

No. 32565

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

**FAMILY MEDICAL IMAGING, LLC,
GARY L. POLING, D.O., and
SCOTT C. LOSTETTER, D.O.,**

Appellants,

v.

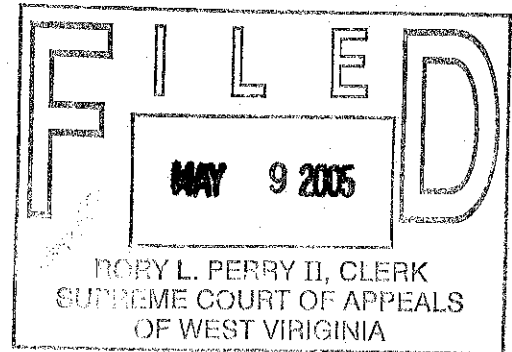
WEST VIRGINIA HEALTH CARE AUTHORITY,

Appellee,

and

RALEIGH GENERAL HOSPITAL,

Intervenor.



BRIEF OF INTERVENOR

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INTRODUCTION

Raleigh General Hospital (hereinafter "RGH") is an acute care facility located in Beckley, Raleigh County, West Virginia. Among its services, RGH provides diagnostic services to patients from Raleigh and Fayette Counties through the use of two ultrasound machines. The Appeal in this matter involves the request for a Certificate of Need (hereinafter "CON") by Family Medical Imaging, LLC, Gary L. Poling, D.O., and Scott C. Lostetter, D.O. (hereinafter collectively "FMI" or "Appellants") for a diagnostic center.¹ The diagnostic center would provide ultrasound services to patients from Raleigh and surrounding counties. The service area proposed by FMI encroaches upon RGH's service area and thus approval of the CON would have an adverse impact on patient volume and revenue received by RGH. RGH was granted affected party status in the matter before the West Virginia Health Care Authority (hereinafter "HCA"), CON File #02-1-7565-X/E, and fully participated in the proceedings conducted by the HCA, the Office of Judges (hereinafter "OOJ") and the Circuit Court of Raleigh County.² RGH intervened in this Appeal, not only because of the direct impact that the decision will have upon RGH, but because of the effect this decision will have on the HCA's ability to review applications for certificates of need in the future.

As will be discussed *infra*, FMI presented an application for a CON which was fatally flawed from the time of its submission. FMI proposed a service area which was too expansive thus affecting the remaining calculations in their application, particularly the demonstration of need calculations.

¹A Certificate of Need is "a document issued by the Board which indicates that a proposed new institutional health service is in compliance with the intent, purposes and provisions of W. Va. Code 16-2D-1 et seq., and that a need exists for the proposed new institutional health service." W. Va. CSR § 65-7-2.6

²The Offices of Judges, Bureau of Employment Programs, is the entity given the authority to review the decisions of the HCA. W. Va. CSR §65-7-18.

The record reflects that the HCA appropriately reviewed FMI's application in accordance with the applicable CON Standards and found that FMI failed to demonstrate that a need exists for the project, a requirement necessary in order to obtain a CON. In their Appeal, FMI erroneously assert that their CON should be granted because expert testimony was wrongly admitted by the HCA. Although the HCA correctly admitted the testimony, FMI's argument is irrelevant because the testimony did not change the outcome of HCA's decision.

The Circuit Court carefully considered the HCA's and OOJ's rulings in accordance with the evidence and the laws of this State. As more fully discussed herein, this Court should affirm the decision of the Circuit Court of Raleigh County, which upholds the denial of the CON by the HCA and OOJ.

SUMMARY OF FACTS AND PROCEDURAL HISTORY

In 2000, the HCA amended the provisions of W. Va. CSR § 65-17-1 et seq., which deals with health services by health professionals. The amended Legislative Rule was adopted and was the method chosen by the Authority to regulate the unbridled expansion of health services in response to both hospitals and health professionals.

The amended Rule listed a number of services provided by health professionals that would be regulated as a part of the CON process. One of the services regulated under the amended Rule is the development of a "Diagnostic Center", which service is the subject of this proceeding.³

³Diagnostic services are defined as "the offering or development of laboratory or imaging services at a new or existing health care facility or health maintenance organization; provided however, that a health care facility or health maintenance organization already offering one or more laboratory or imaging services, including but not limited to, radiology, ultrasound, mammography, fluoroscopy, nuclear imaging, densitometry, or computerized tomography at its existing facility, and proposing to add at its existing health care facility laboratory or imaging services not otherwise

Pursuant to the amended Rule, the development of diagnostic center by a physician, even if it is a part of his private practice, is subject to CON review.

In October, 2002, one of the Appellants, Dr. Gary Poling, acquired an ultrasound unit by lease. The unit was utilized on patients for Dr. Poling's private practice as well as patients that were a part of another practice, that of Appellant, Dr. Scott Lostetter. In December 2002, Dr. Poling requested that the HCA allow the two physicians, Poling and Lostetter, to form an entity that would acquire the ultrasound machine and offer ultrasound services to the general public. On January 8, 2003, the HCA ruled that accepting and treating referrals from other physicians constitutes the development of a diagnostic center and, as a result, the provisions of W. Va. CSR § 65-17-1 et seq. required a CON review. Thus, Drs. Poling and Lostetter filed a Certificate of Need Application ("the Application"). Thereafter RGH filed a letter seeking affected party status and was granted such status, as defined in W. Va. Code § 16-2D-2(a)(5).

Pursuant to a time frame order agreed to by the parties, the parties engaged in discovery. On April 10, 2003, RGH filed its responses to FMI's interrogatories and requests for production of documents. The following day, RGH filed its witness list, which included a summary of the witnesses' topics of expected testimony. On April 13, 2003, FMI filed a motion to exclude RGH's evidence and testimony. RGH requested a public hearing be held in the matter, which was held on April 16, 2003. On that date, the HCA also denied the FMI's Motion to Exclude Evidence and Testimony.

enumerated under subsection 28.1 and not constituting major medical equipment under subdivision 2.16.j, shall not be deemed to be engaged in the addition of health care services under subdivision 2.16.e of this rule." W. Va. CSR § 65-7-2.8.

After the hearing, the court reporter informed the HCA and the parties' counsel of technical difficulties with the taping of the hearing, thus making portions of the hearing transcript unintelligible. In response to the HCA's request for opinions from the parties regarding the transcript, both parties agreed to proceed without a rehearing and accepted the transcript in its current state.

The HCA issued its Decision denying the CON on October 9, 2003 (hereinafter "HCA Decision" or "HCA Order") based on a finding that the project was not needed and not consistent with the State Health Plan. On November 7, 2003, FMI filed a Request for Review of Denial of Certificate of Need Application ("Request for Review") with the OOJ. RGH, along with the other Affected Parties, filed a Motion to Dismiss and a response to the Request for Review. Administrative Law Judge Martha Hill held a hearing on January 12, 2004 and heard arguments on both the Request for Review and the Motions to Dismiss.

On February 2, 2004, Judge Hill entered an Order granting the Motions to Dismiss, which was then appealed by FMI. In the Circuit Court of Raleigh County, Judge H.L. Kirkpatrick, III reversed the Order granting the Motions to Dismiss and remanded the matter for review on the merits. Ruling on the merits, Judge Hill issued an Order upholding HCA's denial of the CON on May 26, 2004 (hereinafter "OOJ Decision"). Subsequently, FMI filed an appeal with the Circuit Court of Raleigh County, West Virginia. On August 13, 2004, a hearing was held before Judge Kirkpatrick. On September 1, 2004, Judge Kirkpatrick entered an Order (hereinafter "Kirkpatrick Order"), denying FMI's appeal and affirming the decision of the HCA and Office of Judges. On December 2, 2004, FMI filed a Petition for Appeal to the Supreme Court.

RGH submits this brief asserting that the West Virginia Supreme Court of Appeals should affirm Judge Kirkpatrick's Order which upholds the HCA and OJ's denial of the request for CON.

ARGUMENT

I. THIS COURT APPLIES A DEFERENTIAL STANDARD OF REVIEW TO THE DECISIONS OF THE WEST VIRGINIA HEALTHCARE AUTHORITY.

This Court has stated that the appellate court is to review a circuit court's decision concerning appeals from an administrative agency with "clearly wrong" and "arbitrary and capricious standards." The W.Va. Health Care Cost Review Authority v. Boone Memorial Hosp., 196 W. Va. 326, 335, 472 S.E.2d 411, 420 (1996). While "interpreting a statute or an administrative rule or regulation presents a purely legal question subject to de novo review, [a]n agency's interpretation of a statutory provision or regulation it is charged with administering is entitled to a **high degree of deference.**" Id. (emphasis added). According to Justice Cleckley's opinion in Boone Memorial, a court reviewing the HCA's "legislative rules is limited to asking (1) whether they were enacted pursuant to the procedures required by law; and (2) whether [HCA]'s interpretation and application of the rules were arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." Id.

Furthermore, in reviewing a decision of an administrative agency, this Court held in St. Mary's Hospital v. State Health Planning and Development Agency, 178 W. Va. 792, 364 S.E.2d 805, 808-809 (1987), that the circuit court should utilize the standard of judicial review applied under the Administrative Procedures Act:

[T]he circuit court may affirm the order or decision of the agency or remand the case for further proceedings. The circuit court shall reverse, vacate, or modify the order or decision of the agency if the substantial rights of the petitioner or petitioners have been prejudiced because the administrative findings, inferences, conclusions, decisions or order are: '(1) In violation of constitutional or statutory

provisions; or (2) In excess of the statutory authority or jurisdiction of the agency; or (3) Made upon unlawful procedures; or (4) Affected by other error of law; or (5) Clearly wrong in view of the reliable, probative and substantial evidence on the whole records; or (6) Arbitrary or capricious or characterized by an abuse of discretion or clearly unwarranted exercise of discretion.'

Citing, Syl. Pt. 2, Shepherdstown Volunteer Fire Department v. Human Rights Commission, 172 W. Va. 627, 309 S. E.2d 342 (1983).

The Order of the Raleigh County Circuit Court reaches a result which is fully supported by the evidence and the controlling case law. The HCA found that FMI failed to demonstrate that a need exists for the project, a requirement necessary in order to obtain a CON. After a discussion of the evidence, the Circuit Court correctly recognized:

The undersigned [circuit court] is not permitted to substitute its own opinion for the decision of the agency. The reviewing court is limited to asking whether the agency's interpretation and application of the rules were arbitrary, capricious, an abuse of discretion, otherwise not in accordance with law. In this instance, the Court finds no reason to overturn the HCA's Decision.

Kirkpatrick Order, p. 9. Likewise, this Court should afford the HCA's decision the appropriate deference and affirm the decision of the Circuit Court of Raleigh County.

II. THE CIRCUIT COURT APPROPRIATELY GAVE THE HCA'S INTERPRETATION AND APPLICATION OF THE CON LAWS DUE DEFERENCE, CORRECTLY FINDING THAT THE HCA'S DECISION WAS REASONABLE AND IN ACCORDANCE WITH LAW.

In any CON matter there are two major issues an applicant must prove. The first issue is proving the need for the project. The second issue involves proof that the project is financially feasible. The Certificate of Need Standards for Ambulatory Care Centers, October 5, 1992 (hereinafter "Standards") contain an explanation of what is required by an applicant to prove each of these requirements, as well as some other minor requirements. The Circuit Court of Raleigh

County gave the HCA decision to deny the CON deference because of their expertise in Certificate of Need review. Contrary to FMI's assertions, the HCA appropriately applied the correct CON Standards. Because FMI failed to demonstrate that its project met the need and financial feasibility requirements, the HCA had no choice but to deny FMI's application for a CON. As the HCA's actions were not arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law, this Court should uphold that decision.

A. The Circuit Court and HCA decisions must be upheld because it was not arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law.

The HCA has explicitly been delegated the power and responsibility to administer the CON program. *See*, W.Va. Code § 16-2D-2(dd) defining the HCA as the "state agency," *and* W.Va. Code §§ 16-2D-5 and 16-2D-8, which gives the state agency the power and responsibility to administer the CON program, promulgate additional rules as deemed necessary by the state agency in administering the CON program and propose revisions to the CON Standards. As a part of the HCA's specifically delegated authority, the HCA is empowered with authoring and enforcing the State Health Plan, which includes the CON Standards. W. Va. Code § 16-2D-5(l). The legislature, however, did not enter into the specifics of a CON or the specific requirements to obtain one. Instead the task of creating the Standards was delegated to the HCA.

This case turns on the HCA's ability to reasonably interpret and apply the Standards and the deference due that interpretation on appeal. This case involves the creation of a diagnostic center by FMI. The Standards do not set forth a specific need methodology for most types of diagnostic centers. Instead, the Standards provide "For ambulatory care centers for which no specific need methodology is set forth in Section III, below, the following general need methodology shall be used." Standards, Ambulatory Care Centers, § II(A). The general need methodology, which the

HCA applied in this case, begins with a requirement that “The applicant shall delineate the **service area** by documenting the expected areas around the ambulatory care facility from which the center is expected to draw patients.” Standards, Ambulatory Care Centers, § II(A) (emphasis added). The CON Standards for ambulatory care centers do not directly address how an applicant should establish a study or service area, but leave it to the applicant to establish the service by documenting the expected areas around the ambulatory care facility from which the center is expected to draw patients.

The service area is crucial to an application for a CON because it sets forth the foundation for demonstrating unmet need. Simply put, the bigger the service area, the more need there is for the service. However, at some point, the size of the service area exceeds both the ability of the provider to provide the service and the practicality of actually providing the service. For example, a provider may treat a small number of patients from a number of counties, but draw the majority of its patients from only one or two counties. The Standards clearly do not intend for an applicant to develop an ever-expansive service area. In fact, the Standards provide that “the applicant may submit **testimony or documentation on the expected service area, based upon national data or statistics, or upon projections generally relied upon by professionals engaged in health planning or the development of health services.**” Standards, Ambulatory Care Centers, § II(A) (emphasis added). Thus, while the service area is left up to the applicant to establish, it is also the applicant who must defend its proposed service area. Once presented with the information from the applicant and the affected parties, it is then the HCA’s duty to weigh the information and determine whether the proposed service area is reasonable. The HCA carried out that duty in rejecting a part of the service area claimed by FMI. The Circuit Court reviewed the HCA’s decision and found that its determination regarding FMI’s service area was proper.

The United State Supreme Court dealt with the issue of the powers and duties of administrative agencies and the deference to be given to an agency's decisions by appellate bodies, in Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 844 (1984). This Court discussed the Chevron case and the issue of deference in The W. Va. Health Care Cost Review Authority v. Boone Memorial Hospital, *supra*. In that case, Justice Cleckley wrote, "[t]he rule of deference [Chevron deference] traditionally applies when an agency's interpretation is a 'product of delegated authority for rule making'...a sphere that ordinarily encompasses legislative rules and *agency adjudication*." Citing, Stinson v. U.S., 508 U.S. 36, 44 (1993) and In re Snuffer, 193 W. Va. 412, 417, 456 S.E.2d 493 (1995)(Cleckley, J. concurring) (*emphasis added*).

As the HCA's Decision is a result of the HCA's interpretation of its Standards, FMI is requesting review of a decision that is the product of agency adjudication; the HCA's adjudicatory power. Thus, for the HCA's Decision to be reversed or remanded in this case, FMI must prove the Decision was devoid of a rational basis, (*i.e.*, arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law). In order to question or discredit the HCA's Decision, FMI must present a "startling reason" to justify the Court overturning the Decision. As Justice Cleckley has stated:

When a legislative rule is constitutionally acceptable, only an unambiguous conflicting statute, contradictory legislative history, a defect in the rulemaking process, evidence of bias or abuse of power, or some other **startling revelation** of fact would overcome the clearly erroneous burden and justify this Court's interference with an agency's legitimate rulemaking authority. *See, Frymier-Halloran v. Paige*, 193 W.Va. 687, 458 S.E.2d 780, 787 (1995)("it [is] evident that courts will not override administrative agency decisions, of whatever kind, unless the decisions contradict some explicit constitutional provision or right, are the results of a flawed process, or are either fundamentally unfair or arbitrary").

Appalachian Power v. State Tax Dept., 195 W.Va. 573, 466 S.E.2d 424, 440 (1995). (emphasis added).

FMI bases its argument on the fact that the Standards do not define the term “service area” and thus HCA must have acted arbitrarily in finding the service area proposed by FMI to be too large. The lower court aptly stated “The Court observes that there can be no brightline rule to specifically describe an appropriate service area for a diagnostic center, but concedes that the HCA should be allowed some leeway to interpret and apply the State Health Plan.” Kirkpatrick Order, p. 6. Because the West Virginia legislature has not fully spoken on the matter of what constitutes the “service area,” the HCA is permitted to determine whether the service area proposed by the applicant is reasonable. Acting within the scope of its statutory authority and after a public hearing on the matter, the HCA determined that the service area proposed by FMI was unreasonable, thus invalidating its later need calculations. Based upon that finding, the HCA then denied FMI’s CON Application to open a new diagnostic center and provide ultrasound services.

B. FMI failed to demonstrate the need for the project.

In its Decision, the HCA ruled that “the applicant has failed to demonstrate need for the service . . .” HCA Decision, p. 19. The OOJ agreed with this finding, upholding the HCA’s decision to deny the CON. OOJ Decision, p. 11-12. Those rulings were primarily based upon the finding that the service area proposed by FMI was too large. Neither the HCA’s statute nor the applicable portion of the State Health Plan, CON Standards, specifically define the service area for a diagnostic center, such as the one proposed by FMI. The Standards do, however, define how a service shall be established and using its expertise the HCA determined that FMI utilized a service area that was too large in its proposal.

The Standards specifically state that

[t]he applicant shall delineate the service area by documenting the expected areas around the ambulatory care facility from which the center is expected to draw patients. The applicant may submit testimony or documentation on the expected service area, based upon national data or statistics, or upon projections generally relied upon by professionals engaged in health planning or the development of health services.

Standards, Ambulatory Care Centers, § II(A). RGH is a full service acute care hospital. It is the largest provider of health care services in Raleigh County and its service area includes only Raleigh and Fayette Counties. FMI however proposed a service area encompassing six counties: Raleigh, Fayette, Wyoming, McDowell, Summers and Nicholas. The Appellants failed to offer one reasonable piece of evidence to support the enlarged service area proposed in the Application, except to state that they serve a few patients from McDowell and Nicholas counties. The Circuit Court appropriately acknowledged that “No other evidence was presented by the applicant to justify inclusion of all six counties in the delineated service area.” Kirkpatrick Order, p. 7.

Historically, it has been recognized that serving a few patients in a particular geographic location does not automatically mean that those locations should be included in the service area. See Raleigh General Hospital v. West Virginia Health Care Cost Review Authority, Civil App. No. 97-AP-09-B. In Raleigh General, RGH proposed that the HCA recognize a service area encompassing nine counties. Id. Contrary to RGH’s proposed service area, the HCA limited it to four counties, finding “the use of the RGH existing cardiac catheterization unit by patients in the proposed secondary service area [the other 5 counties] is insignificant...” Id. Similarly, under these circumstances, this Court should afford the HCA’s interpretation and application of the CON requirements deference and recognize that the service area proposed by is too expansive, covering areas of insignificant service.

In its Decision, the HCA referenced what is typically referred to as the "25/10 service area."

The 25/10 service area is based upon the actual utilization of services by residents of each particular county and is the basis for many of the required need methodologies for new health services in the Standards. The discussion regarding the service area was simple, the HCA found that the area proposed by FMI, which was larger than the Raleigh County 25/10 area, was unreasonable. However, the 25/10 service area did not govern the HCA's decision, nor was it used as a basis for the decision. The HCA stated:

With respect to the need calculation, the Authority finds that the service area set forth in the application is not reasonable. The service area in the application includes the following six West Virginia counties: Raleigh, Wyoming, McDowell, Fayette, Summers, and Nicholas. No justification for this large service area is set forth in the application. At the hearing, Dr. Poling testified that he serves only two families from McDowell County. (Tr. P. 19) However, the entire population of McDowell County was included in the applicant's need methodology. Likewise, Dr. Poling testified that he serves "several" families from Nicholas County, however, the entire population of Nicholas County was included for purposes of determining an unmet need. HCA Order, p. 18.

FMI disagrees with the HCA's decision and essentially argues that because the Standards do not define the service area for a diagnostic center, it is free to establish the service area however it sees fit, and no matter how unreasonable the service area is, the HCA, or RGH, cannot question it. That is, of course, absurd. The HCA found that it was unreasonable to have such an expansive service area without any reasonable justification for including more than the normal service area.

FMI elected to include two counties, Nicholas and McDowell, in its application, but was unable to adequately defend the inclusion of those two counties. The only justification for the expanded area offered at the hearing was testimony from Dr. Poling that he served a few families from Nicholas and McDowell Counties. RGH treats patients from many counties, including

McDowell and Nicholas. However, because the number of patients from the other counties is so small, neither of those counties are in the service area for Raleigh County. In fact, the HCA's own data shows that RGH treats patients from about 26 counties and more than 5 states, yet it would be unreasonable for their established service to be so expansive.

It is clear why the Appellants would include these extra counties in its service area. These counties contain about 50,000 people which translates, using the applicant's methodology, into a need for about 13,500 ultrasounds tests per year. (See FMI's Application for CON). This causes an inflation in the demonstration of the need. While the applicant offered no experts or evidence to support inclusion of the two counties, RGH presented a professional engaged in health planning or the development of health services who offered her opinion that the two counties should not be included in the service area. The HCA reasonably found that having a few families on a patient list does not equate into the need for 13,500 tests in the calculations. This finding restricting the service area to a more reasonable scope invalidated FMI's need calculation. The result was that there could be no finding that the project was needed and thus application had to be denied.

Further, the services proposed to be provided are not specialized services that may justify a larger than normal service area. In fact, these services are widely available and would, if anything, justify a smaller service area. The HCA took all of this into account in making its decision, which was reasonable and was based upon the evidence in the record. It is the HCA's duty to weigh the evidence and testimony. When presented with an unrealistic and unreasonable service area, the HCA looked to its own data, its past decisions and a system already established that determined a reasonable service area [25/10 area], for guidance. The burden was on FMI to establish an appropriate service area and it failed to do so. Had the HCA included Nicholas and McDowell counties in FMI's service area, it would have been acting arbitrarily and irrationally.

Likewise, the OOJ discussed all of the reasons why the service area proffered by FMI was too large and similarly concluded that the HCA's Decision regarding the service area was not erroneous, arbitrary or capricious, or characterized by an abuse of discretion. "The HCA and Judge Hill determined that the expansive service area, from which the applicant calculated its projected patient-load, was grossly inflated. Therefore, the ultimate conclusion in this regard was that because the service area is unacceptable, nothing else presented by the applicant is valid." Kirkpatrick Order, p. 7. The HCA's Decision and the OOJ Decision upholding it were correct and should be upheld.

C. The financial feasibility of the project is irrelevant because the Appellants failed to demonstrate the need for the project.

Upon making the finding that the project was not needed, the HCA's decision-making process ended. As noted in W. Va. Code § 16-2D-9(b)(1), a CON may only be issued if the proposed service is "found to be needed." This Court has ruled that

under West Virginia Code § 16-2D-9(b), the legislature has provided that a certificate of need may only be issued upon a finding that the proposed health service is both needed and consistent with the State Health Plan . . . [O]nce it has been determined that denial of a certificate of need application is clearly mandated by the absence of one of these requirements, a determination regarding the other is unnecessary.

Princeton Community Hospital v. State Health Planning and Development Agency, 174 W. Va. 558, 564, 328 S.E.2d 164, 170-171 (1985). Thus, any findings or rulings made after the finding that the project was not needed are moot.

As a result, the HCA did not even need to address the issue of financial feasibility. It did so, however, in a brief manner, and the issues discussed involved expenses that FMI omitted from the financial projections in the Application. The HCA found:

The applicant failed to consider expenses [including the Medicaid provider tax, city B & O taxes, and payroll taxes] in making its financial projections. Second, the applicant failed to demonstrate the impact of indigent care on net income and therefore, cannot demonstrate that all indigent persons needing the service can be served without jeopardizing the financial viability of the project as required by the State Health Plan. Third, the financial information does not include assumptions for bad debts or contractual write offs. Fourth, the applicant assumes that he will be able to charge and collect \$200 per patient for the new service. However, this assumption ignores the fact that most insurance companies have discount contracts and will not pay the actual charge, but will pay a discounted rate.

HCA Order, 19. Those expenses were, in fact, omitted from the projections and the HCA's made the proper finding that, based upon this omission, FMI failed to demonstrate the project to be financially feasible. In the end, however, financial feasibility is irrelevant because FMI failed in the first step, which is proving that the project was needed.

III. THE CIRCUIT COURT APPROPRIATELY FOUND THAT THE HCA, AS ALLOWED IN ITS DISCRETION, CORRECTLY ADMITTED AND APPLIED THE TESTIMONY OF RAYMONA KINNEBERG AND LAWRENCE A. PACK.

RGH properly disclosed its expert witnesses through a timely filed Witness List that disclosed the general area of testimony of each of its witnesses. Thus, FMI was well aware of the witnesses likely to be called and their anticipated testimony prior to the hearing. After reviewing FMI's general Motion to Exclude, the HCA correctly admitted the testimony of RGH's experts. However, the issue of the admissibility of RGH's expert testimony is moot in this case. The decisions below did not turn on the expert testimony and thus any expert testimony that may have been admitted erroneously constitutes harmless error. Because the final decision to deny the request for a CON did not hinge on the expert testimony, but on the deficiencies in the Appellants' own application, this Court should deny the Appellants' request for relief.

A. The HCA correctly admitted and applied the testimony of Raymona Kinneberg and Lawrence A. Pack.

The Appellants attempt to circumvent the fact that their Application failed on its face by claiming that the HCA wrongly admitted expert testimony. Prior to the hearing, the Appellants filed a general Motion to Exclude, which merely moved to “exclude all evidence and any testimony arising from said evidence not produced or disclosed by Raleigh General Hospital in response to [sic] discovery request. Raleigh General Hospital did not identify, disclose or produce any documents or evidence other than a list of ultrasound exams and charges...” The HCA appropriately denied the Appellants’ motion, finding no basis for exclusion of RGH’s evidence. The Appellants now assert that based upon the timing of discovery deadlines, deadlines to which the Appellants agreed, they were unable to effectively challenge the admissibility of RGH’s experts. However, prior to the filing of their Motion, the Appellants had already received RGH’s answers to discovery and its witness list, thus providing FMI with the information necessary to challenge the admissibility of RGH’s exhibits or testimony.

Specifically, RGH filed a Witness List according to the schedule set by the HCA that disclosed the general area of testimony of each of its witnesses. (See Exhibit 22, HCA file). The Witness List filed by RGH is in a form that is similar, if not identical, to witness lists filed in certificate of need cases before the HCA for many years. Those past witness lists and the information contained in them have been found to be acceptable by the HCA in the past. The Witness List filed in this case contains a listing of witnesses RGH intended to call and description of the topics those witnesses would each testify about. The testimony of those witnesses who were called was limited to the topics listed on the Witness List.

Further, a draft of the Witness List was attached to the Discovery Responses filed by RGH in this case. Thus there is no question that the Applicant was aware of the witnesses likely to be called and their anticipated testimony. Also as a part of its Discovery Responses, RGH disclosed what documents it intended to rely upon in presenting its case against the Application, including the Application itself, the State Health Plan and past Certificate of Need Decisions on diagnostic centers. Those were the documents that were relied upon in the testimony of Raymona Kinneberg in her testimony regarding the need for this project. There were no documents produced by Kinneberg at the hearing or prior to the hearing. She testified, as she usually does, about the project's inconsistency with certain portions of the State Health Plan. The main thrust of her testimony was regarding the service area issue discussed above. The Witness Lists stated that she would testify about "the project's consistency with the State Health Plan." (Exhibit 22, p. 1 HCA file). She offered no evidence that was subject to disclosure and not disclosed. The Appellants failed to raise specific objections and as a result, any objection is now waived.

Lawrence A. Pack's testimony was limited to the financial feasibility of the project, which the HCA did not even have to rule upon because FMI had already failed to establish the required need. Therefore, the dispute regarding the admissibility of Mr. Pack's expert testimony is irrelevant. However, in its witness disclosure, RGH did put the Appellants on notice that "Lawrence A. Pack...may testify and offer opinions regarding financial issues, project financing and other aspects of the application." (See Exhibit 22, HCA file). Moreover, at the hearing, the HCA sustained the Appellants' motion and denied admissibility of a document offered by RGH expert, Lawrence Pack, which had not been disclosed previously. Tr. p. 178. In regard to financial feasibility, it was not expert testimony, but FMI's application and its failure to include certain expenses, that led to the finding that the FMI failed to establish financial feasibility. See HCA Order, p. 19.

B. Even in the absence of RGH's expert testimony, the Decision to deny the request for a CON would remain the same

Most importantly, the result of this case is the same with or without the expert testimony. The HCA relied upon information independent of both Kinneberg and Pack's testimony to make its decision. The HCA's finding regarding the lack of a need for the project was not based on the RGH's experts' testimony, but was based primarily on the use of an expanded service area by FMI. See HCA Decision, p. 18-19. The HCA is allowed to apply information, data and knowledge contained in its files to any case pending before it and did so, when determining that FMI's service area was too large.

There have been past certificate of need decisions regarding service area, which the HCA was able to look to for guidance. For example, in Raleigh General Hospital, RGH applied for a certificate of need to develop an open heart surgery center. CON File No. 92-1-3872-H, Decision, p. 10-12. The application proposed a service area much larger than usual, including nine counties, based upon the fact that open heart surgery services are specialized services that will draw patients from a much wider service area. Id. The HCA specifically rejected the larger service area proposed by RGH and limited RGH to its normal area, citing the fact that RGH's service in the expanded area was insignificant. Id. As a result, the HCA denied the application. Id. Unlike RGH in the Raleigh General case, the services proposed by FMI are not specialized services. They are, in fact, widely available, non-specialized services that would tend to draw patients from a smaller service area, not a larger one.

McDougal v. McCammon, 455 S.E.2d 788, 798, 193 W. Va. 229, 239 (1995), to which FMI makes reference, points out that the Decision should not be overturned if the result would be the same without the questionable evidence. The court in McDougal refused to overturn the lower

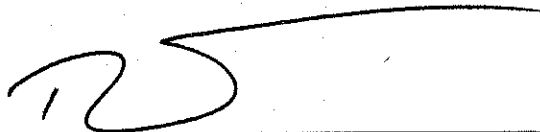
court's verdict because of possible inadmissible evidence because its admission did not affect the outcome of the case. Id. at 799. Likewise, to make its Decision, the HCA relied upon information independent of both Kinneberg and Pack's testimony. Thus, while the testimony offered by Kinneberg and Pack was properly admitted and considered by the HCA, even in its absence, the project should have been denied. Judge Kirkpatrick correctly found that any questionable admissibility of these witnesses' testimony constituted "harmless error." Kirkpatrick Order, p. 8. Therefore, this Court should deny FMI's Appeal and uphold the decisions of the HCA/OOJ and Circuit Court of Raleigh County.

CONCLUSION

WHEREFORE, based upon the foregoing arguments, RGH, respectfully requests this Court affirm the Decision issued by the Circuit Court of Raleigh County, which upholds the HCA and the OOJ's denial of FMI's application for a CON.

**RALEIGH GENERAL HOSPITAL,
By Counsel**

LEWIS, GLASSER CASEY & ROLLINS, PLLC



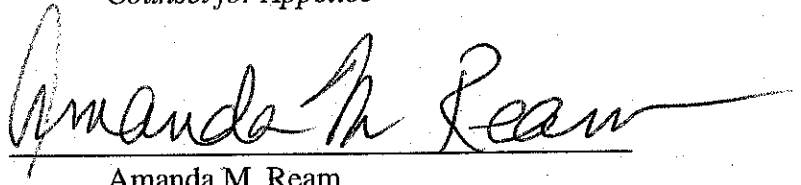
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CERTIFICATE OF SERVICE

The undersigned hereby certifies that on May 9, 2005, she served the foregoing "**BRIEF OF INTERVENOR**" upon the following by enclosing a true and accurate copy thereof in an envelope addressed to their last known address via the United States Mail:

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A handwritten signature in cursive script that reads "Amanda M. Ream". The signature is written in black ink and is positioned above a horizontal line.

Amanda M. Ream