Mr. Sullivan that there is no reason to believe that a psychiatric hospital in Kingsport would be able to draw a significant number of people from Washington County when Washington County residents already have access to inpatient psychiatric care at WPH. He further testified that in health planning the primary service area is the source of approximately 75% of the patients and that he does not believe that Washington County's patients going to SBHK would be within the 75% of patients in the service area definition for a new hospital in Kingsport. Mr. Sullivan projected that approximately 20% of the patient volume at SBHK would likely come from outside the five county service area.

19. Mr. Sullivan did not analyze discharges from Indian Path Pavilion to see where its patients came. He opined that Indian Path Pavilion and WPH during the 2000s involved a different competitive marketplace than 2015. Specifically, Mr. Sullivan argued that after MSHA took over WPH (2005) a decision was made to expand psych services at WPH and de-emphasize those services at Indian Path Pavilion.

20. MSHA offered the testimony of Dr. Deborah Kolb Collier as an expert witness in the areas of Tennessee CON issues and health care planning/finance. Dr. Collier opined that SBHK gerrymandered its proposed service area to exclude consideration of existing psychiatric beds in the surrounding area. She noted that the SBHK CON application did not explain the quantitative basis for the service area and she was surprised that the service area stretches more than 35 miles northwest into an area of Virginia, while it extends only a few miles to the south, excluding Washington County, Tennessee and its population base.

21. Dr. Collier and Mr. Sullivan believe that in formulating a reasonable service area (if a provider does not already offer services in the area) one looks to identify a surrogate or proxy facility which can be used as a reasonable approximation of the proposed project. Dr. Collier opined that Indian Path Pavilion (open until 2009 and less than a mile from the proposed SBHK facility) was the most reasonable proxy. Dr. Collier analyzed Indian Path's historic patient origin mix to identify its service area. According to Dr. Collier, Washington County was the second highest county of origin for patients at Indian Path, accounting for almost 12% of admissions over its last three years of operation, with Hawkins County also almost at 12%. Scott County was fourth with 5.5 %. More patients originated from Washington County than Scott, Wise and Lee Counties combined. Sullivan and Hawkins Counties, Tennessee, and Wise and Scott Counties, Virginia accounted for 66.4% of Indian Path Pavilion's admissions in the 2007-2009 averaged data.

22. Dr. Collier examined existing patient origin data in determining what she considered a reasonable service area for SBHK's project. She concluded that there is flow of patients between Washington and Sullivan Counties for health services, including psychiatric services. From 2012-2014, 26% of patients admitted to WPH were from Sullivan County, which represented the second highest volume from any one county. Patients residing in other counties in the SBHK proposed service area also utilize WPH. Over a three year period, residents of the SBHK claimed service area constituted 36% of WPH's inpatients. Dr. Collier testified that Washington County is experiencing more growth than Sullivan County, particularly as it relates to the child and adolescent population, and that there is a population on the edge of Washington County that could as quickly access Kingsport as WPH.

23. Dr. Collier believes that SBHK's financial and volume projections will require it to capture patients from Johnson City and that SBHK will market its new facility to a broader service area. She determined that SBHK would need a 75% market share in its proposed service area to meet its projected volume and thinks that is unlikely. Dr. Collier concluded that a service area (11 counties, 6 in Tennessee and 5 in Virginia) that includes Washington County, Tennessee and other counties contiguous to Kingsport is a much more reasonable approximation of where SBHK's patients will likely originate. Two of these Virginia counties in Dr. Collier's alternate service area are not designated by MSHA as being part of IPMC's or JCMC's service areas.

24. Mr. Sullivan disagrees with Dr. Collier's proposed alternate service area definition. Mr. Sullivan opined that the area WPH serves is not relevant to what the service area should be for a hospital located in Kingsport, which is in a different location and situation, not part of a major medical center, and would be facing existing competition. He believes WPH currently has no real competition in terms of another comprehensive psychiatric hospital provider and that a hospital in Kingsport would thus have a significant competitive situation than does WPH. Mr. Sullivan thinks it would be very difficult for any psychiatric hospital in Kingsport to draw a material number of patients out of Washington County. Mr. Sullivan opined that the alternate service area proposed by Dr. Collier shows a need for 30 to 38 beds in that area.

25. Dr. Collier included Russell County and Washington County, Virginia in her alternate service area. Mr. Sullivan has not seen any data that would indicate a provider in Sullivan County would serve a material number of patients from Russell County; Russell County patients traveling to Kingsport would have to pass three psychiatric hospitals. Mr. Sullivan testified that he doubts a significant number of people from Washington County, Virginia would leave to go to a provider located in western Sullivan County, noting that neither Washington

County nor Russell County has been a significant source of patients for the HealthSouth hospital in Kingsport. Concerning Carter County, Tennessee, Mr. Sullivan stated that there is not a significant patient flow from Carter County to Kingsport's hospitals. With regard to patient flow to Kingsport from Unicoi County, patients from Unicoi would have to drive past WPH and go a considerable distance farther to get to SBHK. Mr. Sullivan noted that IPMC's recent Community Health Needs Assessment did not include Russell County or Washington County, Virginia or Carter County, Unicoi County or Greene County in Tennessee as part of its primary service area. Mr. Sullivan concluded that the orientation for the Kingsport area healthcare facilities is to the west and north in terms of where their patients come.

26. Mr. Sullivan did not perform the type of impact analysis that Dr. Collier performed because he did not have access to the proprietary information that had been available to Dr. Collier. With regard to Dr. Collier's use rate analysis, Mr. Sullivan, unlike Dr. Collier, was not able to utilize the Tennessee Hospital Association's (THA) detailed discharge data because only members of THA can have access to them. SBH is not a member of THA because it does not currently operate any hospitals in Tennessee.

III. NEED

27. Under the *Guidelines for Growth* bed need formula, Mr. Sullivan determined a total need of 92 beds in 2015, rising to 93 beds by 2020 for the proposed service area. Since the only inpatient psychiatric provider in the SBHK proposed service area is BRMC with its 12 beds, the net inpatient psychiatric bed need is 81 in 2015 and 82 beds by 2020. After applying the *Guidelines for Growth* inpatient psychiatric bed need formula, Mr. Sullivan opined the 72 beds proposed by SBHK is consistent with the overall net need.

28. Mr. Sullivan also analyzed the bed need for the individual categories of beds at the proposed facility, which include geropsychiatric, children and adolescents, and adult. He determined a need for 44 additional beds for adult inpatient psychiatric patients, which is in excess of SBHK's proposal for an 18 bed adult psychiatric unit and a 10 bed adult chemical dependency unit. No methodology exists for calculating chemical dependency bed need under the *Guidelines for Growth* formula, so Mr. Sullivan included the ten adult chemical dependency beds with the adult psychiatric beds. Mr. Sullivan also analyzed the need for the 65 and older population to determine the geropsychiatric bed need. In his expert opinion there is a need for that too.

29. With regard to the 18 and under age group population's bed need calculation, Mr. Sullivan determined that there was a need for 17 child and adolescent beds in 2015 and 15 such beds in 2019. SBHK is proposing 28 of these beds. Mr. Sullivan noted that while SBHK's proposal for 28 beds is in excess of the bed needs guidelines for this age group, very few inpatient psychiatric beds for this population exist in East Tennessee. Mr. Sullivan expects immigration from outside the service area for child and adolescent patients to Kingsport, because of the paucity of inpatient psychiatric bed resources available for these patients in the area and, therefore, he felt it was prudent to have additional inpatient psychiatric bed capacity for child and adolescent services.

30. Dr. Collier determined, using her alternative service area, that there will be a net bed need of 30 total beds in 2019. Using Indian Path Pavilion's historic service area (which removes the populations of Lee, Unicoi, and Russell Counties while also removing the 20 psychiatric beds at Clearview Center), Dr. Collier found a net need of 29 total beds in 2019. She acknowledged that if Russell County, Virginia were excluded from her alternate service area,

that the bed need there would increase since Russell County's 20 psychiatric hospital beds would be excluded from the bed need calculations, along with Russell County's population. If Russell County is eliminated, her proposed alternate service area, under the *Guidelines for Growth* formula, would need 51 new psychiatric beds.

31. Dr. Collier found that 400 patients from SBHK's proposed service area went to facilities in Blount County and as far away as Vanderbilt in FY 2013. Of these 400, Peninsula Hospital in Blount County received 296 (74%).

32. Mr. Sullivan testified that Tennessee has seen a dramatic rise over the last 10-15 years in the number of inpatient psychiatric beds which have been closed, particularly as to state beds. The state regional mental health institute, Lakeshore Mental Health Institute, which had previously served eastern Tennessee, closed in 2012, thereby taking 250 licensed inpatient psychiatric hospital beds out of service in eastern Tennessee. The result is that the regional public mental health institute that now serves eastern Tennessee is Moccasin Bend in Chattanooga, which is over 200 miles from the Tri-Cities area. From 2005 to 2010, hospitals in Tennessee closed 462 psychiatric beds. State facilities typically focus on the chronic, longer stay patients who are typically uninsured.

33. Sullivan County is the ninth largest county in Tennessee by population, but it contains only 12 inpatient adult psychiatric hospital beds. Mr. Sullivan opined there is a high need for additional inpatient and outpatient services in SBHK's proposed five-county service area because the population has limited access to inpatient psychiatric services. According to Dr. Collier, the adolescent population of Sullivan and Hawkins Counties will decline from 2014 to 2019, but combined the adolescent population of Wise, Scott and Lee Counties in Virginia will

slightly increase from 2014 to 2019. There are no inpatient psychiatric facilities in Lee County, Virginia, or between Lee County and Kingsport. Population growth in the area is modest.

34. Dr. Collier concluded that compared to the Tennessee average there is higher use of inpatient psychiatric services by Sullivan County residents. In 2013, the state wide use rate was 938.6 per 100,000 population, compared to 1,026.8 for Sullivan County residents and 983.0 in Dr. Collier's alternative service area. Based on her statistical analysis, Dr. Collier believes there is no obvious access problem to psychiatric services in the SBHK proposed service area.

35. Mr. Sullivan opined that SBHK's application is consistent with the *Guidelines for Growth* both in terms of establishing a numerical need for beds, as well as satisfying the more qualitative aspects of its proposal.

36. Admissions at WPH have been growing at an increasing rate since 2011, and patient days are up by almost 32% since 2011. Since 2013, admissions are higher at WPH in FY 2015 by more than 23%, and patient days are higher by 3,936 patient days, or 17.7%. WPH had 89.5% occupancy for the month of May 2015, 89.9% occupancy in November 2014, and an occupancy rate of 88% for July 2015. MSHA CEO Alan Levine testified that his goal is for MSHA to have fewer inpatient psychiatric admissions, yet WPH grew by 15.5% in inpatient admissions from FY 2014 to FY 2015.

37. Marlene Bailey is the current director of behavioral health programs at WPH, where she has worked for the last 26 years. Ms. Bailey explained that when Lakeshore closed in mid-2012 WPH volunteered to take more patients who typically went to Lakeshore. According to Ms. Bailey, WPH required time to adjust not only to an increase in patient census but also an increase in the acuity of the patients who were previously being treated at Lakeshore. This

transition caused occasional operational issues which resulted in lag between patients presenting for psychiatric treatment and admission to WPH and a higher bed census.

38. As of May 31, 2015, admissions at WPH were running more than 1,000 admissions higher than the number of admissions MSHA had budgeted for WPH for the first 11 months of FY 2015. Dr. Collier forecasts WPH's future results from a period of WPH utilization (2010-2013) which was lower than the last half of FY 2014 and all of FY 2015. WPH is currently running in calendar 2015 between 85.2% and 89.5% occupancy generally. If WPH's utilization increases (as measured by patient days) were to continue at the FY 2015 numeric volume of increase, WPH will be close to 100% full in less than two years from FY 2015.

39. WPH's "patient flow sheets," contain patient data described by Ms. Bailey as a worksheet to show the number of beds available and needed at approximately 7:00 a.m. on the day reported. She noted that patient flow sheets are commonly filled out before discharges have been made on a particular day. Ms. Bailey explained that if a patient is listed as "deferred" on a patient flow sheet, it means that WPH cannot take that patient at that particular moment in time; however, deferred patients are sometimes admitted to WPH later on in the day after morning discharges occur. If a bed does not open at WPH, the deferred patient will be transferred to another available bed in the Tri-Cities region for care and while a patient is deferred, the patient continues to receive psychiatric treatment in a hospital setting. Mr. Sullivan testified that not many people are discharged from a psychiatric hospital between midnight and 7:30 in the morning. He believes the patient flow sheets provide a reasonably close count of the number of patients in the hospital on any given day. The census for 22 of 27 days in May 2015 showed that 90% or more of the WPH beds were occupied. Mr. Sullivan found that the highest levels in the four months of patient flow sheets he examined were as follows: on March 30, 2015, there were

82 patients, and 97.6% occupancy, which was repeated on April 26 and April 27 and on May 5, 2015, there was an occupancy rate of 98.8%. According to Mr. Sullivan, any occupancy at WPH of 76 beds or higher would constitute a WPH occupancy level in excess of 90%.

40. Mr. Sullivan reviewed WPH "deferral" data. (Sullivan defined a "deferral" to mean that if a patient was referred for admission to an inpatient psychiatric bed and could not be admitted, but was deferred for any reason; such action would be considered a "deferral." Deferral could mean that the patient was placed on a waiting list for later admission, or it could mean that the patient was referred to a different facility). He concluded that adult deferrals for the period of June 2013 through December 2013 show 365 deferrals and that 242 of those deferrals were for the following reason: "appropriate bed not available."

41. For the period of January through May 2014, there were 107 adult deferrals (70, appropriate bed not available); for the period of January through May, 2015 there were 194 adult deferrals (126, appropriate bed not available). For the period of January through May, 2014 there were 43 adolescent deferrals (26, no bed); for the period of January through May, 2015 there were 45 adolescent deferrals (36, no bed). In the January 2015 through May 2015 time period, 76 of the total of 194 adult deferrals were from Sullivan County, while 17 deferrals were from Hawkins County. January through May, 2015 resulted in an occupancy rate of 86.5% at WPH. The 172 psychiatric beds in the Tri-Cities region operated at 64% occupancy in 2013.

42. While WPH operates at or around 85% capacity on a routine basis, Ms. Bailey feels that WPH is meeting the current needs of patients and providers. Ms. Bailey testified that since WPH implemented its process improvements, WPH's deferrals have been reduced by half from 2013. Further, despite running at 85% capacity, WPH continues to receive outstanding patient satisfaction surveys and has very low restraint rates.

43. Mr. Sullivan testified that Allen Levine, the CEO of MSHA, issued a press release in April 2015, in which Mr. Levine stated: "Northeast Tennessee and southwest Virginia disproportionately suffer from serious health issues," including "addiction and access to mental health services" which need to be addressed. Mr. Levine explained that he has never advocated for more inpatient beds to be built and wants to drive down use rates by ensuring that alternative services are available in the community. MSHA performs annual community health assessments of Sullivan and Washington Counties. According to Mr. Levine, in the course of those community health assessments, no stakeholder has communicated a need for a new 72-bed inpatient hospital.

44. MSHA recently announced a task force to explore expanding treatment options for mental health and addiction. The task force will help identify areas where MSHA can invest in additional psychiatric services.

45. MSHA has entered into a collaborative relationship with Frontier Health to construct a 12 bed Crisis Stabilization Unit (CSU) for adolescents. The CSU has to receive licensing approval and, if approved, was on pace to be operational before the end of 2015. A CSU provides a level of care prior to psychiatric hospitalization and offers treatment geared towards assessment, evaluation, early intervention, and stabilization within a 24-96 hour time period. Some patients in a CSU can have the same or similar level of severity of psychiatric illness as an inpatient unit. This level of care is advantageous for those with specific psychosocial stressors (loss of job or relationship issues) or readily mitigated treatment issues (a patient who is decompensating due to not taking psychotropic medications). Tennessee currently has some adult CSU beds but no pediatric CSU beds have previously been implemented. Ms. Bailey believes that a CSU meets a different need than an inpatient psychiatric hospital and also

opined that without CSUs more individuals would be needing services at WPH or other area hospitals. The adult CSU located in Johnson City (opened in 2009) has not slowed WPH's utilization rates.

46. Dr. Harsh Trivedi serves as the Executive Director and Chief Medical Officer for Vanderbilt Behavioral Health, the Vice Chair for Clinical Affairs at the Vanderbilt Department of Psychiatry and Vanderbilt, and Regional Chief Medical Officer for the Vanderbilt Affiliated Health Network. Dr. Trivedi expressed that he was not a health planning expert or a financial expert. In Dr. Trivedi's opinion modern psychiatric care should focus on providing patient centered treatment at the level of care most appropriate for that patient. He opined that patients do not want to be locked in an institution or deprived of their civil liberties. Dr. Trivedi feels the SBHK would be duplicative and he would prefer to see a greater availability of lower levels of care.

47. Dr. Trivedi opined that the availability of CSU beds can impact the need for inpatient beds for patients of all ages. He believes that if more patients are treated as outpatients or in other treatment settings, then that should alleviate demand for existing licensed beds. Dr. Trivedi thinks that adding a 12 bed CSU for adolescents has the same impact as adding 28 inpatient adolescent beds to the service area. From a health planning perspective, Dr. Collier opined that the appropriate goal is not to build more inpatient psychiatric care but to try to substitute better community distributed services.

48. Mr. Shaheen testified that coverage changes under the federal Affordable Care Act, which became effective in insurance policy renewals after July 2014, have increased insurance coverage for inpatient psychiatric and substance abuse care and that since January

2015, SBH has seen significant increases in patients who have access to mental health and substance abuse care because of the Affordable Care Act insurance requirements.

IV. ECONOMIC FEASIBILITY

49. Mr. Sullivan opined that the SBHK project is economically feasible and that SBH had demonstrated that it had adequate funds to complete the project. He found SBHK's proposed project cost of \$12 million was reasonable. He further opined that revenue projections were reasonably developed and that SBHK plans to participate in state and federal programs in terms of reimbursement. Mr. Sullivan believes that SBHK has demonstrated conformity with the state health plan criteria regarding economic feasibility.

50. With regard to any alternatives considered to the project, Mr. Sullivan testified that not building a facility in Kingsport would not be the best alternative, because such inaction would do nothing to address the shortage of inpatient psychiatric services and the lack of access to care that he feels currently exists in the area. He testified that it would be possible to build a facility smaller than 72 beds, but given that the *Guidelines for Growth* formula has identified a need for more than 72 beds and that the SBHK project would be serving a service area population of over 300,000 people, Mr. Sullivan opined that building a smaller facility would not be advantageous. He explained that an advantage of a larger psychiatric hospital facility is that it would enable the hospital to treat different patient segments within the populations it serves - a larger facility would create sufficient space within the hospital to separate children from adolescents. Mr. Sullivan was also of the opinion that having a larger facility gives the hospital a clinical advantage in terms of being able to separate patients into different treatment tracks depending on different diagnoses and patient needs. Lastly, he did not believe there would be an

alternative to the SBHK CON project that was less costly or more effective than this project for many of the same reasons listed above.

51. Mr. Shaheen testified that, after revenues of approximately \$105 million in its FY 2014, SBH projected its revenues would be approximately \$127 million in its FY 2015. As of July 2015, SBH was on track to achieve that revenue figure of \$127 million for 2015 and had \$70 million in its line of credit from commercial banks available to fund the project, as well as \$25-30 million available in annual cash flow from the company. SBH's CFO, James Cagle, is licensed as a certified public accountant in Tennessee. Mr. Cagle testified that SBH's operating cash flows and credit availability establish that there is a very good likelihood that SBH can economically establish and maintain the SBHK CON project.

52. In Dr. Collier's opinion, SBH has not set forth sufficient evidence that the project is economically feasible as proposed, although she acknowledges that SBH has a sufficient line of credit to complete the project. She feels one cannot assess the economic feasibility of the project because SBHK failed to apply an accurate service area, and therefore, did not consider the appropriate socio-economic demographics and population density for the project, which effects utilization and financial projection. Dr. Collier testified that SBH did not use a distinct utilization projection for this project but based utilization projection on SBH's prior projects. Dr. Collier did not find any indication that SBH investigated other alternatives to its proposed hospital.

V. ORDERLY DEVELOPMENT

53. As to the statutory CON criterion of orderly development of healthcare, Mr. Sullivan opined that the SBHK project would contribute to the orderly development of healthcare. He noted that the CON application indicates the intent of SBHK to become an

integral part of the healthcare delivery system within its service area by reaching out to community based organizations involved in mental health treatment such as schools, law enforcement agencies and other types of outpatient mental health providers, to try to integrate their services. Mr. Sullivan opined that the SBHK project will be an enhancement to the overall delivery of mental health in the service area.

54. Mr. Sullivan testified that the positive effects attributable to competition were a material consideration supporting the grant of a CON for the proposed project and opined that SBHK would provide a competitive alternative to WPH and to MSHA. He feels that the project will attract additional healthcare professionals, specialized psychiatrists and other staff to the area. Mr. Sullivan believes that SBHK would provide services in ways different from MSHA, giving patients increased choices in terms of where they want to go and could potentially stimulate price competition as it relates to contracting with third-party payors in the market. From these standpoints, Mr. Sullivan opined that any duplication that might occur would be necessary duplication. He explained that in health planning, duplication can be either "necessary" duplication or "unnecessary" duplication. "Unnecessary" duplication would occur where there is no need for what is being proposed and the applicant is merely duplicating what another facility already provides; in the case of SBHK, any duplication that might occur would be "necessary" because more inpatient psychiatric beds are needed in the community.

55. With regard to the project's impact on existing area providers, Mr. Sullivan opined that BRMC primarily serves a Virginia focused population so WPH would be the primary facility that would be impacted. Mr. Sullivan's opinion is that the SBHK project will not materially impair MSHA's operation of WPH. According to Mr. Sullivan, MSHA personnel in

April 2014 projected that the impact of SBHK's operation on WPH in the first year to be \$30,000 and the second year would be only about \$50,000.

56. Mr. Sullivan believes that a factor limiting the impact of the SBHK project on WPH is that WPH is not a distinct hospital; rather, it is a department/service of or satellite hospital of JCMC. On the 2013 Joint Annual Report (JAR) of JCMC to the Tennessee Department of Health, JCMC reports that JCMC owns and operates WPH. The medical staffs of JCMC and WPH are integrated (Dr. Hal Elliott, a former director of the ETSU psychiatry residency program, testified that he was on the medical staff of JCMC while he practiced at WPH). Mr. Sullivan thinks that the more appropriate impact analysis would be to examine the impact of the SBHK project on JCMC or on MSHA. He testified that the 2013 JAR for JCMC indicated that JCMC had a bottom line profit of over \$30 million in fiscal year 2013, and that even if the impact of SBHK were as large as was projected by Dr. Collier's projections, JCMC would not experience a significantly detrimental impact from it. Mr. Sullivan opined a new psychiatric hospital would not require JCMC to discontinue any services and that any impact of SBHK on JCMC would be that which results necessarily when a new facility is approved. He further opined that the weight of health planning analysis favors the benefits that accrue to the community from SBHK's project over and above any monetary impact on WPH or JCMC.

57. An analysis performed by Dr. Collier suggests that the presence of SBHK will result in 1,084 lost cases to WPH or a \$1.5 million loss net income per year (\$1.7 million if there is no indigent care at SBHK) based on the proposed service area. When Dr. Collier assumes patients come from her alternative service area, she shows a loss of \$1.6 million (\$1.9 million if there is no indigent care at SBHK). Dr. Collier's estimate was based on SBHK's application which projected a Year 2 occupancy rate of 72%. SBHK hopes to operate at 85% by Year 3 or 4.

As to fewer patients recently, WPH had more positive financial results with 3,724 patients in the first 11 months of FY 2014 than it had with 4,320 patients in the first 11 months of FY 2015.

58. Dr. Collier made no analysis of the effects of SBHK's hospital on JCMC. SBHK has not prepared an analysis examining the potential impact of SBHK on any existing provider.

59. Mr. Levine testified that MSHA has a yearly cash flow of \$150 million a year with about \$70 million representing debt service and \$70 million a year in depreciation. In the last six years, MSHA has annually spent \$30 million more than its cash flow on capital expenditures and reserving its debt. According to Mr. Levine, MSHA has a BBB-plus bond rating, but MSHA's financial performance metrics are below its bond class median in several respects and MSHA maintains its BBB-plus rating through successful management of its cash flow. If MSHA's bond rating was downgraded, MSHA would be faced with several million dollars per year in additional interest payments.

60. Mr. Levine believes that a loss of a couple of million dollars per year would require an examination of other services to offset the loss of revenue. He feels that a loss of insured patients at WPH may drive up the variable costs of its programs (in part, to help subsidize loss revenue for physicians).

61. Ms. Bailey described WPH as a safety net hospital for psychiatric patients in the region. WPH receives a grant from the State for patients it takes that previously would have been served at Lakeshore. The grant with the State is reviewed annually for renewal and is subject to change and reduction without notice. When WPH sees more indigent patients than are covered by the grant amount (which has occurred every year), WPH must petition the State to cover the remaining costs. SBHK has not had any conversations directly with representatives from the State about caring for the indigent patients formerly seen at Lakeshore. SBHK believes it makes

sense for those patients to continue to be seen at WPH since there is a reimbursement mechanism in place even after SBHK opens.

62. In its application, SBHK projects that 5% of its patient volume will be charity care. In written discovery, SBHK listed 4.5 % of its patients are uncompensated. SBHK's definition of uncompensated care includes bad debt, denials, and administrative adjustments. When an auditor reviewed SBH's 2014 financials, it noted that SBH "maintains records to identify and monitor the level of charity care it provides" and that "[t]hese records include the amount of charges foregone for services and supplies furnished under its charity care policy." Dr. Collier testified that she did not see in documents produced by SBHK any precise breakdown of charity patients. According to the auditor's report, \$491,000 of SBH's total expenses of \$92 million in 2014 was attributed to charity care. Extrapolating this expense ratio, Dr. Collier estimates that SBH saw 150 indigent patients in all 8 of its hospitals in the country in 2014.

63. The treatment staff at SBHK will include licensed physicians who will be board certified or board eligible in adult or child and adolescent psychiatry. Medical surgical nurses will be on staff to serve on the geriatric units. Behavioral health therapy will be delivered by masters level therapists, and some who are license eligible, as well as case managers. While SBH does not employ physicians, its facilities utilize the open medical staff model, as will SBHK. Mr. Shaheen testified that SBH is able to recruit new physicians into the community as well as to permit established physicians in the community to be on its medical staff. Mr. Shaheen stated that while there is a shortage of child and adolescent psychiatrists in the Tri-Cities the revenues SBH generates enables it to recruit board certified child and adolescent psychiatrists to the communities in which its facilities are located.

64. At all SBH facilities, except those in North Carolina, SBH offers outpatient services as well as inpatient services. It also offers partial hospitalization programs. In outpatient programs at SBH facilities, it is not necessary for a participant to have been an inpatient in any SBH hospital prior to utilizing the programs. SBH asks its physicians to participate in outpatient therapy and shares its therapists with the community. SBH takes both voluntary and involuntary patients.

CONCLUSIONS OF LAW

1. The Administrative Law Judge sits without the Agency in this de novo hearing pursuant to Tenn. Code Ann. § 68-11-1610.

2. The party petitioning for the hearing bears the burden of proof to establish, by a preponderance of the evidence, that the CON should be granted or denied. Tenn. Comp. R. & Regs. Rule No. 0720-13-.01(3). SBH has the burden of proof to establish that the SBH CON should be granted.

3. Pursuant to T.C.A. § 68-11-1609(a), the Agency shall approve part or all of the CON application or disapprove part or all of the CON application.

4. Tenn. Code Ann. § 68-11-1609(b) provides:

No certificate of need shall be granted unless the action proposed in the application is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of adequate and effective health care facilities or services. In making such determinations, the agency shall use as guidelines the goals, objectives, criteria and standards in the state health plan. Until the state health plan is approved and adopted, the agency shall use as guidelines the current criteria and standards adopted by the state health planning and advisory board, and any changes implemented by the planning division pursuant to § 68-11-1625. Additional criteria for review of applications shall also be prescribed by rules of the agency....

Therefore, the CON can be approved only if it satisfies the three criteria set forth above.

5. Pursuant to T.C.A. § 68-11-1609(b) the Agency should use "*Tennessee's Health: Guidelines for Growth*," 2000 edition (*Guidelines*) as guidelines until such time as a comprehensive state health plan is prepared. The *Guidelines* sets forth a specific methodology for determining need for many types of health care services, including inpatient psychiatric hospital services. The applicable Guidelines for Growth section provides as follows (2000 edition) as to "Psychiatric Inpatient Services:"

A. Need

1. The population-based estimate of the total need for psychiatric inpatient services is 30 beds per 100,000 general population (using population estimates prepared by the Department of Health and applying the data in Joint Annual Reports).
2. For adult programs, the age group of 18 years and older should be used in calculating the estimated total number of beds needed.
3. For child inpatient under age 13 and if adolescent program the age group of 13-17 should be used.
4. These estimates for total need should be adjusted by the existing staffed beds operating in the area as counted by the Department of Health in the Joint Annual Report.

B. Service Area

1. The geographic service area should be reasonable and based on an optimal balance between population density and service proximity or the Community Service Agency.
2. The relationship of the socio-demographics of the service area, and the projected population to receive services, should be considered. The proposal's sensitivity to and responsiveness to the special needs of the service area should be considered including accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, and those needing services involuntarily.

C. Relationship to Existing Applicable Plans

1. The proposal's relationship to policy as formulated in state, city, county, and/or regional plans and other documents should be a significant consideration.
2. The proposal's relationship to underserved geographic areas and underserved population groups as identified in state, city, county and/or regional plans and other documents should be a significant consideration
3. The impact of the proposal on similar services supported by state appropriations should be assessed and considered.
4. The proposal's relationship to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility serves acute and/or long-term patients, should be assessed and considered.
5. The degree of projected financial participation in the Medicare and TennCare programs should be considered.

D. Relationship to Existing Similar Services in the Area

1. The area's trends in occupancy and utilization of similar services should be considered.
2. Accessibility to specific special needs groups should be an important factor.

E. Feasibility

The ability of the applicant to meet Tennessee Department of Mental Health licensure requirements (related to personnel and staffing for psychiatric inpatient facilities) should be considered.

6. Rule 0720-11-.01 of the Rules of the Tennessee Health Services and Development

Agency sets forth additional criteria for review of CON applications as adopted by the Agency:

GENERAL CRITERIA FOR CERTIFICATE OF NEED. The Agency will consider the following general criteria in determining whether an application for a certificate of need should be granted:

- (1) Need. The health care needed in the area to be served may be evaluated upon the following factors:

- (a) The relationship of the proposal to any existing applicable plans;
 - (b) The population served by the proposal;
 - (c) The existing or certified services or institutions in the area;
 - (d) The reasonableness of the service area;
 - (e) The special needs of the service area population, including the accessibility to consumers, particularly women, racial and ethnic minorities, TennCare participants, and low-income groups;
 - (f) Comparison of utilization/occupancy trends and services offered by other area providers;
 - (g) The extent to which Medicare, Medicaid, TennCare, medically indigent, charity care patients and low income patients will be served by the project. In determining whether this criteria is met, the Agency shall consider how the applicant has assessed that providers of services which will operate in conjunction with the project will also meet these needs.
- (2) Economic Factors. The probability that the proposal can be economically accomplished and maintained may be evaluated upon the following factors:
- (a) Whether adequate funds are available to the applicant to complete the project;
 - (b) The reasonableness of the proposed project costs;
 - (c) Anticipated revenue from the proposed project and the impact on existing patient charges;
 - (d) Participation in state/federal revenue programs;
 - (e) Alternatives considered; and
 - (f) The availability of less costly or more effective alternative methods of providing the benefits intended by the proposal.
- (3) Contribution to the Orderly Development of Adequate and Effective Healthcare Facilities and/or Services. The contribution which the proposed project will make to the orderly development of an adequate and effective health care system may be evaluated upon the following factors:

(a) The relationship of the proposal to the existing health care system (for example: transfer agreements, contractual agreements for health services, the applicant's proposed TennCare participation, affiliation of the project with health professional schools);

(b) The positive or negative effects attributed to duplication or competition;

(c) The availability and accessibility of human resources required by the proposal, including consumers and related providers;

(d) The quality of the proposed project in relation to applicable governmental or professional standards.

7. Rule 0720-11-.01(23) of the Rules of the Tennessee Health Services and Development Agency provides that "Service area' means the county or counties, or portions thereof, representing a reasonable area in which a health care institution intends to provide services and in which the majority of its service recipients reside."

NEED

8. SBH was initially drawn to the Kingsport area by doing a national evaluation of psychiatric bed need. MSHA questions the process SBH used in formulating its SBHK CON request. However, the need criterion of the Agency in weighing a CON does not prescribe a certain protocol to be followed in developing an application. The applicant must demonstrate a need for the project and satisfy the other statutory criteria for the grant of the CON by the Agency.

9. The designated service area should be reasonable. Including Washington County, Tennessee and other nearby counties in the proposed SBHK service area may arguably create a more reasonable service area than that proposed. Yet, the rules of the Agency specifically

provide that "service area" means the counties representing a reasonable area in which the services are provided and in which the majority of its service recipients reside.

10. The two health care planning experts in this matter, both deemed credible, differ as to whether the SBHK proposed service area is reasonable. They examined the region's past and current health care providers' service areas in support of their respective positions. Similar to SBHKs designated services area, several medical facilities in Kingsport and Sullivan County (including MSHA's IPMC) have service areas that consist of Sullivan and Hawkins Counties and a few counties in Virginia, while excluding Washington County, Tennessee. The Agency has accepted CON applicants' service area definitions, even when the proposed service area excludes contiguous counties from which an applicant might draw patients.

11. The prior psychiatric hospital in Kingsport, Indian Path Pavilion, drew just 12% of admissions over its last three-years of operation (2007-09) from Washington County. From 2012-2014, 26% of patients admitted to WPH were from Sullivan County. In 2013, both Wellmont Holston in Kingsport and BRMC had very few patients from Washington County and four of the five counties in the proposed area accounted for approximately 66% of Indian Path Pavilion's admissions from 2007-2009. Mr. Sullivan projected that approximately 20% of the patient volume at SBHK would likely come from outside the five-county service area.

12. Not including a contiguous county (Washington, Tennessee) where some patients may originate does not make the service area unreasonable. SBHK has established that its designated service area is reasonable.

13. A 72 bed facility for the proposed service area meets the *Guidelines for Growth* bed need formula. Applying Indian Path Pavilion's service area the need is 29 beds in 2019;

using Dr. Collier's alternative service area the need is 30, though eliminating one county in Virginia (Russell) increases the need to 51.

14. Admissions and patient days at WPH have been growing steadily since 2011 with a considerably higher number of admissions than budgeted for fiscal year 2015 (as of May 31, 2015). Occupancy at WPH in 2015 (January-May) has been between 82-89%. There were days in 2014 and 2015 (January-May) when WPH had in excess of 90% occupancy and deferrals because a bed was not available for both adults and adolescents.

15. Population growth is not spurring the need for more beds; nonetheless, Sullivan County is the ninth largest county in Tennessee by population, but it contains only 12 inpatient adult psychiatric hospital beds. Hundreds of patients from SBHK's proposed service area have been traveling over 100 miles outside SBHK's proposed service area to obtain psychiatric inpatient psychiatric hospital services at Peninsula Hospital (Blount County) and elsewhere. The presence of SBHK could eliminate some of this out of service area inpatient psychiatric patient flow.

16. MSHA is actively working to provide mental health services to the region. It is assisting with treating patients who previously went to Lakeshore and is collaborating on a CSU project. A CSU should decrease the need for inpatient psychiatric beds. However, as evidenced by the Johnson City adult CSU not curtailing WPH's utilization rate, a CSU in of itself does not alleviate the total need for inpatient beds for some CSU patients and non-CSU patients.

17. When all of need criterion are considered, SBHK has established, by a preponderance of the evidence, that SBHK is necessary to provide needed health care to the proposed service area.

ECONOMIC FACTORS

18. SBH has adequate funds through its cash flow and line of credit to complete the project and the projected project costs are reasonable. Mr. Sullivan found the revenue projections also to be reasonable and SBHK will participate in Medicare and Medicaid. Dr. Collier's criticisms of the economic feasibility of the project are primarily based on her opinion that the proposed service area is inappropriate.

19. As to alternatives to the project, Mr. Sullivan did acknowledge that it would be possible to build a facility smaller than 72 beds. However, he felt the need for a 72 bed facility exists under the *Guidelines* formula and that there are advantages to a larger facility in terms of spacing and separating age groups.

20. The *Guidelines* address feasibility in terms of the ability of the applicant to meet Tennessee Department of Mental Health licensure requirements related to personnel and staffing for psychiatric inpatient facilities. SBH has retained and recruited the requisite personnel at its other facilities and should be able to draw upon its resources to do the same at SBHK.

21. When all of these factors are considered, SBHK has established by a preponderance of the evidence, that SBHK can be economically accomplished and maintained.

ORDERLY DEVELOPMENT

22. SBHK proposes to provide 5% indigent or charity care, take Medicaid/Medicare patients, accept involuntary patient commitments and participate in the TennCare program. SBH has been able to attract medical professionals to staff its other facilities and there was no indication it could not do so for SBHK. The area should benefit from the addition of healthcare professionals.

23. The only provider of inpatient beds in the proposed service area, BRMC, has only 12 beds which generally service an adult population; SBHK would provide additional beds for this population as well as for children and adolescents. The presence of SBHK should enhance the overall delivery of mental care in the area.

24. WPH would be the facility most impacted by SBHK. WPH is safety-net hospital for psychiatric patients in the region and plays a vital role in the area serving TennCare, Medicaid and patients formerly seen at Lakeshore. Dr. Collier estimates a possible loss of \$1.5 million per year to WPH if SBHK is built, though WPH did have more positive financial results with 3,724 patients in the first 11 months of FY 2014 than it had with 4,320 patients in the first 11 months of FY 2015. The impact of SBHK on WPH is limited by the fact WPH is a satellite or department of JCMC and consideration should be given to SBHK's impact on JCMC and MSHA. No expert analysis was done regarding the effect of SBHK on JCMC or MSHA. JCMC had profits of over \$30 million in fiscal year 2013 and MSHA is financially operationally healthy. Any adverse impacts on WPH/JCMC/MSHA by the approval of SBHK are outweighed by the benefits that accrue to the community from SBHK and the provision of the additional inpatient psychiatric beds that SBHK brings.

25. When all of these factors are considered, SBHK has established, by a preponderance of the evidence, that SBHK will contribute to the orderly development of adequate and effective health care facilities and care.

CONCLUSION

SBH-Kingsport having established by a preponderance of the evidence that the application for a Certificate of Need for a 72 bed psychiatric hospital in Kingsport, Tennessee meets the statutory and regulatory criteria, it is hereby **ORDERED** that the Certificate of Need filed for SBH-Kingsport be **GRANTED**.

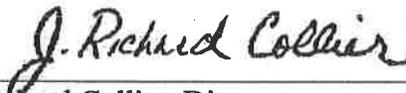
It is further **ORDERED**, pursuant to Tennessee Code Annotated § 68-11-1610(i), that all of the costs of this contested case proceeding are assessed to and shall be paid by MSHA.

This Initial Order entered this 8th day of February, 2016.



Leonard Pogue
Administrative Judge

Filed in the Administrative Procedures Division, Office of the Secretary of State,
this 8th day of February, 2016.



J. Richard Collier, Director
Administrative Procedures Division

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**APPENDIX A TO INITIAL ORDER
NOTICE OF APPEAL PROCEDURES**

Review of Initial Order

This Initial Order shall become a Final Order (reviewable as set forth below) fifteen (15) days after the entry date of this Initial Order, unless either or both of the following actions are taken:

(1) A party files a petition for appeal to the agency, stating the basis of the appeal, or the agency on its own motion gives written notice of its intention to review the Initial Order, within fifteen (15) days after the entry date of the Initial Order. If either of these actions occurs, there is no Final Order until review by the agency and entry of a new Final Order or adoption and entry of the Initial Order, in whole or in part, as the Final Order. A petition for appeal to the agency must be filed within the proper time period with the Administrative Procedures Division of the Office of the Secretary of State, 8th Floor, William R. Snodgrass Tower, 312 Rosa L. Parks Avenue, Nashville, Tennessee, 37243. (Telephone No. (615) 741-7008). See Tennessee Code Annotated, Section (T.C.A. §) 4-5-315, on review of initial orders by the agency.

(2) A party files a petition for reconsideration of this Initial Order, stating the specific reasons why the Initial Order was in error within fifteen (15) days after the entry date of the Initial Order. This petition must be filed with the Administrative Procedures Division at the above address. A petition for reconsideration is deemed denied if no action is taken within twenty (20) days of filing. A new fifteen (15) day period for the filing of an appeal to the agency (as set forth in paragraph (1) above) starts to run from the entry date of an order disposing of a petition for reconsideration, or from the twentieth day after filing of the petition, if no order is issued. See T.C.A. §4-5-317 on petitions for reconsideration.

A party may petition the agency for a stay of the Initial Order within seven (7) days after the entry date of the order. See T.C.A. §4-5-316.

Review of Final Order

Within fifteen (15) days after the Initial Order becomes a Final Order, a party may file a petition for reconsideration of the Final Order, in which petitioner shall state the specific reasons why the Initial Order was in error. If no action is taken within twenty (20) days of filing of the petition, it is deemed denied. See T.C.A. §4-5-317 on petitions for reconsideration.

A party may petition the agency for a stay of the Final Order within seven (7) days after the entry date of the order. See T.C.A. §4-5-316.

YOU WILL NOT RECEIVE FURTHER NOTICE OF THE INITIAL ORDER BECOMING A FINAL ORDER

A person who is aggrieved by a final decision in a contested case may seek judicial review of the Final Order by filing a petition for review in a Chancery Court having jurisdiction (generally, Davidson County Chancery Court) within sixty (60) days after the entry date of a Final Order or, if a petition for reconsideration is granted, within sixty (60) days of the entry date of the Final Order disposing of the petition. (However, the filing of a petition for reconsideration does not itself act to extend the sixty day period, if the petition is not granted.) A reviewing court also may order a stay of the Final Order upon appropriate terms. See T.C.A. §4-5-322 and §4-5-317.

**BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee**

FEB 24 16 09 20

IN THE MATTER OF:

SBH-KINGSPORT, LLC

Applicant.

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Docket No. 25.00-126908J

CON no. CN1312-050

**MOUNTAIN STATES HEALTH ALLIANCE'S PETITION FOR APPEAL OF
ADMINISTRATIVE JUDGE'S INITIAL ORDER**

Pursuant to Tenn. Code Ann. §§ 4-5-315 and 68-11-1610, Respondent Mountain States Health Alliance ("MHA") respectfully requests that the Health Services and Development Agency review and reverse the Initial Order entered in this proceeding on February 8, 2016. The Administrative Law Judge overturned the action of this Agency and granted a Certificate of Need ("CON") to SBH-Kingsport, LLC. The Initial Order is contrary to this Agency's rules and regulations and is inconsistent with the State Health Plan.

CASE OVERVIEW

1. MHA is a non-profit health care system with its principal offices in Johnson City. MSHA provides comprehensive medical care to 29 counties in Tennessee, Virginia, Kentucky, and North Carolina. MSHA owns and operates 13 hospitals, including Johnson City Medical Center, a 501-bed regional tertiary referral and Level I trauma center, Indian Path Medical Center, a 239-bed hospital in Kingsport, and Niswonger Children's Hospital, a 69-bed children's hospital in Johnson City that is one of only six St. Jude Affiliate Clinics and serves more than 200,000 children in the area. As one of the largest TennCare providers in the State, MSHA plays an essential role in supporting the TennCare program. In Fiscal Year 2014, MSHA provided more than \$40 million in unreimbursed care to Medicaid and TennCare patients, and

more than \$20 million in charity care, as well as subsidized health care and community health improvement services totaling approximately \$90 million.

2. MSHA's hospitals also include Woodridge Psychiatric Hospital ("Woodridge"), an 84-bed facility in Johnson City that treats more than 4,000 inpatients a year. When Lakeshore Mental Health Institute, the public psychiatric hospital for East Tennessee, closed in mid-2012, Woodridge volunteered to become the primary provider for psychiatric patients who were historically cared for in state psychiatric hospitals. Woodridge has served more than 3,000 such patients since that time. MSHA also promotes intensive outpatient mental health programs in outlying communities so patients can avoid the expense and inconvenience of inpatient care.

3. Strategic Behavioral Health ("SBH") is a privately-owned, for-profit company that develops, owns and operates psychiatric hospitals. SBH currently operates eight facilities in Nevada, New Mexico, North Carolina, and Texas. SBH served only 150 charity patients in all 8 of its hospitals in 2014. SBH does not currently own or operate any hospitals in Tennessee.

4. On December 13, 2013, SBH filed an application for a CON to build a new, freestanding 72-bed psychiatric hospital in Kingsport. As discovered during the contested case proceeding, this project was not conceived to address any community healthcare need, but was conceived solely to further the financial objectives of SBH, who decided to pursue the project mainly because of cheap building and labor costs in the Tri-Cities. SBH initially planned to locate its new hospital in Johnson City, but moved the location to Kingsport in an effort to avoid opposition to its CON, not for any legitimate health planning reason. Moreover, SBH's plan to build 72-bed facility is not based on any analysis supporting a need for 72 beds, but is based solely on SBH's 72-bed architectural plan "template" that it builds throughout the country.

5. The Agency considered the SBH application at its regular meeting on June 25, 2014. MHSA opposed the application. At the hearing, MHSA explained that SBH's project is duplicative and will not offer any services not already available in the Tri-Cities area. MHSA also pointed to SBH's lack of commitment to care for uninsured patients, including public statements by SBH officials that indigent patients could continue to be seen at Woodridge, to establish that SBH's project is focused on serving well-insured and affluent patients with significant adverse consequences to Woodridge.

6. After presentations from both parties, and comments from the Tennessee Department of Mental Health, which did not support the project, the Agency denied the application by a 4-4 vote. SBH subsequently filed its Petition for Contested Case pursuant to Tenn. Code Ann. §§ 68-11-1601, *et seq.*

7. The contested case hearing was held on July 27-31, 2015, before Leonard Pogue, Administrative Law Judge (the "ALJ"), sitting for the Agency. On February 8, 2016, the ALJ entered an Initial Order reversing the Agency's decision and granting a CON to SBH.

REASONS TO ACCEPT REVIEW

The Agency should exercise its authority under Tenn. Code Ann. §§ 4-5-315 and 68-11-1610 to review and reverse the ALJ's Initial Order and deny the CON to SBH. The following reasons support review:

1. Proof in the contested case established that SBH intentionally gerrymandered its proposed service area to exclude consideration of existing psychiatric beds in the adjacent county thereby artificially creating the appearance of quantitative need under the State Health Plan criteria. SBH's unrealistic service area excludes Washington County, which has 150,000 residents and is directly contiguous to Sullivan County. On the other hand, the service area

includes Lee County, Virginia, which is two counties away, separated from Kingsport by a large mountain range, and has only 25,000 residents. In other words, the proposed service area stretches more than 35 miles northwest, deep into an area of Virginia that is mountainous and sparsely populated, while it extends only a few miles to the south, excluding Washington County. SBH manipulated the State Health Plan's need formula by creating a service area that excluded consideration of existing psychiatric resources, primarily Woodridge, the largest provider in the region. If the contrived and unreasonable service area is disregarded and an appropriate service area is applied to the project, it is undisputed that there is no need for a new 72-bed psychiatric hospital under the State Health Plan.

2. While the ALJ acknowledged that a service area that includes Washington County might be more reasonable than the service area in the application, the ALJ noted that the Agency's Rules and Regulations are silent as to how an applicant should determine its service area. In effect, the ALJ concluded that an applicant can simply pick and choose counties it wishes to claim as a service area even if the underlying reason for doing so is to avoid the State Health Plan criteria. The ALJ's Initial Order contradicts the Agency's Rules, the Agency's long-standing practices, and the purpose and intent of the State Health Plan.

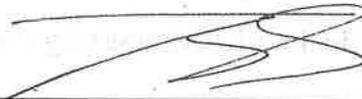
3. The ALJ's Initial Order incorrectly addresses the consequences of the project to the existing health care system. The ALJ found that Woodridge is the safety-net hospital for psychiatric patients in the region and plays a vital role in servicing TennCare, Medicare and patients formerly seen at Lakeshore. The ALJ also found that SBH's project would result in a potential annual loss of \$1.5 million by Woodridge. The ALJ concluded, however, that this negative impact on the health care system, including the safety net provider of inpatient psychiatric care in Northeast Tennessee, was not sufficient to justify denial of the application.

This conclusion is contrary to the plain meaning and intent of the Agency's Rules and the policies underlying the CON process.

CONCLUSION

For the foregoing reasons, MHSA respectfully requests that the Agency accept review of the ALJ's Initial Order dated February 8, 2016, and that the Agency place this matter on the agenda to be considered at its earliest opportunity.

Respectfully Submitted,



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CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing has been served by U.S. Mail, postage prepaid, to the following:

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William H. West
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this 22nd day of February, 2016.

A handwritten signature in black ink, appearing to be "W. West", written over a horizontal line.

**BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee**

IN THE MATTER OF:)
) **Docket No. 25.00-126908J**
SBH-KINGSPORT, LLC) **CON No. CN1312-050**
)
Applicant.)

**SBH-KINGSPORT, LLC'S BRIEF URGING THE HSDA TO DECLINE TO HEAR
MSHA'S APPEAL OF THE INITIAL ORDER HEREIN**

SBH-Kingsport, LLC, the CON Applicant which filed certificate of need application number CN1312-050 to establish a new, 72-bed psychiatric hospital in Kingsport, Sullivan County, Tennessee, hereby files this brief to urge the HSDA to decline to hear the appeal, filed by Mountain States Health Alliance ("MSHA"), of the Initial Order issued by the Administrative Judge in this contested case matter. SBH-Kingsport, LLC ("SBHK"), the CON Applicant herein, files this brief pursuant to T.C.A. § 68-11-1610(e) and HSDA Rule 0720-13-.03(1).

BACKGROUND

On February 8, 2016, the Administrative Judge filed his Initial Order in the contested case proceeding on CON application number CN1312-050. CON application CN1312-050 had originally been denied by HSDA at its June 2014 meeting by a tie vote of four members in favor of granting the CON to four members opposed. SBHK appealed this denial. The appeal hearing took five days, from July 27 to July 31, 2015, and generated a substantial record of testimony transcripts and exhibits in evidence.

In the Initial Order in this proceeding, which is the subject of the petition for appeal filed by MSHA on February 23, 2016, the Administrative Judge, Judge Pogue, concluded, after having heard the witnesses at the contested case hearing testify in person and after considering

the record in this matter, that: "After consideration of the record in this matter, it is determined that the SBHK CON should be granted."¹ He made this ruling based upon the Findings of Fact and Conclusions of Law he reached and set forth in his Initial Order.

ARGUMENT

The HSDA's contested case proceedings are held, by law, pursuant to the Tennessee Uniform Administrative Procedures Act. This law requires, at T.C.A. § 4-5-315(c), that in a petition for appeal of an Initial Order, "the petition for appeal shall state its basis." The HSDA is empowered by T.C.A. § 68-11-1610(e) to "decline to hear any appeal." MSHA's petition for appeal essentially makes three arguments as the basis for its appeal of Judge Pogue's Initial Order herein. SBHK asserts that none of MSHA's bases for appeal justify an appeal, and that therefore the HSDA should decline to hear any appeal in this matter.

The bases for MSHA's appeal are set forth in pages 3 through 5 of its petition, in which MSHA asserts three reasons why it believes that the HSDA should accept its appeal of the Administrative Judge's Initial Order herein. As argued below, none of the arguments MSHA makes in its appeal petition justify a decision by the HSDA to accept the appeal petition. Judge Pogue made the correct decision in his Initial Order. His decision is amply justified by his Findings of Fact and Conclusions of Law set forth in the Initial Order. A decision by the HSDA to refuse to accept the appeal will result in Judge Pogue's Initial Order becoming the Final Order in this matter. Any subsequent appeal by MSHA would be to the Chancery Court of Davidson County.

I.

The first basis for MSHA's appeal petition asserts that the service area claimed by SBHK in its CON application (Sullivan and Hawkins Counties in Tennessee, plus Scott, Wise and Lee

¹ Initial Order, page 1.

Counties in Virginia) is a "contrived and unreasonable service area". One of the main reasons why MSHA asserts that the service area claimed by SBHK is "unreasonable" is because it "excludes Washington County" in Tennessee.²

While MSHA argues that SBHK's claimed service area is "unreasonable", Judge Pogue expressly concluded on page 28 of the Initial Order as a matter of law that the HSDA's regulations require that "the designated service area should be reasonable." Judge Pogue analyzed the proof on this issue at length in his Initial Order. He then found and concluded that SBHK's proposed service area for its Kingsport hospital "is reasonable."³ He held further, in Conclusion of Law No. 9 in the Initial Order, that: "the rules of the Agency specifically provide that 'service area' means the counties representing a reasonable area in which the services are provided and in which the majority of its service recipients reside." (Emphasis added.) See HSDA Rule 0720-9-.01(23). (The text of this HSDA rule is set forth more fully in the Initial Order at Conclusion of Law No. 7, on page 28 of the Order.)

As noted in the Initial Order, and as required by the HSDA rule cited above, the service area designated by an applicant in its CON application must represent "a reasonable area" in which the institution intends to provide services and in which the majority of its service recipients reside. The HSDA's service area definition rule does not require that the proposed service area be "the most reasonable" service area possible or that it must exclude the capability of any other party to design a different, alternative "reasonable" service area.⁴

² Appeal petition, page 3.

³ Initial Order, page 29 (Conclusion of Law No. 12).

⁴ In Finding of Fact No. 30, on page 12 of the Initial Order, Judge Pogue found that Dr. Collier's proposed alternative service area for this project would itself have a need for 51 psychiatric hospital beds (if Russell County, Virginia were excluded; residents of that county would have to pass three other psychiatric hospitals to get to SBHK). Judge Pogue found that there was a net inpatient psychiatric bed need of 81 to 82 beds in SBHK's five-county service area, based upon the 30 beds per 100,000 population need standard in the *Guidelines for Growth*. (Finding of Fact No. 27, page 10: "Since the only psychiatric provider in the SBHK proposed service area is BRMC with its 12 beds, the net inpatient psychiatric bed need is 81 in 2015 and 82 beds by 2020.")

The full text of the HSDA's rule defining service area must be examined in evaluating this basis for MSHA's appeal petition. This provision is found in the HSDA's "Definitions" rule, HSDA Rule 0720-9-.01, of which subsection (23), cited earlier herein, is a subsection. The entire text of the HSDA rule defining the term "service area" is set forth immediately below (a copy of the complete HSDA rule from the Secretary of State's website is attached hereto as

Exhibit A to this brief):

Tenn. Comp. R. & Regs. R. 0720-9-.01: DEFINITIONS. The following terms shall have the following meanings.

(23) "Service Area" means the county or counties or portions thereof, representing a reasonable area in which a healthcare institution intends to provide services and in which the majority of its service recipients reside. (Emphasis added.)

The HSDA's own rules require that the "service area" claimed for CON applications to be defined as set forth in this rule. Other HSDA rules, such as those cited by Judge Pogue at pp. 26-27, contain provisions that state that CON applications "may be evaluated" on the basis of listed criteria set forth in those rules. The use in those rules of the verb "may be" instead of "shall" indicate that such criteria are not required to be considered. However, the use of the verb "shall" in the HSDA's service area definition rule mandates the use of its express terms in defining the CON project's service area: the service area must be "a reasonable area in which a healthcare institution intends to provide services and in which a majority of its service recipients reside."

The Tennessee Supreme Court has held that administrative agencies must act consistently with their own rules. *Jackson Express v. Tenn. Public Service Commission*, 679 S.W.2d 942, 945 (Tenn. 1984). Judge Pogue's Initial Order is consistent with the rules of the HSDA.

MSHA does not assert that the majority of SBHK's service recipients for its psychiatric hospital in Kingsport, once developed, will not come from the five-county service area SBHK

has claimed in its CON application. Rather, MSHA's attack on the Initial Order's approval of SBHK's proposed service area focuses on whether Judge Pogue correctly construed what the term "reasonable" means in CON application service area determinations.

The HSDA's definition by rule of what defines a "service area" does not look to or require a particular process to be followed for designating such a service area, other than that the service area must be "reasonable" and that a majority of the service recipients for the healthcare institution must come from the service area it designates. In the Initial Order, Judge Pogue cites and specifically applies the HSDA's service area designation rule. In the Initial Order, Judge Pogue analyzed the service areas, past and present, of hospital facilities located in Kingsport and elsewhere in Sullivan County as part of his assessment of whether SBHK's proposed service area is reasonable.

For example, Judge Pogue held, in Conclusion 10 on page 29, that:

Similar to SBHK's designated service area, several medical facilities in Kingsport and Sullivan County (including MSHA's IPMC)* have service areas that consist of Sullivan and Hawkins County and a few counties in Virginia, while excluding Washington County, Tennessee. The agency has accepted CON applicants' service area definitions even when the proposed service area excludes contiguous counties from which an applicant might draw patients.

In Conclusion 11 on page 29 of the Order Judge Pogue concluded as follows:

The prior psychiatric hospital in Kingsport, Indian Path Pavilion, drew just 12% of admissions over its last three years of operation (2007-09) from Washington County. . . . In 2013, both Wellmont Holston in Kingsport and BRMC had very few patients from Washington County and four of the five counties in the proposed service area accounted for approximately 66% of Indian Path Pavilion's admissions from 2007-2009. Mr. Sullivan projected that approximately 20% of the patient volume at SBHK would likely come from outside the five-county service area.

Based on these facts, in the Initial Order Judge Pogue went on to conclude, at Conclusion 12 on page 29, as follows:

IPMC means MSHA's acute care hospital facility, Indian Path Medical Center, located in Kingsport in Sullivan County.

Not including a contiguous county (Washington, Tennessee) where some patients may originate does not make the service area unreasonable. SBHK has established that its designated service area is reasonable.

Earlier in the Order's Findings of Fact, Judge Pogue made numerous Findings of Fact which support his Conclusions of Law that the service area proposed by SBHK is reasonable as required by the HSDA rule. For example, in Finding of Fact No. 16 on page 6 of the Initial Order, the Judge stated:

According to Mr. Sullivan, Indian Path Pavilion, a 61-bed psychiatric hospital formerly located in Kingsport, filed a CON for a project that involved combining IPMC and Indian Path Pavilion hospital licenses and described its primary service area as Hawkins and Sullivan Counties in Tennessee and Wise, Scott and Lee Counties in Virginia.

Earlier, in Finding No. 13 on page 5 of the Initial Order, Judge Pogue made the following factual finding:

IPMC has defined its service area (based on MSHA's 2012 Social Responsibility Plan) as Sullivan and Hawkins County, Tennessee plus Scott, Lee, Dickenson and Wise Counties in Virginia and in MSHA's June 2015 Community Health Needs Assessment, IPMC's primary service area was listed as western Sullivan County, Hawkins County, Wise and Scott Counties.

Thus, it is clear that Indian Path Medical Center ("IPMC"), an acute care hospital owned by MSHA and located in Kingsport in Sullivan County, has itself excluded Washington County from its own service area as early as 2012, and repeated such exclusion in June 2015, shortly before the contested case hearing herein.

In Finding of Fact No. 14 on page 5 of the Initial Order, Judge Pogue made the following Finding:

In 2013 HealthSouth Rehabilitation Hospital in Kingsport received 91% of its admissions from Sullivan and Hawkins County, Tennessee and certain Virginia counties. Wellmont Holston Valley Medical Center (Wellmont Holston) in Kingsport, in 2013, received 86.5% of its admissions from Sullivan and Hawkins County in Tennessee and Scott, Wise and other counties in Virginia.

Judge Pogue found as facts that Indian Path Medical Center in Kingsport, Wellmont Holston Valley Medical Center in Kingsport, and HealthSouth Rehabilitation Hospital in Kingsport all draw the majority of their patients from groups of counties which do not include Washington County, Tennessee. IPMC, owned by MSHA, has specifically and repeatedly excluded Washington County, Tennessee from its primary service area even though it is located in Kingsport, in western Sullivan County, Tennessee. Furthermore, Judge Pogue expressly found that IPMC has recently claimed (as noted above) to serve Lee County, Virginia, as part of its service area, while simultaneously excluding Washington County, Tennessee from its service area even though Washington County, Tennessee is contiguous to Sullivan County, Tennessee. Therefore, MSHA's own hospital facility and other hospital facilities located in Kingsport have identified Lee County, Virginia as being in their service area, while excluding Washington County, Tennessee from their service area. It is therefore fully "reasonable" for SBH-Kingsport to include Lee County, Virginia in its service area while excluding Washington County, Tennessee from its service area.

The Findings listed above support the Initial Order's Conclusion of Law that SBHK established that its service area was reasonable. If it is reasonable for Indian Path Medical Center to include Lee County, Virginia in its service area while excluding Washington County, Tennessee, that fact constitutes an admission by MSHA that the process of including Lee County, Virginia in IPMC's service area while excluding Washington County, Tennessee from its service area is "reasonable" for hospital facilities based in Kingsport in western Sullivan County, Tennessee. If MSHA has defined its Kingsport hospital facility's service area in such a fashion, it is certainly "reasonable" for SBHK to do so also. The service areas of other hospitals in Kingsport and Sullivan County were also proven in this record not to include Washington County, Tennessee.

II.

The second basis for appeal set forth by MSHA in its Petition for Appeal is set forth on page 4 of its Petition and is comprised of the following statements by MSHA:

While the ALJ acknowledged that a service area that includes Washington County might be more reasonable than the service area in the application, the ALJ noted that the agency's rules and regulations are silent as to how an applicant should determine its service area. In effect, the ALJ concluded that an applicant can simply pick and choose counties it wishes to claim as a service area even if the underlying reason for doing so is to avoid the State Health Plan criteria. The ALJ's Initial Order contradicts the agency's rules, the agency's long-standing practices, and the purpose and intent of the State Health Plan.

This purported basis for appeal contains material misstatements about what the Initial Order actually states. The first one is its assertion that "the ALJ noted that the agency's rules and regulations are silent as to how an applicant should determine its service area." The ALJ made no such notation, Finding or Conclusion in the Initial Order. The contents of the Initial Order directly contradict this assertion. The Initial Order simply does not contain any statement that "the agency's rules and regulations are silent as to how an applicant should determine its service area."

For example, Conclusion of Law No. 9 on pages 9-10 of the Initial Order expressly states:

The designated service area should be reasonable. Including Washington County, Tennessee and other nearby counties in the proposed SBHK service area may arguably create a more reasonable service area than that proposed. Yet, the rules of the Agency specifically provide that "service area" means the counties representing a reasonable area in which the services are provided and which the majority of its service recipients reside. (Emphasis added.)

In Conclusion of Law number 9 of the Initial Order, the underlying statements set forth above are virtually a direct quote of the HSDA's service area definition rule, rule 0720-9-.01(23) of the rules of the HSDA. The language of the rule itself is set forth by the Initial Order in Conclusion of Law number 7 on page 28. Thus, the Initial Order directly cites the contents of

the agency's own mandatory rule on an applicant's determination of its service area, and specifically applies it to the CON application at issue.

In the Initial Order, Judge Pogue goes on in Conclusion of Law 10 to point out that the health planning experts in this case, Mr. Sullivan for SBHK and Dr. Collier for MSHA, are both credible health planning experts. However, they differ in describing the reasonableness of the SBHK proposed service area: Mr. Sullivan finds it reasonable, while Dr. Collier does not. The ALJ notes in Conclusion 10 that both experts "examined the region's past and current healthcare providers' service areas in support of their respective positions." The Initial Order points out, at Conclusions of Law 10 and 11 (page 29) that several medical facilities in Kingsport in Sullivan County, including Indian Path Medical Center, now owned by MSHA and located in Kingsport, have service areas that consist of Sullivan and Hawkins Counties plus a few counties in Virginia, while excluding Washington County, Tennessee from the service area. The Initial Order concludes in Conclusion number 10 (page 29) as follows: "The Agency has accepted CON applicants' service area definitions even when the proposed service area excludes contiguous counties from which an applicant might draw patients." As noted above, in Conclusion number 11 the Initial Order then reviews the experience of the prior psychiatric hospital in Kingsport, Indian Path Pavilion, over the last three years of its operation (2007-2009), particularly as to the share of its patients that came from Washington County, Tennessee.

Thereafter, in Conclusion of Law number 12, on page 29, the ALJ concluded specifically as follows:

Not including a contiguous county (Washington, Tennessee) where some patients may originate does not make the service area unreasonable. SBHK has established that its designated service area is reasonable.

Clearly, in Conclusion 12, the ALJ, through the Initial Order, is directly applying the HSDA's own mandatory rule defining what a service area is to the facts of this certificate of need

application. In the Initial Order, the ALJ never finds or "notes" that the agency's rules and regulations are "silent as to how an applicant should determine its service area." Instead, in the Initial Order Judge Pogue directly applies the actual service area definition rule of the HSDA to the facts of the SBHK CON application and the record of the contested case proceeding, and in doing so specifically determines that the service area proposed by SBHK is reasonable even though it does not include a certain county contiguous to it. Therefore, contrary to MSHA's assertions in its appeal petition, there is no basis in this Initial Order to claim that the ALJ had concluded that the agency's rules and regulations are silent as to how an applicant should determine its service area. Such an assertion is false; it is contradicted by the text of the Initial Order itself.

Contrary to the Petition for Appeal, there is no basis in the Initial Order itself to conclude that an applicant can simply pick and choose counties it wishes to claim for a service area. The ALJ has made it clear in his Initial Order that the designation of service area must comply with the rules of the HSDA, which require the service area to represent a reasonable area in which the services are provided and in which the majority of its service recipients reside. Thus, the second sentence in MSHA's appeal petition's basis number 2 simply is not supported by the contents of the Initial Order itself; instead, it is contradicted by those contents.

There is similarly no support in the Initial Order itself for the assertion in MSHA's appeal petition's basis for appeal number 2 that: "The ALJ's Initial Order contradicts the Agency's rules, the Agency's long-standing practices, and the purpose and intent of the State Health Plan."

To the contrary, as noted above, the Initial Order clearly and directly applies the rules of the HSDA to the CON application at issue, CN1312-050. Furthermore, the Initial Order directly cites and applies the long-standing practice of the HSDA in "accepting CON applicants' service

area definitions, even when the proposed service area excludes contiguous counties from which an applicant might draw patients." See Conclusion of Law No. 10, at p. 29 of the Order.

In the ALJ's Findings of Fact and Conclusions of Law, Judge Pogue also directly cites and utilizes the applicable provisions of the *Guidelines for Growth*. Therefore, the claimed basis for appeal number 2 in MSHA's appeal petition is contrary to the actual text of the Initial Order. Judge Pogue's Initial Order does not contradict the Agency's rules, the Agency's long-standing practices, or the purpose and intent of the State Health Plan. To the contrary, Judge Pogue clearly cites and utilizes all three of these provisions in his Initial Order to reach his Findings of Fact and Conclusions of Law. Thus, MSHA's appeal petition's asserted basis for appeal number 2 constitutes no reason for the HSDA to accept this appeal -- the appeal petition is factually and legally inaccurate when examined in light of the actual text and contents of the Initial Order. Therefore, the appeal petition should be declined by the HSDA.

III.

The final basis MSHA cites for its appeal is contained in paragraph number 3 beginning on page 4 of its appeal petition, which begins: "The ALJ's Initial Order incorrectly addresses the consequences of the project to the existing healthcare system."

In its support of this assertion, at pages 4-5 of the appeal petition, MSHA fails to challenge or assert as error a core Conclusion of Law and Finding of Fact in the Initial Order: MSHA's psychiatric hospital, Woodridge Psychiatric Hospital, is a department of the Johnson City Medical Center, a much larger and very profitable hospital institution owned and operated by MSHA. Judge Pogue concluded, in Conclusion of Law No. 24 on page 32 of the Initial Order that "The impact of SBHK on WPH is limited by the fact WPH is a satellite or department of JCMC . . .". In its appeal petition, MSHA does not challenge this Conclusion of Law (in Conclusion of Law number 24) in the Initial Order, nor does it contradict in any manner

whatsoever or assert as error the Findings of Fact which support this Conclusion of Law, such as Findings number 56 on page 21 of the Initial Order and Finding number 58 on page 22 of the Initial Order:

Finding 56: "On the 2013 Joint Annual Report (JAR) of JCMC to the Tennessee Department of Health, JCMC reports that JCMC owns and operates WPH. The medical staffs of JCMC and WPH are integrated . . ."

Finding 58: "Dr. Collier made no analysis of the effects of SBHK's hospital on JCMC."

The MSHA appeal petition's asserted basis for appeal no. 3 also contains a factual error. The third sentence in basis number 3 on page 4 of the MSHA appeal petition states as follows: "The ALJ also found that SBH's project would result in a potential annual loss of \$1.5 million by Woodridge."

There is no such Finding in the Initial Order. In Finding No. 57 on page 21 of the Initial Order, Judge Pogue notes "an analysis performed by Dr. Collier suggests that the presence of SBHK will result in 1,084 lost cases to WPH or a \$1.5 million loss net income per year (\$1.7 million if there is no indigent care at SBHK) based on the proposed service area." (Emphasis added.) In partial contradiction of Dr. Collier's analysis, Judge Pogue then specifically finds as a fact, on page 22 of the Initial Order, the following: "As to fewer patients recently, WPH had more positive financial results with 3,724 patients in the first 11 months of FY2014 than it had with 4,320 in the first 11 months of FY2015."

In Conclusion 24 on page 32 of the Initial Order, Judge Pogue reviews these Findings and makes the following Conclusion of Law:

Dr. Collier estimates a possible loss of \$1.5 million per year to WPH if SBHK is built, though WPH did have more positive financial results with 3,724 patients in the first 11 months of FY2014 than it had with 4,320 in the first 11 months of FY2015. The impact of SBHK on WPH is limited by the fact that WPH is a satellite or department of JCMC and consideration should be given to SBHK's impact on JCMC and MSHA. No expert analysis was done regarding the effect

of SBHK on JCMC or MSHA. JCMC had profits of over \$30 million in fiscal year 2013 and MSHA is financially operationally healthy. Any adverse impacts on WPH/JCMC/MSHA by the approval of SBHK are outweighed by the benefits that accrue to the community by SBHK and the provision of the additional inpatient psychiatric beds that SBHK brings.

Nowhere in the Initial Order did Judge Pogue "find" as a fact that SBHK's project would result in a potential annual loss of \$1.5 million by Woodridge. Instead Judge Pogue found that Dr. Collier made such estimates, but he did not find that that such an impact would in fact occur or that it would form a factual basis for any conclusion of law.

MSHA never claims in its appeal petition that WPH is not a department of JCMC; nor does MSHA ever assert in its appeal petition that the ALJ's conclusion that WPH was a department of JCMC is erroneous. Simply put, MSHA does not challenge the Initial Order's Findings of Fact and Conclusions of Law that WPH is a department of JCMC. Therefore, as Judge Pogue did, the HSDA should accept as a fact that WPH is merely a department of JCMC. MSHA articulates no basis whatsoever in its appeal petition for appealing the Initial Order's Conclusion of Law that WPH is a department of the Johnson City Medical Center, a large and profitable MSHA hospital. Similarly, MSHA does not assert in its appeal petition that the ALJ erred in concluding that JCMC had over \$30 million in profit in fiscal year 2013 and that MSHA is "financially operationally healthy".

Given the appeal petition's failures to make any challenge to those Conclusions of Law by the ALJ in the Initial Order, or even to assert that they are erroneous, the appeal petition's basis for appeal number 3 simply fails to identify any mistake or error in the Initial Order or elsewhere that would justify the HSDA's hearing the appeal of MSHA in this matter by granting the appeal petition. If WPH is a department of JCMC, a Conclusion not challenged by MSHA's appeal petition, then MSHA's claims of the CON project's impact on WPH focus on the wrong facility: MSHA should have focused on the CON project's impact on JCMC (which includes its

department, WPH). Instead, MSHA and its expert totally failed to conduct this analysis. There is no dispute that this failure occurred.

IV.

In his Initial Order, Judge Pogue carefully laid out the HSDA rules applicable in this case and then expressly applied them in the Order.

For example, he held in Conclusion of Law No. 2 on page 24 that the party which asked for the contested case hearing (SBH-Kingsport, LLC in this case) "bears the burden of proof to establish, by a preponderance of the evidence, that the CON should be granted or denied." This is a direct quote by Judge Pogue of the HSDA's rule governing appeals (Rule 0720-13-.01(3)) which states, in relevant part: "The Petitioner shall have the burden of proving, by a preponderance of the evidence, that a certificate of need should be granted or should be denied."

The Tennessee Supreme Court has defined the term "preponderance of evidence" in the 2005 case of *Teter v. Republic Parking System*, 181 S.W.3d 330, 341 (Tenn. 2005), as follows:

Generally, in civil cases, facts are proved by a mere preponderance of the evidence. (Citations omitted.) The preponderance of the evidence standard requires that the truth of the facts asserted be more probable than not, whereas the clear and convincing evidence standard requires that the truth be highly probable. "Clear and convincing evidence means evidence in which there is no serious or substantial doubt about the correctness of the conclusions drawn from the evidence." (Emphasis added, citation omitted.)

Under the "preponderance of the evidence" standard applicable by law and HSDA rule to this civil matter, the existence of any doubt about the correctness of conclusions drawn from the evidence, does not cause the conclusions reached by the judge in this case to be wrong or reversible. Judge Pogue's statements citing Dr. Collier's impact statement or that another service area definition might have included Washington County, Tennessee merely articulate some possible potential for doubt about the correctness of his decision. However, those doubts (if they

exist), by law, do not mean that Judge Pogue's Initial Order is not supported by the preponderance of the evidence and is therefore correct.

In his Initial Order, Judge Pogue emphasized a great deal of record proof in this case that supports his conclusion that a preponderance of the evidence in this case supports the grant of the CON to SBHK. These include, but are not limited to, the following:

Finding 28, p. 14:

"WPH is currently running in calendar 2015 between 85.2% and 89.5% occupancy generally. If WPH's utilization increases (as measured by patient days) were to continue at the FY 2015 numeric volume of increase, WPH will be close to 100% full in less than two years from FY 2015."

Finding 39, pp. 14-15:

"The census for 22 of 27 days in May 2015 showed that 90% or more of the WPH beds were occupied. On May 5, 2015, there was an occupancy rate of 98.8%."

Finding 31, p. 12:

"Dr. Collier found that 400 patients from SBHK's proposed service area went to facilities in Blount County and as far away as Vanderbilt in FY 2013. Of these 400 patients, Peninsula Hospital in Blount County received 296 (74%)."

Finding 41, p. 15:

WPH records show that hundreds of potential patients were deferred at WPH in years 2014-2015 because WPH did not have appropriate beds available.

Finding 36 on p. 13:

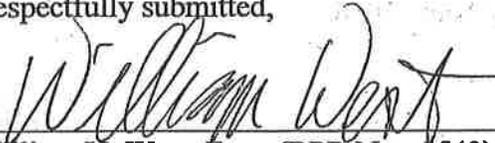
- WPH patient days are up 32% since 2011.
- Since 2013, by 2015 patient days at WPH increased by 17.7%, while admissions increased more than 23%.
- "WPH had 89.5% occupancy for the month of May 2015, 89.9% occupancy in November 2014, and an occupancy rate of 88% for July 2015."

Clearly, in light of these and other facts set forth in the Initial Order, Judge Pogue's determination that "the SBHK CON should be GRANTED" is well justified. Thus, MSHA's appeal petition should be declined by the HSDA.

CONCLUSION

The Findings and Conclusions reached by Judge Pogue in his Initial Order demonstrate that the CON criteria of need, economic feasibility, and contribution to the orderly development of healthcare are satisfied by the project set forth by SBHK in CON application CN1312-050, and are established to be proven by the preponderance of the evidence in the record in this case. Since MSHA has failed in its appeal petition to cite any legally effective basis to justify granting its appeal of the Initial Order entered in this matter by the Administrative Judge, SBHK respectfully asserts that the HSDA should decline to hear the appeal sought by MSHA. The Initial Order should, by operation of law, become the Agency's Final Order in this matter. Counsel for SBHK will appear at the appropriate HSDA meeting to articulate this position in oral argument before the Agency.

Respectfully submitted,



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MAR 31 '16 PM 12:15

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the foregoing has been delivered via email to:

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and

Jim Christoffersen, Esq.
General Counsel
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Nashville, TN 37243

this 31 day of March, 2016.



William West

**BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee**

APR 10 10 42:29

IN THE MATTER OF:

SBH-KINGSPORT, LLC

Applicant.

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Docket No. 25.00-126908J

CON no. CN1312-050

**MOUNTAIN STATES HEALTH ALLIANCE'S REPLY IN SUPPORT OF ITS
PETITION FOR APPEAL**

The applicant, SBH-Kingsport, LLC, crafted a service area in its application to create the perception of need for its proposed 72-bed psychiatric hospital when no actual need exists. Specifically, SBH excluded Washington County – the adjacent county of 125,000 people home to the 84-bed Woodridge Psychiatric Hospital, the primary provider of psychiatric services in the Tri-Cities. SBH did not perform any health planning analysis to justify this exclusion. Instead, SBH's service area was designed to manipulate the application of the State Health Plan's bed need formula and to avoid Certificate of Need opposition from Woodridge's parent company, Mountain States Health Alliance ("MHSA"). Excluding Washington County from the service area meant that Woodridge was simply ignored in evaluating the need for a new psychiatric hospital in Kingsport, even though the two facilities would be in adjacent counties, only 24 miles apart. If the contrived service area is disregarded and a more reasonable service area is applied to the project, it is undisputed that there is no need for a new 72-bed psychiatric hospital under the State Health Plan.

Indeed, even as SBH claimed a service area excluding Washington County in its application, discovery in the contested case revealed that, for internal financial purposes, SBH continues to believe that it will capture significant market share from all of its surrounding areas, including Washington County. Although the Administrative Judge recognized that SBH

manipulated its service area, he incorrectly concluded that the Health Services and Development Agency's criteria do not establish a method or protocol by which an applicant must establish its proposed service area. By this rationale, an applicant's actual plans about where its patients will originate are irrelevant, no matter how inconsistent they may be with the application. Allowing the Initial Order to stand will establish dangerous precedent that undermines the CON process by sanctioning the use of unrealistic service areas.

The proof at trial also showed that MHSA is a cornerstone of the TennCare program in Northeast Tennessee, and it provides hundreds of millions of dollars in charity and uncompensated care. Woodridge is the safety-net psychiatric provider for its region, serving thousands of patients without resources who were formerly treated at the State mental health hospital. The proof further showed that SBH provides virtually no charity care at its existing hospitals and that SBH's focus will be on capturing the insured patient population while the indigent population would continue to be seen at Woodridge. MHSA's health planning expert concluded that the proposed project would have a significant negative financial impact on Woodridge. The CEO of MHSA testified that the SBH facility would impair Woodridge's ability to continue to offer a full array of psychiatric services to its community. Despite the economic damage the project would cause to Woodridge, the Administrative Judge concluded that the impact on Woodridge was insufficient to warrant denial of the application, because the MHSA system as a whole is financially stable. This conclusion is contrary to Agency's policy and practice of considering the consequences of a project in the context of the entire health care system, including safety-net providers.

The Agency retains the authority to review the findings of fact and conclusions of law made by an Administrative Judge sitting on its behalf. This project offers only duplicative

services to an area already sufficiently served and will do real and lasting harm to a nonprofit hospital that is providing essential community services. The Agency should review the Initial Order to determine whether its conclusions are consistent with the Agency's policies and objectives.

ARGUMENT

I. SBH'S CLAIM THAT JOHNSON CITY IS NOT IN THE SERVICE AREA OF A KINGSPORT PSYCHIATRIC HOSPITAL IS UNREASONABLE ON ITS FACE AND THE EVIDENCE SHOWED THAT THE CLAIMED SERVICE AREA WAS ADOPTED SOLELY TO IMPROVE THE CHANCES OF CON APPROVAL.

The State Health Plan includes a population-based need formula for psychiatric services of 30 psychiatric beds per 100,000 population. The calculated need is then compared with existing staffed beds to determine whether there is any shortage of beds in an area. In performing this analysis, the selection of the service area is critical—both in order to ascertain the appropriate population for the need calculation and to identify the number of existing beds.

Typically, CON applicants present health planning assumptions in an application; a good faith service area is projected, divided into county units or zip codes, demonstrating the size of the market, the projected market share, and patient volumes that the applicant expects to receive from each area. The Agency and the Agency's staff expect these assumptions to be bona fide and not concocted simply to drive a numerical result that circumvents the State Health Plan's bed need formula.

In this case, discovery into SBH's internal application process revealed that SBH's service area development was anything but genuine. SBH knew that if it included Washington County and its 84-bed psychiatric hospital in its service area, then it could never justify a new 72-bed psychiatric hospital in adjacent Kingsport. In order to circumvent the State Health Plan's quantitative criteria, SBH devised a service area – for CON purposes only – to generate an

artificial “need” for its project. SBH creatively included counties to the west and northwest, connected to Kingsport by rural roads and over mountain ranges, that have no existing psychiatric providers. SBH’s approach circumvents the spirit and the letter of the HSDA’s rules and undermines the CON process. Specifically, the proof at trial showed:

- SBH chose the Tri-Cities as a potential location for a new psychiatric hospital, not because of any documented need for additional psychiatric services, but because of costs – the Tri-Cities had available staffing and staff wages and building costs are relatively low. (Initial Order, p. 4, ¶ 10).
- SBH initially planned on placing its facility in Johnson City. (Initial Order, p. 4, ¶ 10). SBH applied for economic development incentives from the Johnson City Industrial Bond Board. (*Id.*) SBH representatives met with seven psychiatric stakeholders prior to filing, six of whom were in Johnson City. (*Id.*)
- Approximately one month before the application was filed, however, SBH executives reversed course and decided to locate the proposed new hospital in Kingsport instead of Johnson City. (Initial Order, p. 4, ¶ 10). SBH did not create a single document setting out the health planning rationale for a new psychiatric hospital in Kingsport versus the case for need in Johnson City. (*Id.*) Instead, internal SBH documents established that the change in location was made simply to avoid MHSA contesting the CON application. (*Id.*)
- SBH filed its application for a CON in December 2013, less than 60 days after the company first visited the Tri-Cities. Despite the geographic proximity and historical ties between Johnson City and Kingsport, SBH’s proposed service area excluded Johnson City and Washington County and instead claimed a number of rural Virginia counties to the Northwest of the Tri-Cities. Only by ignoring Washington County and Woodridge’s 84 beds could SBH successfully derive a need for its proposed 72-bed facility under the State Health Plan’s quantitative criteria.
- SBH did not provide in its application any projections of how many patients would come from any particular county or zip code. (Initial Order, p. 4, ¶ 11). SBH performed no analysis of historical patient patterns to determine probable patient origins. (*Id.*) SBH never performed a written analysis of where patients in its proposed service area are currently receiving their psychiatric care. (*Id.*) No health planning analysis of any sort was done to support SBH’s service area.
- At the same time that SBH was presenting a service area to the Agency that excluded Washington County, SBH’s internal financial projections – setting forth the financial rationale and anticipated return on investment for the proposed

project – identified a service area that included Johnson City and Washington County. (Initial Order, pp. 4-5, ¶ 12).

- SBH’s proposed catchment area for its internal business analysis is similar to the service area MSHA argued at trial is appropriate for CON purposes. (Initial Order, p. 5, ¶ 12). Contrarily, SBH executives never used the application’s proposed service area as a basis for evaluating the financial return on investment for the project.

SBH does not dispute that this “process” occurred - SBH’s brief focuses only on the post hoc rationales presented by SBH’s litigation-retained health planner as to why excluding Washington County was reasonable.

Despite the blatant conflict between what SBH viewed as its service area internally and the service area declared in the application, the Administrative Judge found that an applicant can devise its service area however it chooses:

MSHA questions the process SBH used in formulating its SBHK CON request. However, the need criterion of the Agency in weighing a CON does not prescribe a certain protocol to be followed in developing an application. The applicant must demonstrate a need for a project and satisfy the other statutory criteria for the grant of the CON by the Agency.

(Initial Order, p. 28, ¶ 8). The Administrative Judge held that the Agency’s rules and regulations do not establish a method for deriving a service area and that so long as the quantitative need criteria are met, the underlying rationale for the service area should not be considered.

Any evaluation of the need for new psychiatric resources in the Tri-Cities must include consideration of the 84-bed Woodridge Hospital in Johnson City, which is the primary psychiatric provider for every county in SBH’s proposed service area. The Administrative Judge erred in disregarding these existing community assets, especially in light of the uncontroverted evidence that those resources were excluded by SBH solely to increase the chances of CON approval. The Agency should review the Initial Order to evaluate SBH’s process for defining its service area and the reasonableness of such service area.

II. SBH FAILED TO OFFER SPECIFIC EVIDENCE ESTABLISHING ANY DIFFICULTIES ACCESSING MENTAL HEALTH SERVICES IN THE TRI-CITIES

Even if the Agency accepts the proposed service area as reasonable, SBH provided no evidence at trial that there is an actual need for additional psychiatric services in the Tri-Cities, let alone a new 72-bed hospital. The 172 psychiatric beds in the Tri-Cities operated at 64% occupancy in 2013, demonstrating that capacity exists in the community. (Initial Order, p. 15, ¶ 42). SBH did not call as a witness a single patient or medical provider practicing in the Tri-Cities to testify that there are any access issues. Similarly, SBH provided no evidence that a significant number of patients from its service area are out-migrating (leaving the region for treatment).

Unlike SBH, MHSA called two clinical providers to discuss available resources in the area – Marlene Bailey, the Director of Behavioral Health Programs at Woodridge, and Dr. Randall Jesse, the Senior Vice President of Specialty Services at Frontier Health, the leading outpatient psychiatric service provider in Upper East Tennessee and Southwest Virginia. (Initial Order, p. 15, ¶ 42). Ms. Bailey testified that Woodridge is meeting the current needs of patients and providers in the region, that Woodridge has implemented numerous process improvements to increase efficiencies, and that its deferral rates have been reduced by half in the last two years. (*Id.*) Moreover, Woodridge continues to excel in quality control measures including outstanding patient satisfaction surveys and very low restraint rates. (*Id.*)

Dr. Jesse spoke at length about the various outpatient psychiatric and outreach services that Frontier has developed across the Tri-Cities. Dr. Jesse also testified regarding Frontier's construction of a 12-bed Crisis Stabilization Unit ("CSU") for adolescents in collaboration with MHSA. (Initial Order, p. 16, ¶ 45). A CSU is a non-hospital facility offering 24-hour, 7-days a week, intensive behavioral health treatment geared towards assessment, evaluation, early

intervention, and stabilization within a 72 hour time period. (*Id.*) While patients in a CSU can have the same or similar level of severity of psychiatric illness as an inpatient unit, care provided in a CSU setting tends to be less costly than an inpatient stay both in daily cost as well as overall cost due to shorter length of stay. (*Id.*) Both Dr. Jessee and Dr. Harsh Trivedi, the Chief Medical Officer of Vanderbilt Behavioral Health, described how the CSU will help alleviate any periodic capacity constraints in the Tri-Cities once it opens. (Initial Order, p. 17, ¶¶ 46, 47).

The focus of the Initial Order is whether the Applicant meets the quantitative criteria of the State Health Plan formula. The Initial Order does not engage the evidence regarding the existing mental health resources in the Tri-Cities, or the utter lack of testimony from patients or providers having difficulty accessing care. Similarly, the Initial Order fails to evaluate the impact the creation of the CSU will have on inpatient demand.

SBH failed to demonstrate a lack of access to psychiatric services in the region justifying the creation of a new 72-bed psychiatric hospital. The evidence demonstrated that Woodridge has taken and continues to take steps to provide additional community resources to increase availability of inpatient beds, including the joint venture with Frontier Health to establish a CSU for children and adolescents. SBH's proposed Project will simply duplicate existing psychiatric services and will harm existing health care providers.

III. The Economic Impact On Woodridge Is Contrary to the Orderly Development of Health Care

Woodridge serves a critical role as a safety-net hospital for psychiatric patients in the Tri-Cities. In 2012, the State closed the Lakeshore Mental Health Institute, the public mental health hospital for East Tennessee. Woodridge volunteered to accept those patients who would have otherwise been treated at Lakeshore and since 2012, Woodridge has provided care for over 3,000 chronically mentally ill and uninsured patients. (Initial Order, p. 13, ¶ 31).

SBH has no intention to serve these indigent patients. SBH has had no conversations with representatives from the State about caring for the indigent patients formerly served at Lakeshore. (Initial Order, pp. 22-23, ¶ 61.) SBH executives admitted that, in SBH's opinion, these indigent patients should continue to be served at Woodridge (*Id.*) Moreover, while SBH claimed in its application that it would admit 70 charity care patients annually, even these minimal projections were proven at trial to be inflated. (Initial Order, p. 23, ¶ 62). Based on audited financials produced in discovery, SBH admitted only 150 indigent patients in all 8 of its existing hospitals in 2014, slightly more than one half of one percent (.053%) of its total patient population. (*Id.*)

Given SBH's location in the middle of Woodridge's service area, it is undeniable that many if not most of the patients admitted to SBH would be patients that otherwise would have been treated at Woodridge. Because of SBH's goal in securing only the best paying patients, MHSA's health planning expert conservatively estimated that Woodridge would lose between \$1.51 and \$1.92 million in net income each year. (Initial Order, p. 21, ¶ 57).

SBH offered no analysis to contradict these projections. Instead, SBH simply argued that Woodridge was one part of Johnson City Medical Center ("JCMC") and that because JCMC is financially stable, the loss of a few million dollars to Woodridge could be absorbed. SBH is licensed as a department of JCMC for administrative convenience. But Woodridge files its own Joint Annual Report, has its own profit and loss statement, and, most importantly, for the last few years has operated at marginal profitability. It is inconsistent with the purposes of the CON process to conclude that it is acceptable for a safety-net facility to be forced into a chronic loss position.

Alan Levine, MHSA's CEO testified at length regarding the financial challenges facing his health system. (Initial Order, p. 22, ¶¶ 59, 60). While operationally healthy, MHSA is burdened by substantial debt and faces formidable challenges. (*Id.*) The loss of at least \$1.51 to 1.91 million in contribution margin per year would represent a major challenge to the ability of Woodridge to support the full range of its current services, especially in today's environment of federal and state budgetary pressures to reduce/control health care payments. (*Id.*) An impact of this magnitude would cause serious financial stress on Woodridge and could result in the elimination or reduction of needed services or investment. (*Id.*)

The CON process is not designed to insulate healthcare providers from competition. The Agency, however, has sought to protect the safety-net providers of Tennessee – those institutions that provide the necessary community healthcare services regardless of the patients' ability to pay – from duplicative projects designed only to cherry-pick the well-insured patients. The Initial Order is contrary to the Agency's policy objectives and there is a compelling reason for the Agency to exercise its discretion to review the Initial Order.

CONCLUSION

For the foregoing reasons, MHSA respectfully requests that the Agency accept review of the Administrative Judge's Initial Order dated February 8, 2016.

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Respectfully Submitted,



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CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing has been served by U.S. Mail, postage prepaid, to the following:

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this 13th day of April, 2016.

