BEFORE THE TENNESSEE HEALTH FACILITIES COMMISSION

IN RE: **SAINT THOMAS RUTHERFORD HOSPITAL, TRISTAR STONECREST MEDICAL CENTER, WILLIAMSON MEDICAL CENTER,** ***Petitioners,***	)	**Docket No. 25.00-220022J** **CON No. CN2109-026**
v.	)	
TENNESSEE HEALTH FACILITIES COMMISSION, ***Respondent,***	)	
and	)	
VANDERBILT UNIVERSITY MEDICAL CENTER d/b/a VANDERBILT RUTHERFORD HOSPITAL, ***Intervenor.***	)	

VANDERBILT UNIVERSITY MEDICAL CENTER, D/B/A VANDERBILT RUTHERFORD HOSPITAL'S PETITION TO APPEAL INITIAL ORDER

On December 15, 2021, the Health Facilities Commission ("Commission") overwhelmingly approved a Certificate of Need ("CON") for Vanderbilt Rutherford Hospital ("VRH"), a new state-of-the-art facility in Rutherford County, one of the fastest growing communities in the nation. Thousands of Rutherford County residents now travel to Vanderbilt University Medical Center ("VUMC") for inpatient care they could receive closer to home. The proposed hospital was supported by dozens of local doctors, numerous elected officials, and thousands of Rutherford County residents, both because of the improved access VRH would

provide and because the primary existing hospital in Rutherford County—Saint Thomas Rutherford—is full and has difficulty providing timely care to patients.

The CON was appealed, and an Administrative Law Judge ("ALJ") entered an Initial Order reversing the Commission's 5-1 vote. The ALJ made numerous flawed and inappropriate legal conclusions that contradict longstanding precedent, rules, and statutes. Specifically, the ALJ:

- Exceeded her limited statutory authority by basing her decision on the grounds that the VRH presentation to the Commission in December 2021 was "false and misleading;"
- Inappropriately concluded that competition between health care providers should be discouraged—directly contrary to legislative intent and the public policy of Tennessee;
- Mistakenly concluded that the numerical formulas in the State Health Plan's need criteria should be mechanically applied, overriding the Commission's right to use its expertise and discretion to decide whether health care projects are needed;
- Disregarded evidence that Saint Thomas Rutherford is so overwhelmed that patients endure long waits for service, are frequently diverted to other facilities, are treated in hallways and closets, and otherwise lack timely access to local hospital services;
- Swept aside testimony by Rutherford County physicians that the community desperately needs additional inpatient hospital beds;
- Erroneously labeled thousands of petition signatures, letters of support, and affidavits from Rutherford County residents as a meaningless "popularity contest;" and
- Improperly determined that hospital beds in other counties, outside the proposed service area, were adequate substitutes for a new hospital needed in Murfreesboro.

The ALJ failed to apply the law correctly and created precedents that will undermine the CON process in the future. The Commission has the authority to review ALJ's initial orders in contested cases and should do so here.

OVERVIEW

The Commission approved the VRH application by a 5-1 vote. The project was opposed by Saint Thomas Rutherford, TriStar StoneCrest Medical Center, and Williamson Medical Center (the "Opponents"). The Opponents filed a contested case, the trial of which was held over ten

days beginning on December 5, 2022. In addition to live testimony, the parties submitted 26 depositions, most of which were testimony by local physicians supporting the need for the new hospital.

VRH will be a separately licensed community hospital located near the intersection of Veterans Parkway and S.R. 840, approximately eight miles from downtown Murfreesboro. It will include a licensed bed complement of 26 adult medical/surgical beds, four intensive care beds, six pediatric beds, and six obstetrical beds, along with an eight-bed observation unit and 14 emergency bays. VRH will provide both diagnostic and therapeutic cardiac catheterization services. The new facility will be a full-service hospital, offering the full spectrum of services generally found in community hospitals, including medical services such as internal medicine, urology, gastroenterology, cardiology, neurology, and oncology, as well as surgical services such as general surgery, gynecology and obstetrics, ophthalmic surgery, plastics, orthopaedic surgery, ENT, and community-level neurosurgery.

VRH is needed for three main reasons:

1. Saint Thomas Rutherford, the primary existing provider of hospital services in Murfreesboro, constantly operates at or above its capacity limits and has done so for years —before, during, and after the COVID epidemic. Local physicians, health planning experts and hospital executives testified that the patient volumes at STR have led to patients being diverted to other facilities, enduring long waits for services, and being seen in waiting rooms, hallways, closets, and other inappropriate treatment spaces.

2. VRH will offer an inpatient pediatric unit staffed by pediatric-trained providers supervised under the award-winning Monroe Carell Jr. Children's Hospital at Vanderbilt model of care. The current acute care providers in Rutherford County offer only the most basic pediatric services, requiring almost all (99%) of Rutherford County children to travel to Nashville to receive hospital care.

3. Thousands of Rutherford County residents currently travel to hospitals in Davidson County to receive care, including services that could be provided in a community

> hospital such as VRH. In fact, VUMC is the third largest provider of inpatient acute care to Rutherford County residents, despite being located 35 miles from Murfreesboro through often heavy traffic. The proposed new hospital would provide a convenient option for VUMC patients to receive appropriate hospital care closer to their homes. By admitting some patients who would otherwise be seen at VUMC, VRH will also provide increased flexibility and capacity at the downtown campus to help VUMC treat more specialized patients who require care for which VUMC is the only regional provider.

Despite the significant proof establishing these health planning rationales and the Commission's near unanimous agreement, on June 8, 2023, the ALJ entered an Initial Order denying the CON.

REASONS TO ACCEPT REVIEW

Consistent with Tenn. Code Ann. § 4-5-315, Commission Rule 0720-13-.03 provides that "[a]n Initial Order issued by an Administrative Judge, sitting alone, may be reviewed by the Commission…" For the reasons explained below, the Commission should review the Initial Order in this case.

A. The ALJ Overstepped Her Statutory Authority by Revoking the CON on the Basis that VUMC Presented False and Misleading Information to the Commission.

An ALJ has a limited role in a contested case. The ALJ sits on behalf of the Commission to determine whether the petitioner has met its burden to prove "that a certificate of need should be granted or denied" based on a preponderance of the evidence presented during the *de novo* contested case hearing. Tenn. Code Ann. §§68-11-1610, 4-5-301; Commission Rule 0720-13.01(3). In this context, "*de novo*" means that the issues are determined anew, based on the evidence presented at trial, as if there had been no prior proceeding.

It is not the ALJ's role to review or evaluate what was presented to the Commission. That power rests solely with the Commission pursuant to Tenn. Code Ann. § 68-11-1617(3): "**the Commission** has the power to revoke a certificate of need" if "the decision to issue a certificate of need was based, in whole or in part, on information or data in the application which was false,

incorrect, or misleading, whether intentional or not." (emphasis added). In other words, if the Commission issues a CON, and later concludes that an applicant provided incorrect or misleading information to the Commission to obtain the CON, then the Commission, not an ALJ, can initiate a revocation proceeding. The statutes do not delegate this power to the ALJ.

Despite the clear language of the statute, the ALJ took it upon herself to decide whether information provided by VUMC in its application or to the Commission at the December 15, 2021, meeting was "false, incorrect or misleading," and she denied the VRH CON in part on this basis. (Initial Order, pg. 30). First, to be clear, VUMC did not make "false, incorrect or misleading" statements in connection with the application and strongly disagrees with this finding. But by turning the contested case into a trial over what was presented to the Commission, the ALJ exceeded her limited authority, usurped the Commission's authority, and decided the case on the wrong grounds.

B. The ALJ's Legal Conclusions Regarding Whether VUMC Presented False and Misleading Information to the Commission Were Flawed.

Not only did the ALJ usurp the role of the Commission by "revoking" a CON under a statute that did not give her such authority, her legal conclusion that VUMC made "false or misleading," statements was incorrect. The ALJ mainly focused on three allegedly "misleading" representations:

- That at the December 2021 Commission hearing regarding VUMC's proposed new hospital in Rutherford County, VUMC did not "disclose" that it was evaluating potential options to expand its downtown Nashville campus (the Link Building Project);

- That VUMC's counsel, Dan Elrod, told the Commission in December 2021 that nurse staffing at VUMC had not been an "overwhelming challenge" during COVID; and

- That VUMC somehow should have told the Commission—in December 2021—that it was going to have an insurance dispute with Humana/Wellcare more than a year in the future.

These findings were clearly erroneous and cannot form the basis for "revoking" the CON.

1. Link Building Project

On July 25, 2022, months after the Commission's December 2021 approval of VRH, VUMC announced a substantial expansion project on its downtown campus. Initially referred to as the "Link Building" because it will connect two existing towers on VUMC's campus, the project will consist of a new building constructed around an existing antiquated administrative office building and on top of an existing garage. The existing building will then be demolished.

VUMC did not "mislead" the Commission in its application or at the December 2021 hearing by not "disclosing" the Link Building Project. At the time the VRH application was filed, the Link Building Project was still under conceptual evaluation and a final decision had not been made as to whether it would include inpatient beds and if so, how many. In fact, the evidence in the contested case demonstrated that the Link Building Project was first conceived as a medical office building. As VUMC continued to evaluate its needs, the project evolved, and it was not until April 2022 – four months after the Commission granted this CON – that the VUMC Board approved the project with the addition of 180 inpatient beds.

In its application for this CON filed in October 2021, VUMC expressly stated that "Vanderbilt continues to take all reasonable measures to expand and improve the efficiency and convenience of its downtown location..." As of the December 2021 Commission meeting, the Link Building planning process was still incomplete, with near daily changes in assumptions, financial modeling, and feasibility analyses. There was no evidence presented in the contested case that VUMC attempted to "hide" its consideration of the Link Building Project. For example,

no internal e-mails or testimony suggested that VUMC purposefully delayed announcing the expansion until after the Commission meeting about this CON or otherwise timed the planning process in any way based on the VRH CON process. Like every other large health system, VUMC is continually evaluating potential expansion projects. Most of these plans never come to fruition for a variety of reasons. Thus, the ALJ's finding that VUMC intentionally concealed the Link Building Project—during a CON for a hospital project in another county—is completely unfounded.

The Commission has established requirements for what applicants must disclose about other projects in a CON application, specifically requiring disclosure of approved and underway projects. Applicants are not required to disclose projects that are simply being evaluated, nor could an applicant effectively disclose undetermined, incomplete, and unfinalized plans in any way that would be meaningful to the Commission. The ALJ effectively adopted a new standard, far exceeding the Commission's precedent, that will require applicants, including large health care systems such as VUMC, to disclose all internal planning activities, regardless of their status, feasibility, likelihood of completion, or location, lest they run the risk of having their CON "revoked" by an ALJ later. The ALJ had no authority to do so. This misapplication of the law requires review.

2. Staffing Representation

At the December 15, 2021, Commission meeting, VUMC was asked the following question by a Commission member:

> MR. SCARBORO: Before, I had a follow up to that question. Mr. Elrod, before you leave, follow up with one question. From the -- what is the consideration -- is there concern about the pulling from staff that will be in the Nashville facility now even though they may live in Rutherford going up to Nashville? Obviously, it's always a shortage, I know, of nurses. But what's the concern there? And how is that being addressed?

In response, VUMC's counsel responded that:

> MR. ELROD: Vanderbilt main campus hospital is fully staffed now, and staffing has not been an overwhelming challenge. It's somewhat of a challenge for all hospitals, but they have made it very well through the situation and they're fully staffed. Every bed at the hospital is staffed, which is not true in a number of hospitals.

Essentially, the response contained two components – (1) that staffing during COVID had been a challenge for all hospitals, but not an overwhelming challenge for VUMC and (2) that VUMC had been able to successfully staff its inpatient hospital beds. Both statements were correct.

There was no evidence presented at the contested case or set forth in the Initial Order that as of December 2021, VUMC was not fully staffing its inpatient hospital beds. While the ALJ focused on the fact that VUMC had open clinical positions, the fact that VUMC could staff all of its hospital beds despite COVID, lends context and credence to the statement by VUMC's counsel that staffing was a "challenge" but not an "overwhelming challenge." The important metric is not whether VUMC has open positions but whether VUMC has been able to keep its hospital beds fully staffed, which it has.

3. Humana/Wellcare Negotiations

Health systems routinely negotiate with health insurance companies about the terms on which the health systems will provide care to persons who are enrolled in the insurers' plans—including the amounts to be paid for that care. Typically, the timing of these negotiations is dictated by the relevant contracts, which come up for renewal at various intervals and typically require the health system to provide advance notice of any decision not to renew the contract. Occasionally, the parties reach an impasse, and begin the process of terminating the contract. That may or may not happen depending on negotiations.

[redacted], VUMC notified Humana and Wellcare of its intent terminate its participation in those insurers' Medicare Advantage plans, effective April 1, 2023. This notice was not a final decision and both VUMC and each of the insurers expressed willingness to continue negotiations up until the proposed termination date of their respective contracts. VUMC ultimately reached a resolution with both Humana and Wellcare.

After the contested case had concluded, the Opponents submitted newspaper articles to the ALJ about VUMC's contract disputes with these two insurers, including its notices of contract termination. Even though these disputes were only tangentially relevant to the VRH CON, involved termination notices whose timing was dictated by the relevant contract, and were ultimately successfully resolved, the ALJ found that the VRH CON should be "revoked" because "[t]he timing of the decision and the failure of VUMC to be forthcoming with its decision is tantamount to providing false, incorrect, or misleading information in the CON application." The ALJ's conclusion makes no sense on its face: a contract termination notice delivered by VUMC to an insurance company [redacted] could not be a "false, incorrect, or misleading" statement in a CON application filed in October 2021, more than a year earlier. The ALJ's conclusion here further underscores her misunderstanding of her authority and the law.

C. The ALJ Erroneously Concluded that Competition Between Medical Providers Should be Discouraged—the Opposite of What Tennessee Law Provides.

In July 2021, the Legislature passed the Tennessee Health Services and Planning Act of 2021, which substantially amended the CON law by eliminating the "economic feasibility" and "orderly development" criteria and replacing them with a consumer-focused inquiry as to whether a proposed CON project would be advantageous to consumers and patients. According to the legislative history, two of the purposes of the 2021 CON Legislation were (1) to "make[] it easier

for existing and new providers to enter our health care market and compete," and (2) to evolve Tennessee's CON regime towards a position where it "is based more on the standards and the quality of care that [a party] provide[s] rather than some survey or some legal argument about why you should be in a particular community." The Legislature specifically noted that the bill was intended to "eliminate[] the protectionist aspects of CON," and added language that while the merits of any opposition will be considered, "[a] healthcare institution or other person expressing opposition to an application does not have a veto over an application."

But according to the ALJ, "[a]llowing more hospitals into a given healthcare market simply for the sake of competition shows a lack of understanding of how the healthcare system and hospitals in particular work." (Initial Order, pg. 28). Not only is the ALJ's legal conclusion contrary to the clear legislative mandate of the revised CON law, it also ignores that the mere filing of the VRH application has resulted in STR expending significant resources in an effort to compete. After STR learned that VUMC had purchased property in Murfreesboro and might be competing in that community, STR invested millions of dollars to build a "micro hospital" across the street from the proposed site of VRH. The day after VUMC filed its notice of intent to refile the VRH application on September 15, 2021, STR announced a 58-bed addition to its facility (after repeatedly insisting to the Commission that there was no need for additional hospital capacity in Rutherford County.) If the mere threat of competition spurred STR to make major investments and improvements to meet consumer needs, the actual construction of a new hospital will bring to Murfreesboro the positive effects of competition as intended by the CON law.

Although the benefits of competition must always be weighed against the need for the proposed project and any potential negative consequences to consumers, for the ALJ to completely disregard the Legislature's emphasis on promoting competition is a mistake that must be rectified.

D. Despite the Consumer Advantage Criterion, the ALJ Disparaged Thousands of Petition Signatures, Letters of Support, and Sworn Testimony from Community Members as an Irrelevant "Popularity Contest"

Following the 2021 amendments to the CON law one of the most important CON considerations is whether competition from a new provider will benefit consumers. Since the adoption of this "Consumer Advantage" criterion, community support for projects has carried greater weight. While not the only factor for meeting Consumer Advantage, Commission members have routinely cited evidence of strong community support as an indication that a proposed project would benefit consumers. In support of this application, VUMC submitted more than 6,000 online petition signatures, 39 affidavits from independent local physicians, and 184 letters of support from community members and government officials. Since the new criteria were adopted in 2021, VUMC is not aware of any project garnering as much community support as VRH. Subsequent applicants to VRH have similarly embraced submission of petition signatures and community support letters as indicia of consumer advantage.

The ALJ brushed this support aside, stating that "[t]he granting or denial of a CON application is not a popularity contest based on a number of signatures or affidavits." (Initial Order, pg. 22). This conclusion directly contradicts the Legislature's intent and the Commission's practice. The ALJ also rejected dozens of Rutherford County physicians who offered testimony in support of the project, explaining how the lack of accessible inpatient beds was affecting their patients. Instead of assessing or even discussing the substance of their concerns, the ALJ impugned the motives of these physicians, especially those of Murfreesboro Medical Clinic ("MMC"), the largest physician group in the county, suggesting that their support of the CON application was just "an ongoing effort to pit one hospital provider against another to advance its own goals." (Initial Order, pg. 26). The evidence ignored and dismissed by the ALJ included

internal emails showing the real-world implications of not having enough available hospital beds in the community, including this email by Dr. Shawn Horwitz:

> "Just some examples of what I'm talking about. One of my patients was admitted yesterday for dehydration – 24 hours later they are still in the emergency room, no fluids have been started, no one can explain why. She needs an EGD for a GI bleed – they don't know if she can get it down today because "they are too busy." On another patient, an order I put in 2 days ago has still not been completed which as a result could lead to pneumonia. This happens every day. Currently Hospital [sic] has a 25 bed hold in ED, more waiting for bed coming out of surgery. STR currently on Med/surg diversion. Meaning if one of our patients need surgery or admitted we would have to send them to ED and sit there for a day or more. Nurses are mostly new and have no idea what they are doing, taking care of way too many patients. It is literally a third world hell hole – I have never seen anything like this place…"

The MMC physicians who offered testimony in this case deserve better than to have their opinions summarily discounted.

The ALJ further ignored multiple other local physicians, unaffiliated with MMC, who also supported the need for the new hospital. While either ignoring or criticizing the motive of the doctors who testified, the ALJ failed to note that the Opposition offered ***no*** testimony from ***any*** independent doctors opposing the new hospital, even though the Opposition carried the burden of proof.

To belittle the testimony of local doctors, patients, and elected officials as a "popularity contest" is contrary consumer advantage criterion. The Commission should review this case to make it clear that, in the future, ALJs are required to evaluate such testimony thoughtfully and seriously.

E. <u>The ALJ Mechanically Applied the Discretionary Acute Bed Need Formula and Unfairly Criticized the Commission for Failing to Amend the State Health Plan.</u>

It is well-understood that the State Health Plan numerical criteria for need are discretionary ***guidelines***, not strict rules to be mechanically applied. In fact, under the Acute Bed Need formula,

essentially every county in Tennessee, including Rutherford County, has too many hospital beds. But the Commission has long recognized that determining need for new health care services is more than a mathematical calculation. The Commission routinely exercises its discretion and expertise to approve CONs even if an area is technically "overbedded" under the formula. The Commission's authority to do so has been approved by the Court of Appeals. *See Covenant Health v. Tennessee Health Servs. & Dev. Agency*, 2016 WL 1559508, at *16 (Tenn. Ct. App. April 14, 2016) ("'[T]he [Commission] has the authority and the discretion to deviate from the State Health Plan, ….').

The ALJ ignored the Commission's long history of discretionary approvals that diverge from the formula in the State Health Plan. Rather, the ALJ found that the Acute Bed Need criteria must be followed:

> The current CON law requires a new hospital to prove a need for additional hospital beds using the acute care bed standards and criteria in the State Health Plan. Any existing hospital can add acute care beds as budgets and space permit. **It has been argued by VRH and Commission that the acute care bed need formula is outdated and should not be followed. However, under the current law and guidelines, it is required that VRH prove the beds are needed**.
>
> . . .
>
> **While the State Health Plan is a guideline and not law, it provides the only objective measurements by which a CON application can be evaluated. The absence of the only applicable guideline would leave the approval process completely subjective as to which measurements should be used to prove that the new facility is needed.**

(Initial Order at pp. 23, 24) (emphasis added). The ALJ incorrectly concluded that disregarding the bed need formula would lead to a "completely subjective" process and that the formula is the only way to assess need. This approach would make the Commission superfluous. If the assessment of a CON was just a matter of mechanically applying a bed need formula, the staff, or for that matter a computer, could just perform the calculation and issue or deny the CON

accordingly. But such is not the law. The numerical guidelines are a starting point, but do not control the determination of need.

The ALJ further erred in her implicit criticism of the Commission for not updating the bed need criteria:

> **If HFC does not believe the acute care need bed formula is accurate or applicable, HFC has the authority to change the State Health Plan.** The last change to the acute care bed need formula was in 2017-2018. The State Health Plan has been updated three times since the acute care bed need formula was put into place. **This formula also could have been changed when the CON law changed in 2021, but HFC chose not to do so.** The governing statute states the commission "*shall* use as guidelines the goals, objectives, criteria, and standards adopted .... Until the commission adopts its own criteria and standards by rule, those in the state health plan apply." TENN. CODE ANN. § 68-11-1609(b) (emphasis added).

In other words, the ALJ found that if the Commission wants to approve projects that do not strictly satisfy the need formula, the Commission must amend the State Health Plan. As the Commission knows, the staff were in the process of drafting new Acute Care Bed criteria in 2022 when the decision was made to pause the revisions pending possible further changes to the CON process. The current draft revised criteria delete the Acute Care Bed need formula entirely and change how inpatient occupancy is to be calculated. It is evident that the Commission staff and the State Health Planning Division appreciate that the Bed Need Formula is antiquated and of limited utility. The fact that those changes have not yet been formally implemented is a result of both the continuing changes in CON law and the time-consuming nature of rulemaking.

The ALJ's criticisms reflect a fundamental misunderstanding of the administrative process and the Commission's discretionary authority to deviate from numerical formulas as it deems appropriate. The Commission should review the present Order to make clear to future ALJs that the guidelines in the State Health Plan are not mandatory.

F. The ALJ Erred by Concluding that COVID Made All Hospital Occupancy Data "Unreliable."

The fundamental question posed by the VRH application is whether there are enough acute care hospital beds to provide timely care to Rutherford County residents. At its December 2021 hearing approving the VRH application, the Commission heard from multiple independent Rutherford County physicians who painted a disturbing picture of the operations at Saint Thomas Rutherford ("STR"), the primary local hospital. In the contested case testimony, the additional information summarized below only strengthened the conclusion that STR constantly operates at or above its patient capacity:

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

- [redacted]
- [redacted]

The ALJ disregarded this evidence, stating that "[t]he data from 2020-2022 is challenging to analyze when looking at daily average census and hospital utilization rates. As such, **the data from 2020-2022 is not reliable**…" In other words, without any real analysis or discussion, the ALJ concluded that the Commission should not consider utilization of healthcare services during any part of the COVID pandemic. The ALJ's legal conclusion flies in the face of the Commission's approval and denial of applications over the past three years – many of which were based on utilization data generated during the pandemic.

Moreover, the ALJ's failure to discuss these data ignored that serious COVID infections declined substantially after February 2022. For instance, from March 15 through August 9, 2022,

[redacted]

[redacted]

The STR occupancy crisis was not caused by COVID. The ALJs dismissal of these important facts by declaring the data "unreliable" provides a further basis for review of the Initial Order.

G. The ALJ Improperly Determined that Hospital Beds Outside the Proposed Service Area Were Adequate Substitutes for a New Community Hospital in Murfreesboro

The Acute Care Bed service specific criteria require consideration of the availability of services in the project's proposed service area:

> ***4. Relationship to Existing Similar Services in the Area***: *The proposal shall discuss what similar services are available in the service area and the trends in occupancy and utilization of those services.*

(emphasis added). The VRH service area is Rutherford County, which the ALJ found to be appropriate and reasonable. (Initial Order, p.19). As such, in assessing need, the ALJ should have evaluated the availability of hospital services in Rutherford County. Instead, the ALJ concluded that VRH was not needed because there were existing beds in other counties, 45 to 60 minutes away.

Evidence at trial demonstrated that current VUMC patients lack geographic access to VUMC inpatient services. In 2021, approximately 30 percent of Rutherford County residents who required a hospital admission travelled to Nashville. Of those, nearly 4,000 patients went to VUMC. While it would be expected that Rutherford County residents may travel to Nashville to receive certain complex medical services, there are currently thousands of residents traveling to Nashville for conditions that could be treated in a community hospital in Murfreesboro. The Commission concluded that the establishment of a new, state-of-the-art community hospital in

Murfreesboro will significantly enhance patient accessibility in Rutherford County and provide an option to VUMC's existing patients to receive care from their provider of choice closer to home.

The ALJ disagreed with the Commission and demonstrated a lack of understanding of some basic principles of health planning, which aim to place resources closer to patients. The ALJ asserted that: "VRH has conflated desire and need," "[c]onsumer advantage does not just mean convenience," and because "Vanderbilt has hospitals or units within another hospital in five of the seven counties adjacent to Rutherford County." (Initial Order, p. 20). The facilities the ALJ references are the three VUMC community hospitals in Lebanon, Shelbyville, and Tullahoma. Murfreesboro is farther from Tullahoma than it is from Nashville. Lebanon is approximately the same distance from Murfreesboro as Nashville. The Shelbyville hospital is located approximately 30-40 minutes from VRH's proposed location on an increasingly busy stretch of two-lane local highway. In the ALJ's opinion, VUMC's patients (and the thousands of other patients leaving the community) should just continue to drive to those locations for their care despite their complete lack of geographic accessibility. Existing patient flow patterns demonstrate that patients from Rutherford County do not seek care in these other outlying communities. In 2020, only 39 patients from Rutherford County sought care at Vanderbilt Bedford Hospital, 29 patients at Vanderbilt Tullahoma-Harton and 69 patients at Vanderbilt Wilson County.

VRH will also provide healthcare to the underserved pediatric population of Rutherford County—another problem the ALJ believes should be remedied by patients driving to another county. Currently, the 72,000 children living in Rutherford County lack essentially any access to pediatric inpatient care in the service area. In 2020, of the 964 Rutherford County children who required hospitalization, 99 percent of them left Rutherford County for care. For any pediatric patient who requires a hospital admission, even for relatively mild conditions, that patient must

drive into either Nashville or Franklin. For patients living in the southern or eastern portions of Rutherford County, the trip to either location can last over an hour. A hospital admission for a child can be a harrowing experience for that child and its family. For families with multiple children, trying to manage the needs of a sick child, the childcare burden of the other children, not to mention the work responsibilities of the parents, can create an untenable situation when the child must be admitted to the hospital one hour away.

In the face of testimony about this need, the ALJ simply concluded the proposed pediatric services at VRH are "duplicative of the service that [Monroe Carroll Jr. Children's Hospital at Vanderbilt] pediatricians already offer at [Williamson Medical Center]" and that "[t]he various pediatric units at [Williamson Medical Center] are underutilized and have capacity to admit all lower acuity pediatric patients from Rutherford County…" and as such "Rutherford County pediatric patients have reasonable access to services within the geographic area [sic]." The ALJ's legal conclusion completely ignores that in 2020, only 4 Rutherford County families chose to drive the 30-40 minutes to admit their child to Williamson Medical Center. Moreover, under the CON law, "the geographic area" is the service area of Rutherford County, not other counties.

Not only did the ALJ deviate from the Acute Bed Need in relying on these facilities located outside the VRH service area, but the ALJ's offhand statement that "consumer advantage does not just mean convenience" defies a fundamental health planning principle, long recognized by this Commission, that treating patients closer to their homes is not simply a matter of patient convenience. From a clinical perspective, providing care closer to a patients' community improves public health because it increases the timeliness of care and the likelihood that family members can participate in both the diagnosis of the patient and the execution of any treatment care plan. Localized care generates more compliant patients and improves follow-up. Medical literature

further supports that patient outcomes are improved when patients can receive care more quickly and conveniently. The Commission has approved hundreds of projects in the past 10 years based on the health-planning concept that geographic accessibility is critical to quality patient care.

According to the ALJ, it is "reasonable access" for the residents of Murfreesboro who want to choose VUMC, perhaps because of a prior good experience, a relationship with a VUMC doctor, or simply VUMC's nationally recognized reputation, to drive hours to Nashville or Lebanon or Shelbyville or Tullahoma. Or, if their child needs to be admitted to the hospital, they can drive 30 to 45 minutes to the pediatric unit at WMC in Franklin. These "alternatives" in other counties, outside the proposed service area, are contrary to the CON criteria, the acknowledged advantages consumers obtain in receiving care close to where they live, and longstanding Commission precedent.

CONCLUSION

As set forth above, the ALJ made numerous incorrect legal conclusions, any one of which serves as adequate justification for the Commission to review her Initial Order. The ALJ:

- Exceeded her statutory role by "revoking" the VRH CON based on unsupported findings that VUMC misled the Commission;
- Mechanically applied the Acute Care Beed need criteria and limited the Commission's discretion in deviating from the applicable formulas;
- Wrongfully concluded that competition between providers should be discouraged;
- Improperly deemphasized the relevance of consumer and physician support;
- Incorrectly minimized geographic access in evaluating CON applications; and
- Disregarded data routinely relied on by the Commission in determining need.

For the foregoing reasons, VUMC respectfully requests that the Commission accept review of the ALJ's Initial Order dated June 8, 2023, and that the Commission 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 e-mail on the following this 26th day of July, 2023:

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