

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

IN THE MATTER OF:)	
)	
SBH-KINGSPORT, LLC)	Docket No. 25.00-126908J
)	
Applicant,)	
)	
v.)	
)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,)	
)	
Respondent,)	
)	
and)	
)	
MOUNTAIN STATES HEALTH ALLIANCE,)	
)	
Intervenor.)	

**MOUNTAIN STATE HEALTH ALLIANCE’S BRIEF IN SUPPORT OF
PETITION FOR REVIEW OF INITIAL ORDER**

The Health Services and Development Agency (“HSDA”) should enter a Final Order denying the application of SBH-Kingsport, LLC (“SBH”) for a certificate of need to construct a new 72-bed inpatient psychiatric hospital in Kingsport.

A new psychiatric hospital is simply not needed in the Tri-Cities. Existing inpatient psychiatric facilities are only 63% full. In this contested case, no area resident, psychiatrist, psychologist, nurse, clinical provider, government official, or law enforcement representative has testified that the region’s supply of inpatient psychiatric beds is insufficient today. To the contrary, the only witnesses in this case who actually provide health care in the area do not believe this project is needed. In fact, existing providers are investing resources into outpatient

and clinic-based care to *reduce* the demand for inpatient psychiatric hospitalization, which is the most restrictive and least desirable form of care.

In an effort to circumvent this lack of need for a new hospital, SBH intentionally gerrymandered its proposed service area to create the false appearance that there is a need under the State Health Plan formula. SBH's unrealistic service area excludes Washington County, which has 150,000 residents and is directly contiguous to Sullivan County, and excludes consideration of existing psychiatric resources, primarily Woodridge Hospital ("Woodridge") in Johnson City, which is the largest provider of psychiatric care 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 formula.

Additionally, a new psychiatric hospital in Kingsport would not contribute to the orderly development of healthcare in the Tri-Cities. Woodridge, as the safety-net hospital for patients in the region, plays a vital role in serving indigent patients. SBH admits it plans to target well-insured patients, while leaving charity and indigent care to be served by Woodridge. The proposed SBH hospital will cause Woodridge serious financial stress, which could result in the elimination or reduction of needed services or investment.

In the Initial Order, the Administrative Judge reversed the HSDA's decision to deny SBH's application. As noted above, the Administrative Judge heard no evidence from any Tri-Cities residences asking for the Project. Instead, the Administrative Judge accepted SBH's proposed service area, despite the fact that it was inconsistent with historical patient trends and despite SBH's internal analysis of where its patients would come from. After accepting SBH's service area, the Administrative Judge simply applied the State Health Plan's need formula

without giving proper weight to the care that existing providers are currently offering in the community. Moreover, the Administrative Judge approved the Project even though he acknowledged that it would result in a potential annual loss of \$1.5 million by Woodridge, the safety net provider of inpatient psychiatric care in Northeast Tennessee.

As the Tennessee Court of Appeals recently held, “Courts defer to the decisions of administrative agencies when they are acting within their area of specialized knowledge, experience, and expertise.” *Covenant Health v. Tenn. Health Servs. & Dev. Agency*, 2016 WL 1559508, at *3 (Tenn. Ct. App. Apr. 14, 2016) (citations omitted). Here, the HSDA has the opportunity to bring its specialized knowledge, experience, and expertise to bear in its review of the Administrative Judge’s Initial Order, which contradicts the Agency’s Rules, the Agency’s long-standing practices, and the purpose and intent of the State Health Plan. The proposed 72-bed psychiatric hospital is not needed and would not contribute to the orderly development of health care. The Administrative Judge’s Initial Order should be reversed and the HSDA should enter a Final Order consistent with its initial decision denying this application.

I. The Project Is Not Needed

Typically, in a contested case proceeding where an applicant seeks to establish a new facility in a community, representatives, stakeholders, and residents from the service area clamor in support of the need for that service, particularly where it is claimed that the current providers are not providing adequate services. Here, SBH did not present a single Tri-Cities resident to testify in support of its Project. No local government officials claimed there was a need for a new 72-bed psychiatric hospital. No doctors testified that they had trouble getting patients

admitted to existing inpatient facilities.¹ No law enforcement officers testified that they were struggling to place involuntary commitments using existing resources. This is particularly telling in light of the fact that the contested case process allows for affidavits to be submitted in lieu of in-person testimony. *See* Tenn. Code Ann. § 4-5-313(2). SBH did not file any such affidavits in support of its application.

On the other hand, MHSA called three medical care providers to testify – all of whom confirmed that the existing psychiatric health care model in the Tri-Cities is working well and meeting the needs of the current population.

A. Woodridge and Other Existing Providers Are Meeting the Needs of the Community

There are six providers of inpatient psychiatric care within 45 miles of Kingsport. These providers are geographically well-dispersed throughout the Tri-Cities region and are currently 63% full. Woodridge is an 84-bed facility in Johnson City, only 25 miles from Kingsport,² which treats over 4,000 inpatients annually. (Tr. Vol. 5, p. 001410-1414; Ex. 250, p. 001666). Marlene Bailey, the Director of Behavioral Health Programs at Woodridge, where she has worked for the last 26 years, testified that these existing providers are meeting the psychiatric care needs of the Tri-Cities region. (Tr. Vol. 3, p. 001087-1089). Over the last few years, Woodridge has implemented numerous process improvements to increase clinical efficiencies. (Tr. Vol. 3, p. 001115). As a result, Woodridge's deferral rates have been reduced by half in the last two years. (*Id.*) Additionally, Woodridge continues to excel at quality control measures

¹ SBH did call Dr. Hal Elliott, a former director of the ETSU psychiatry residency program. (Tr. Vol. 1, p. 000658). At the time he testified, Dr. Elliott had left the Tri-Cities and was en route to his new home in Michigan, stopping in Nashville to testify before driving out of state permanently. (*Id.*) Dr. Elliott offered several opinions about deficiencies in the psychiatry residency program at ETSU (his former employer), but had nothing to offer that supported the need for a new 72-bed hospital in Kingsport.

² SBH's health planning expert concedes that a 1-hour drive time is a reasonable standard for inpatient psychiatric care. (Tr. Vol. 2, pp. 000987-988).

including outstanding patient satisfaction surveys and very low restraint rates. (Tr. Vol. 3, p. 001113).

SBH's health planning expert, Dan Sullivan, argued that there were "access issues" because Woodridge operates at or near 85% capacity, and is full on a handful of occasions annually.³ Mr. Sullivan's superficial analysis, however, ignored that Woodridge has made efforts to solve any temporary capacity issues, and there are other providers in the region with plenty of capacity when Woodridge is full.

Ms. Bailey explained that when Lakeshore, the public psychiatric hospital for East Tennessee, closed in mid-2012, Woodridge volunteered to become the primary provider for patients who typically would have been cared for in State psychiatric hospitals. (Tr. Vol. 3, p. 001096-1100). Unsurprisingly, Woodridge required time to adjust to an increase in patient census and to an increase in the acuity of the patients who were previously being treated at Lakeshore. (Tr. Vol. 3, p. 001105-1106). This transition caused occasional operational issues which resulted in lag between patients presenting for psychiatric treatment and admission to Woodridge. (*Id.*)

But beginning in late 2012 through today, Woodridge efforts to increase efficiencies and remove barriers to access have solved many of the issues associated with the closing of Lakeshore. (Tr. Vol. 3, p. 001107-1110). For instance, in 2013, Woodridge initiated a LEAN process review to transform the manner in which it triaged, evaluated, and admitted psychiatric patients from local emergency rooms into its facility. (*Id.*) As a result of these process improvements, Woodridge has seen a steady decrease in the number of patients who had to be deferred because of the lack of an available bed. (*Id.*)

³ While SBH critiques Woodridge as being too full because it has recently operated at 85% capacity, SBH concedes that its goal is to operate at 85% capacity. (Tr. Vol. 1, pp. 000772-773).

Ms. Bailey further explained that deferrals at Woodridge do not mean that its patients are not receiving excellent care. (Tr. Vol. 3, p. 001105-1106). If a patient is listed as “deferred,” it simply means that Woodridge cannot take that patient at that particular moment in time for a variety of reasons.⁴ (Tr. Vol. 3, p. 001105-1106). Deferred patients often are admitted to Woodridge later on in the day after morning discharges occur. (Tr. Vol. 3, p. 001106-1107). If a bed does not open at Woodridge, the deferred patient can be transferred to another available bed in the Tri-Cities region for care. (*Id.*) While a patient is deferred, they continue to receive psychiatric treatment in a hospital setting until an appropriate psychiatric bed becomes available. (Tr. Vol. 3, p. 001115-1116, Tr. Vol. 4, p. 001381-1382). In a cooperative manner, Woodridge and its partners are working to meet the needs of the community and ensuring that patients promptly are receiving appropriate psychiatric care.

B. Existing Psychiatric Providers Are Partnering Together To Improve Outpatient Psychiatric Services and Avoid the Need for Inpatient Hospitalization

In addition to its robust inpatient capabilities, the Tri-Cities region also has plenty of outpatient psychiatric services: Dr. Randall Jesse is the Senior Vice President of Specialty Services at Frontier Health, which is the leading outpatient psychiatric service provider in North East Tennessee and Southwest Virginia. He testified in opposition to the SBH application. Dr. Jesse spoke at length about the various outpatient psychiatric and outreach services that Frontier has developed across the Tri-Cities. Dr. Jesse described the network of outpatient clinics that Frontier has established to meet the treatment needs of the community.

Dr. Jesse also testified regarding Frontier’s construction of a 12-bed Crisis Stabilization Unit (“CSU”) for adolescents in collaboration with MHSA. A CSU is a non-hospital facility

⁴ Patients are often deferred for medical reasons – they are in a medical condition that cannot be treated in a psychiatric unit. (Tr. Vol. 3, 001105-1106). Once that medical condition clears, those patients are often reevaluated by Woodridge’s response team and admitted at that time. (*Id.*)

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 expensive than an inpatient stay both in daily cost as well as overall cost due to shorter length of stay. (*Id.*) Dr. Jesse described how the CSU will help alleviate any periodic capacity constraints in the Tri-Cities once it opens.

To further assist Frontier Health in its community based approach, MSHA recently announced a task force to explore expanding treatment options for mental health and addiction. (Tr. Vol. 5, pp. 001416-1417). The Quillen Psychiatric Department at East Tennessee State University has accepted responsibility for performing an analytics-driven mental health assessment that will determine the actual psychiatric needs of Northeast Tennessee and Southwest Virginia. (Tr. Vol. 5, pp. 001436-1437). The task force will identify areas where MSHA and Frontier can invest together to add additional community-based psychiatric services. (*Id.*)

Dr. Harsh Trivedi, 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, also testified in opposition to SBH's project. (Tr. Vol. 4, pp. 001358-1359). 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. (Tr. Vol. 4, p. 001369). Patients do not want to be locked in an institution or deprived of their civil liberties, nor should that be the goal of the psychiatric health system. (*Id.*) From a health planning perspective, the appropriate goal is to replace inpatient psychiatric care with outpatient alternatives to ultimately

reduce the necessity of inpatient beds. (Tr. Vol. 4, p. 001369; Tr. Vol. 4, pp. 001250-1251). In Dr. Trivedi's opinion, the further commitment of resources to inpatient psychiatric beds, as SBH has proposed in its application, is an unsound health planning strategy, and is contrary to the orderly development of the psychiatric service community in the Tri-Cities. (Tr. Vol. 4, pp. 001383-1384).

While SBH repeatedly cited comments made by MHSA's CEO, Alan Levine, that the Tri-Cities region disproportionately suffers from mental health issues, that statement did not mean that there was a need for additional inpatient beds. (Tr. Vol. 5, pp. 001414-1415). Instead, MHSA is focusing on an analytics-based approach to determine what gaps in service may exist and how best to push effective outpatient psychiatric services into the communities. (*Id.*) This community-based analysis with involvement of key stakeholders is the opposite of SBH's strategy, i.e., the assumption that one-size fits all and simply doubling down on centralized inpatient beds as the appropriate solution to any limited service gaps that may exist in the region. (Tr. Vol. 5, pp. 001416-1417). MHSA performs annual community health assessments of Sullivan and Washington Counties. (Tr. Vol. 4, p. 001354; Tr. Vol. 5, p. 001416). In the course of those community health assessments, no stakeholder has communicated that there is a need for a new 72-bed inpatient hospital for psychiatric services in the Tri-Cities. (Tr. Vol. 4, 001354; Tr. Vol. 5, p. 001416).

The existing psychiatric care model in the Tri-Cities is working. SBH failed to demonstrate that there is a lack of access to psychiatric services in the region justifying a new 72-bed psychiatric hospital. At most, SBH proved that there are transient operational bed shortages during peak times of demand. There are far more economical and efficient ways of addressing any such suggested shortages than simply creating significantly more inpatient beds.

The evidence demonstrated that Woodridge and Frontier Health have taken steps to provide additional community resources, including the Crisis Stabilization Unit for adolescents, which will create functional bed capacity. Moreover, the development of outpatient services will reduce the necessity of inpatient hospitalization for many patients.

The Administrative Judge's Initial Order is virtually silent as to the changing clinical landscape in the Tri-Cities. The Administrative Judge did not evaluate the need for a new 72-bed psychiatric hospital in the context the testimony of clinical providers in the community – Dr. Jesse is barely mentioned despite having the most clinical experience of any witness in the contested case hearing. Unlike the Administrative Judge, the Agency should look beyond the mere application of the bed need formula to determine whether there is a need for a new provider.⁵ That is particularly true where the new provider will disrupt existing providers serving vital roles in the state's health care system. The proof at trial established that existing providers are rendering the necessary psychiatric care in the Tri-Cities community and there is not a need for a new 72-bed psychiatric hospital.

II. The Claimed Service Area Is Not Reasonable

Without any local residents, doctors or other healthcare providers testifying in support of its Project, SBH relied solely on the State Health Plan's population-based need formula – 30 psychiatric beds per 100,000 population. In order to make the formula produce the desired result, SBH claimed a service area of Sullivan County and Hawkins County in Tennessee and Scott, Lee and Wise Counties in Virginia. The contested case showed, however, that SBH created this service area for CON purposes only. SBH knew that if it included Washington County and its 84-bed psychiatric hospital in its service area the bed need formula would not

⁵ As noted below, however, if a reasonable service area is applied to the Project, there is no need for a new 72-bed psychiatric hospital under the quantitative criteria either.

justify a new 72-bed psychiatric hospital next door in Kingsport. 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. This creative gerrymandering circumvents the spirit and the letter of the HSDA's rules and undermines the CON process.

Any evaluation of the need for new psychiatric resources in the Tri-Cities must include Woodridge, 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.

A. The Contested Case Showed that SBH's Own Analysis and Plans Contradict Its Proposed Service Area

In the summer of 2012, SBH asked a statistician to evaluate 95 potential expansion markets across the United States where SBH might want to construct a new psychiatric hospital. (Tr. Vol. 1, p. 000732-734; Ex. 6, pp. 001547-1559). The statistician prepared a series of spreadsheets in connection with this assignment. (*Id.*) One of the 95 potential locations evaluated by SBH was "Johnson City, Tennessee." (Tr. Vol. 1, p. 000734-735; Ex. 6, pp. 001547-1559). Johnson City ranked 34th out of 95 potential locations in terms of overall bed need, and 25th out of 95 in terms of unmet bed need. (Tr. Vol. 1, p. 000737-739; Ex. 6, pp. 001547-1559). In calculating bed need for these 95 locations, the statistician was instructed by SBH leadership to consider all existing psychiatric beds within a 60 mile radius (Woodridge is within 25 miles of all major Tri-Cities population centers). (*Id.*)

From these 95 locations, the statistician identified the top 27 potential locations, which he analyzed further. (Tr. Vol. 1, p. 000740-741; Ex. 6, pp. 001547-1559). The additional analyses ranked each potential location using weighted scores for a number of categories. In this analysis,

the location for the potential Johnson City project (now described as the “Tri-Cities”) scored at or below the median in every category except for building costs (10th cheapest out of 27) and staffing costs (2nd cheapest out of 27). (*Id.* at 000743-746; Ex. 6, pp. 1551, 1552). On the other hand, SBH determined that the Tri-Cities region had plentiful access to psychiatric services with robust competition among providers. For example, the Tri-Cities area was 23rd out of 27 regions for “Market Demand” which gauged bed need. (Tr. Vol. 1, p. 000741-743; Ex. 6, p. 1549). The Tri-Cities area was ranked 21st out of 27 regions for “Competition,” which gauged the number and diversity of existing providers. (*Id.* at 000743; Ex. 6, p. 1550). In the final weighted analysis, the Tri-Cities ranked 15th out of 27 potential locations for a new psychiatric hospital. (*Id.* at 000741; Ex. 6, p. 1547). In early September 2013, SBH leadership chose to proceed with the Project, not because its analysis had uncovered any need for additional psychiatric services in the Tri-Cities, but because the Project would be financially lucrative – staffing in the Tri-Cities was plentiful and cheap and construction costs were low. (Tr. Vol. 1, p. 000622-623).

Initially, SBH planned to build a new hospital in Johnson City. (Tr. Vol. 3, p. 001071). In fact, on October 1, 2013, SBH submitted an application for economic development incentives from the Johnson City Industrial Bond Board. (Tr. Vol. 1, p. 000747-749; Ex. 380 p. 002626-2629; Tr. Vol. 3, p. 001071). SBH never submitted a similar application to the Kingsport government. (*Id.*) In early October, SBH made its only visit to the Tri-Cities prior to filing its application. (Tr. Vol. 1, p. 000750-754; Ex. 14, p. 001778-1781). While there, they met with seven people, six of whom worked in Johnson City. (Tr. Vol. 1, p. 000750-754; Ex. 14, p. 001778-1781).

Despite focusing all of its due diligence on Johnson City, less than a month before filing its application, SBH executives decided to switch the site of the proposed new hospital to

Kingsport instead of Johnson City. SBH did not create a single document analyzing or setting out the need for a new psychiatric hospital in Kingsport versus the case for need in Johnson City. (Tr. Vol. 3, p. 001072) SBH did not analyze how the service area for a Kingsport hospital would differ from a Johnson City hospital. Instead, SBH moved the Project from Johnson City to Kingsport for CON purposes, and in an effort to avoid a “political war with Mountain States.” (Tr. Vol. 3., p. 001077; Exhibit 378, p. 002598). As stated in an email from SBH leadership:

You will notice that we have switched the physical location of the project from Johnson City to Kingsport in an attempt to avoid Mountain States Health Alliance from contesting our application.

(Tr. Vol. 3, p. 001073; Ex. 325, p. 2596).

SBH filed its application for a CON in December 2013, less than 60 days after the company first visited the Tri-Cities. (Ex. 9, p. 001596-1747). The CON application not only moved the location of the hospital to Kingsport, but SBH’s service area now excluded Johnson City and Washington County and instead claimed a number of rural Virginia counties to the Northwest of the Tri-Cities. (Ex. 9, p. 001596-1747).

In other words, although the project had initially been planned for Johnson City, and although all of SBH’s internal analyses had looked at need in terms of the Tri-Cities area as a whole, including evaluation of all existing beds in a 60-mile radius, Washington County and Woodridge were hardly mentioned in SBH’s application. SBH claimed a service area that included a larger area in Virginia than in Tennessee. The claimed service area reached two counties beyond Sullivan County into Virginia, but inexplicably excluded counties to the south that were immediately contiguous to Sullivan County, including Washington County (Johnson City). Consistent with SBH’s plan to “avoid Mountain States Health Alliance from contesting our application,” 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.

Typically, CON applicants present assumptions in an application that divide the service area 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. (Tr. Vol. 4, pp. 1230-1231). In this instance, SBH did not provide any projections of how many patients would come from any particular county or zip code within its claimed service area. (Tr. Vol. 4, pp. 001230-1231). In choosing its service area, SBH never examined historical patient origins for existing medical providers in Kingsport to extrapolate a reasonable proxy for its own service area. (Tr. Vol. 3, pp. 001078-1079; Tr. Vol. 4, p. 001241). SBH never performed a written analysis of where patients in its proposed service area are currently receiving their psychiatric care. (Tr. Vol. 3, p. 001079). SBH never determined where its volumes would originate. (Tr. Vol. 3, p. 001080). SBH did not engage a health planning expert to assist in determining a reasonable service area for the application. (Tr. Vol. 3, p. 001079; Tr. Vol. 2, p. 000966-968).⁶ In other words, none of the rationales presented at trial by SBH's litigation-retained health planner were ever actually used by the Applicant to determine a reasonable service area. (Tr. Vol. 4, p. 001241).

Although SBH's claimed service area in its application excluded Washington County, for internal purposes SBH continued to evaluate the Project in the context of the larger Tri-Cities region. For example, on January 10, 2014, at the same time SBH was presenting a service area to the Agency that excluded Washington County, SBH executives made an internal presentation to representatives of the company's investors setting forth the financial rationale and anticipated

⁶ SBH's litigation expert, Dan Sullivan, had previously performed health planning work for SBH. (Tr. Vol. 2, 000966-967). SBH never contacted Mr. Sullivan prior to filing its application. (*Id.*)

return on investment for the proposed Project. (Tr. Vol. 1, p. 000759-769; Ex. 10, p. 001748-1763). As part of the proposal, SBH identified a service area which included Johnson City, Washington County, and Woodridge. (*Id.* at p. 000763-766; Ex. 10, p. 001753). SBH further identified its “immediate market” as the area within 25 miles of the facility that included Woodridge, and two other psychiatric providers, Ridgeview Pavilion and Magnolia Ridge. (*Id.* at p. 000767-768; Ex. 10, pp. 001755-1756). SBH’s proposed service area used for its internal business analysis is nearly identical to the service area MSHA has argued is appropriate for CON purposes. (Ex. 381, Map 8 p. 002672). On the other hand, the SBH executives never used the service area in the CON application as a basis for evaluating the financial return on investment for the project. (*Id.* at p. 000768-769; Ex. 10, p. 001748-1763).

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 p. 000485). 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 Woodridge and other area providers who are currently treating the population SBH claims to serve. The Administrative Judge erred in disregarding these existing community assets,

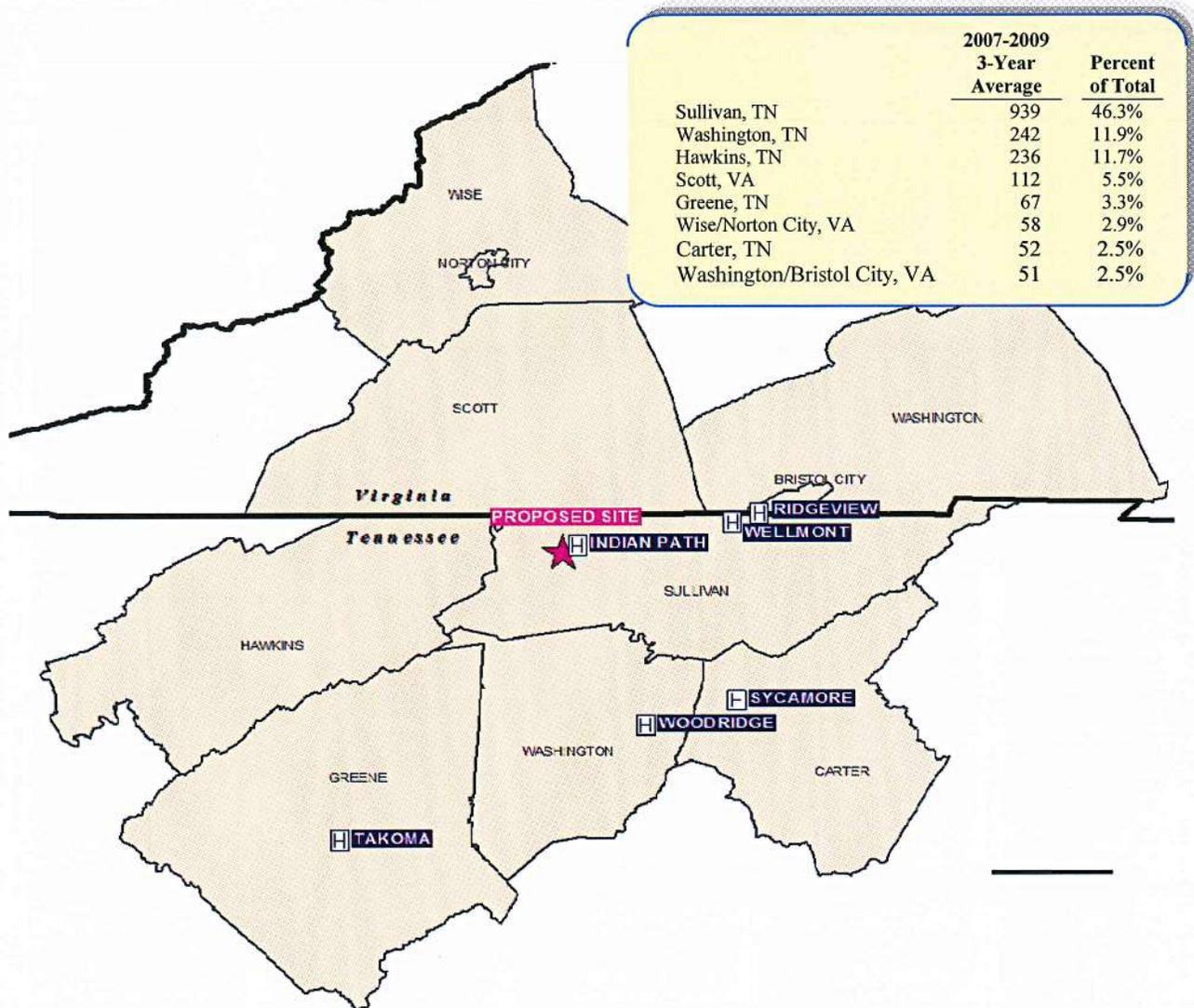
especially in light of the uncontroverted evidence that those resources were excluded by SBH solely to increase the chances of CON approval.

B. The Rationalization For the Project Offered By SBH's Litigation Expert Is Simply Not Credible

SBH did not perform any health planning analysis to determine a reasonable service area to be used for its Project. As discussed above, SBH's proposed service area was intended to manipulate the State Health Plan and to avoid opposition from other existing psychiatric providers in the region. At the contested case hearing, SBH's litigation expert, Mr. Sullivan, attempted to create a "reasonable" explanation for the proposed Project after the fact. Mr. Sullivan's rationales are not credible.

Mr. Sullivan argued that SBH's service area excluding Washington County was reasonable because Indian Path Medical Center, an acute care hospital operated by MHSA in Kingsport, also has excluded Washington County from its service area in Community Health Needs Assessments published on MHSA's website. (Tr. Vol. 2, p. 000829-830). Mr. Sullivan's position is based on a false premise – the Community Health Needs Assessments were never intended to identify "service areas" in the context of the State Health Plan. MHSA's CEO specifically testified that the "markets" set forth in the assessments were for internal administrative purposes, not for a Certificate of Need planning. (Tr. Vol. 5, pp. 1455-1457.) Mr. Sullivan's position is further undermined by his concession that acute care hospitals like Indian Path Medical Center are localized in nature and, thus, typically have smaller service areas. (Tr. Vol. 2, p. 000971). Psychiatric services, on the other hand, are more regional in nature, with much broader geographic service areas. (Tr. Vol. 2, p. 000972). In fact, there are currently only 15 freestanding psychiatric hospitals in Tennessee. (*Id.*)

The more appropriate proxy to use in evaluating SBH's proposed service is Indian Path Psychiatric Pavilion, the previous 61-bed psychiatric hospital in Kingsport that operated until 2009, when it was closed due to lack of demand. (Tr. Vol. 4, p. 001240-1242, Ex. 381, pp. 002630-2697). Geographically, the two facilities are located less than a mile apart. (Tr. Vol. 4, p. 001240-1242, Ex. 381, pp. 002630-2697). Indian Path Pavilion was a full-service psychiatric hospital with a similar size to SBH's Project. (Tr. Vol. 3, p. 001092-1093). Moreover, Indian Path Pavilion primarily targeted commercially insured and other profitable payer mixes similar to SBH's proposed business plan. (Tr. Vol. 3, p. 001092-1093). Located essentially next door to the proposed SBH facility, Indian Path Pavilion provides a comparative snapshot for what the true service area for a psychiatric hospital located in Kingsport would look like. The map below shows the Indian Path Pavilion service area for its last three years of operation:



Not surprisingly considering its geographic proximity, Washington County was the second highest county of origin for patients at Indian Path Pavilion, accounting for almost 12% of admissions over its last three-years of operation. (Tr. Vol. 4, p. 001238-12407, Ex. 381, Map 8, p., 002672). Washington County patients exceeded those from Hawkins, Scott, Wise, and Lee Counties, all of which SBH included in its service area. (*Id.*) In fact, more patients originated from Washington County than Scott, Wise and Lee Counties combined. (*Id.*)

Indian Path Pavilion’s service area is also not surprising because, historically, there has always been a demonstrable flow of patients between Washington and Sullivan counties for health services, including psychiatric services. (Tr. Vol. 4, p. 001236). For example, in 2014,

24.9% of patients admitted to Woodridge were from Sullivan County, which represented the second highest volume from any one county. (Tr. Vol. 4, p. 001236). Patients residing in other counties claimed as the service area by SBH also utilize Woodridge; in fact over a three-year period, residents of the SBH claimed service area constituted 36% of Woodridge's inpatients. (Tr. Vol. 4, p. 001236).

The free movement of patients between Sullivan and Washington County would likely continue if SBH's Project is approved. This is especially true considering that Washington County is experiencing more growth than Sullivan County. (Tr. Vol. 4, p. 001236-1237). Specifically as it relates to child and adolescent patients – a principal focus of SBH's proposed Project – Washington County is the only county in the area with a growing pediatric population, while Sullivan County has a projected 20 percent decline. (Tr. Vol. 4, p. 001236-1237; Tr. Vol. 5, p. 001423-1424). Furthermore, thousands of people living in Washington County live in closer proximity to the new SBH facility than Woodridge. (Tr. Vol. 2, p. 000983; Tr. Vol. 4, 001274-1275).

The Administrative Judge's determination that SBH's proposed service area is reasonable is contrary to the historical patient utilization patterns in Upper East Tennessee, the close economic and other ties among the Tri-Cities, SBH's own internal planning documents, and the history of this project. It is clear that a new psychiatric hospital in Kingsport would admit a substantial number of patients that otherwise would have been seen at Woodridge, including patients from Washington County and from other counties in Woodridge's service area. SBH's claimed service area is arbitrary, and was developed only in the hope of facilitating CON approval, and should be rejected by the Agency.

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

Although the CON process is not designed to insulate health care providers from any competition, the Agency has always sought to preserve the health of safety-net providers. The Agency has been justifiably skeptical of projects that offer only duplicative services and seem designed to cherry-pick well-insured patients to the detriment of these existing providers.

Woodridge serves a critical role as the safety-net hospital for psychiatric patients in the region. (Tr. Vol. 3, pp. 001090-1091). When Lakeshore closed, Woodridge made the commitment to provide mental health services to uninsured patients who otherwise would have no access to care. (Tr. Vol. 3, pp. 001096-1100). Although Woodridge receives a grant from the State for these services, the grant covers substantially less than the costs associated with treating grant eligible patients. (*Id.*) The grant with the State of Tennessee is reviewed annually for renewal and is subject to change and reduction without notice. (*Id.*) Furthermore, when Woodridge sees more indigent patients than are covered by the grant amount (which has occurred every year), Woodridge must petition the State to cover the remaining costs. (*Id.*)

By contrast, SBH proposes to serve very few uninsured patients—the application projects only 70 charity care patients annually, while Woodridge served more than 1,250 such patients in FY 2014. (Tr. Vol. 4, pp. 001258-1261). Even this minimal participation by SBH to serve medically indigent patients, however, was called into question by evidence presented at trial. (Tr. Vol. 4, pp. 001258-1261). In written discovery, MHSA asked SBH to identify the percentage of charity and indigent patients that SBH treats at its existing operational facilities. Instead of providing a direct response to the straightforward question, SBH suggested 4.5 percent of its patients are “uncompensated.” (Tr. Vol. 1, pp. 000727-728). SBH’s definition of “uncompensated” care, however, includes bad debt, denials, and administrative adjustments, i.e.

patients with commercial insurance who were treated, but were later denied coverage. (Tr. Vol. 1, p. 000727-728). When an independent auditor reviewed SBH's 2014 financials, however, 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." (Tr. Vol. 2, p. 000799-800; Exhibit 79, p. 001922, n. 8). No explanation was given for why SBH did not produce the requested charity care information in discovery. (Tr. Vol. 4, pp. 001259-1260). According to the independent auditor's report, approximately one half of one percent (.53%) of SBH's expenses in 2014 was attributed to charity care. (Tr. Vol. 3, pp. 000731-732). Extrapolating this expense ratio, SBH saw 150 indigent patients in all 8 of its hospitals in the country in 2014. (Tr. Vol. 4, pp. 001258-1260).

It is uncontested that Woodridge bears, by far, the largest share of the indigent psychiatric care in the region. Furthermore, SBH expects Woodridge to continue to be the destination for indigent patients. (Tr. Vol. 3, p. 001082). SBH has not had any conversations with representatives from the State of Tennessee about caring for the indigent patients formerly seen at Lakeshore. (*Id.*) Moreover, SBH believes it makes sense for those patients to continue to be seen at Woodridge even after SBH opens. (*Id.*)

Given SBH's location in the middle of Woodridge's service area, it is obvious that many if not most of the patients admitted to SBH would be patients that otherwise would have been treated at Woodridge. Conservatively, the SBH project will result in 1,084 lost cases to Woodridge – 27% percent of its 2014 volume. (Tr. Vol. 4, pp. 001270-1274). The diversion of such a large number, including a disproportionately larger number of insured patients, from Woodridge to an SBH facility would have a significant financial impact on Woodridge, conservatively estimated at between \$1.51 and \$1.92 million in lost net income per year. (Tr.

Vol. 4, pp. 001270-1274). As SBH's utilization increases in subsequent years, the impact on Woodridge can be expected to grow.

The loss of insured patients to a new SBH facility would have severe adverse consequences to Woodridge, given that it has accepted the financial burden of uninsured patients, only partially subsidized by the State. (Tr. Vol. 5, p. 001418-1423). If the SBH facility is built in Kingsport, Woodridge would still be the only facility receiving indigent cases from SBH's Tennessee service area, but would have a much smaller base of insured patients to support its operations. (*Id.*)

The financial impact on Woodridge will be significant. (Tr. Vol. 5, p. 001418-1423). 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. (Tr. Vol. 5, p. 001418-1423). An impact of this magnitude would cause serious financial stress on Woodridge and might result in the elimination or reduction of needed services or investment. (*Id.*)

While the CON process does not create immunity from competition, it exists to prevent unnecessary duplicative services and to preclude the proliferation of new services in the absence of a genuine need. The Administrative Judge incorrectly failed to adequately weigh the impact on existing providers and the damage that a new unnecessary provider would have on the existing health care system. The Initial Order is contrary to the Agency's policy objectives and should be reversed.

Conclusion

The Agency made the correct decision when it denied the SBH application in June 2014. The Agency was right to determine that there was not a need for a new 72-bed psychiatric hospital in the Tri-Cities, that the existing providers were adequately meeting the needs of the community, and that building a new hospital would cause significant damage to Woodridge, the safety-net psychiatric hospital for the region. The Administrative Judge incorrectly reversed that decision, and misinterpreted the Agency's rules as it relates to the construction of a reasonable service area. Allowing the Initial Order to stand will undermine the Certificate of Need process and establish unacceptable precedent for future applications. The Agency should enter a Final Order that affirms its previous decision denying the CON for the SBH Project.

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CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing has been sent to the following counsel of record by the means indicated to the addresses below:

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