Civil Docket No. CL18-3132
Circuit court of Virginia

Chesapeake Hosp. Auth. v. State Health Comm'r

Decided Mar 27, 2019

Civil Docket No. CL18-3132

03-27-2019

RE: Chesapeake Hospital Authority d/b/a Chesapeake General Hospital v. State Health Commissioner, et al.

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P.O. Box 1320
Richmond, VA 23219 Dear Counsel:

The matter comes before the Court on a Petition for Appeal by the Chesapeake Hospital Authority d/b/a/ Chesapeake Regional Medical Center ("CRMC") from a February 21, 2018 case decision by the Virginia State Health Commissioner. The Commissioner determined that Sentara Hospitals demonstrated good cause standing in accordance with Certificate of Public Need ("COPN") law and is thus a party to the review of CRMC's COPN application to establish open heart surgery services in Planning District 20 ("PD 20").

The matter has been fully briefed, and the submissions by the parties include a comprehensive summary of the factual background, the agency proceedings, and the events surrounding the agency's review of CRMC's application and Sentara's good cause petition. The Court does not restate those background details here.

BACKGROUND

CRMC filed a COPN application proposing to introduce an open heart surgery service center and to expand cardiac catheterization services at its Chesapeake medical facility. According *2 to procedure, the Department of COPN ("DCOPN") reviewed CRMC's application and issued the DCOPN Staff Report on November 20, 2017, recommending approval of CRMC's project.

Sentara timely filed a good cause petition, seeking to become a named party to the administrative review of CRMC's COPN application. COPN law authorizes the Commissioner to grant good cause party status to a person who has demonstrated that:

> (i) there is significant relevant information not previously presented at and not available at the time of the public hearing, (ii) there have been significant changes in factors or circumstances relating to the application subsequent to the public hearing, or (iii) there is a substantial material mistake of fact or law in the Department staff's report on the application or in the report submitted by the health planning agency.

Va. Code § 32.1-102.6(D)(G)

Sentara's petition set forth seven allegations of substantial and material mistakes of fact or law in the DCOPN Staff Report and one allegation of significant and relevant information not presented at and not available at the time of the public hearing. On December 7, 2017, the agency's Adjudication Officer conducted an informal fact-finding conference ("IFFC") to consider Sentara's Good Cause Petition and CRMC's COPN application. By case decision issued on February 21, 2018, the Commissioner adopted the Adjudication Officer's recommended decision and concluded that Sentara had demonstrated good cause with respect to seven of its eight allegations, any one of which would be sufficient to establish good cause standing. CRMC appeals that decision.

STANDARD OF REVIEW

Virginia law establishes that "the party complaining of an agency action has the burden of demonstrating an error of law subject to review." *Hilliards v. Jackson*, 28 Va. App. 475, 479 (1998). The Commissioner's determination of good cause standing is entitled to considerable deference as a matter of law and must be upheld as long as it was supported by substantial evidence. *Chippenham & Johnston-Willis Hosp.s, Inc. v. Peterson*, 36 Va. App. 469, 480 (2001). The Court of Appeals has cautioned that a good cause determination may be reversed only if it was "arbitrary and capricious...or [based on] findings of fact [that] were not supported by substantial evidence." *Id.* at 480. This Court, reviewing an agency action, must view the facts "in the light most favorable to the agency." *Hilliards*, 28 Va. App. at 479. "The sole determination *3 as to factual issues is whether substantial evidence exists in the agency record to support the agency's decision." *Johnston-Willis, Ltd. v. Kenley*, 6 Va. App. 231, 242 (1988). An agency's factual findings may be rejected if "'considering the record as a whole, a reasonable mind would necessarily come to a different conclusion.'" *State Health Comm'r v. Sentara Norfolk General Hosp.*, 260 Va. 267, 275-76 (2000) (citing *Virginia Real Estate Comm'n v. Bias*, 226 Va. 264, 268-69, 308 S.E.2d 123, 125 (1983)).

ANALYSIS

Sentara's Good Cause Petition advanced eight separate arguments, which the Commissioner's decision addressed in turn. CRMC's Petition for Appeal includes five assignments of error, which do not precisely track the eight allegations that Sentara raised in its Good Cause Petition and that the Commissioner addressed sequentially in her decision. For example, CRMC's first assignment of error addresses the Commissioner's decision regarding the first and fourth allegations in the Good Cause Petition. For clarity's sake, this Court addresses in order the seven allegations ruled by the Commissioner to support Sentara's Good Cause Petition.

1. The first allegation

Sentara argued that DCOPN erred as a matter of fact and law in concluding that CRMC's project satisfied the applicable utilization standard for new open heart services:

> No new open heart services should be approved unless ... [o]pen heart surgery services located in the health planning district performed an average of 400 open heart and closed heart surgical procedures for the relevant reporting period.

12 VAC 5-230-450(A)(2). Sentara argued that CRMC had relied upon and cited utilization data that was over inclusive and that counted more procedures than just open and closed heart surgeries. CRMC did not contest that this data, collected and published by Virginia Health Information ("VHI") as the "Annual Licensure Survey Data Report," does count and report more procedures than just the "open and closed heart surgical procedures" referenced in the above standard. CRMC argues that the only other data set available (and upon which Sentara relies), the "Open Heart Surgery Service Line Report," undercounts procedures by excluding "closed heart" surgery. That data, argues CRMC, should thus not be considered when evaluating utilization.

Sentara cited corrected information for three open heart surgery programs in the planning district: its own
4 programs in Norfolk and Virginia Beach, and the Bon Secours program in *4 Portsmouth. That corrected data showed fewer cardiac surgical procedures than the totals attributed to them in the DCOPN Staff Report. AR at 1983, 1994-97.

The Adjudication Officer's decision noted the difficulty of measuring compliance with the SMFP utilization standard with the data available: "Due to the manner in which cardiac utilization is reported to [VHI], the utilization that is *operative* in making the SMFP determination is not readily discernible." AR at 17 (emphasis in original). The Adjudication Officer determined DCOPN mistakenly relied upon over inclusive data: "Compliance with the operative utilization standard cannot be reliably shown, due mainly to indicators that DCOPN overstated the operative data for PD 20." *Id*. He wrote, and the Commissioner agreed, that by overstating the number of relevant procedures in the planning district, the DCOPN Staff Report reflected a substantial or material mistake of law, establishing that Sentara had set forth grounds for concluding that good cause exists in relation to the CRMC project.

This Court cannot determine that a reasonable person would, upon consideration of the record as a whole, necessarily come to a different conclusion. To the contrary, the conclusion appears perfectly sounds. The Court finds that the Commissioner properly accepted Sentara's first allegation in its conclusion that DCOPN's Staff Report included a substantial and material mistake of fact or law.

That single mistake was sufficient to grant Sentara good cause standing in this matter, and the Court need not address the remaining allegations. Nonetheless, in the interest of compressing any issues that may arise upon further appellate review of this matter, the Court will review the remaining six alleged errors identified by the Commissioner that supported her decision to grant Sentara's petition.

2. The second allegation

Sentara alleged that it had identified significant relevant information not previously presented at and not available at the time of the public hearing relating to open and closed heart surgery case volumes in PD 20. The first such data cited was an Open heart Surgery Service Line report released by VHI on November 20, 2016, after DCOPN had issued the Staff Report. That data indicated declining or stagnant utilization of open heart surgery services at each program in PD 20. In addition, Sentara presented its own analysis of open heart surgery case volumes at Sentara Norfolk General Hospital and Sentara Virginia Beach General Hospital in an effort to *5 isolate the relevant "open and closed heart" surgical procedures from the larger body of procedure data reported in VHI's Annual Licensure Survey Data Report.

CRMC argues the new information in the VHI Open Heart Surgery Service Line report does not constitute significant relevant information sufficient to establish good cause standing. Conceding that it was not previously presented at nor available at the time of the public hearing, CRMC challenges nonetheless its relevance for COPN review purposes because it reports only open heart, and not closed heart, surgeries. CRMC also asserts that the data included is outside of the relevant reporting period. CRMC further takes issue with Sentara's reliance upon its own revisited utilization numbers from its two programs because that information was not "unavailable" at the time of the public hearing. Sentara could have done the analysis earlier and presented that information to DCOPN, according to CRMC.

This conundrum that requires applicants to prove an average of 400 open and closed heart surgical procedures without access to any report that transmits that particular set of data to VHI has only arisen recently. According to Sentara, neither DCOPN nor the hospital community had focused on the mismatch between the SMFP open heart surgery standards and the two available reports from VHI, one of which includes more than just open and closed heart procedures and the other of which includes less. Sentara argued that there is neither any definition nor general consensus on what even constitutes a "closed heart" procedure. Sentara's identification of the issue and its subsequent analysis and recount of all cardiac procedures done in its two PD 20 facilities in an effort to determine whether the procedure constitutes a "closed heart" procedure, can be fairly characterized as information that was not available at the time of the public hearing. Sentara represented that its personnel had to dig back through records and billing codes for hundreds of procedures and conducted interviews of clinicians to arrive at the new calculation of utilization data; and that new calculation was not available until that legwork had been done.

CRMC maintains that the ALSD set of data is correct and historically used in COPN reviews: "VHI's ALSD is the most accurate and most commonly used data in reviewing COPN applications" (CRMC Mem. in Supp. of Pet. at 15), and "Previous decisions (both approving and denying COPN applications) have relied on VHI ALSD as an appropriate and comprehensive data source" (CRMC Mem. in Supp. of Pet. at 19). Its references to the record in support of these assertions, however, cite a DCOPN Staff Report analyzing an application to add a cardiac catheterization laboratory - not an open heart surgery program. The inaccuracy noted by Sentara respecting the ALSD data relates to its reporting of open and closed heart procedures. *6

The Commissioner, whose task it is to evaluate whether a public need exists for new open heart surgical services, has the discretion to consider the available data that will aid in that decision. She determined that the VHI OHS data reported in November 2016 as well as Sentara's own recalculated cardiac surgery volumes would be relevant to her analysis. The Court does not conclude that her decision in that regard was arbitrary or capricious. No regulation forbids that reference or restricts her consideration to any particular reporting period. *Lewis-Gale Med. Ctr. LLC v. Romero*, No. 1289-13-3, 2014 WL 1707-055 at *10 (Va. Ct. App. Apr. 29, 2014).

The Court finds that the Commissioner properly concluded that significant relevant information not previously presented nor available at the time of the public hearing existed, which was sufficient to support granting good cause standing to Sentara.

3) The third allegation

Sentara's Good Cause Petition alleged that the DCOPN Staff Report made a substantial and material mistake of law in concluding that existing open heart surgery services performed an average of 400 open heart and closed heart surgical procedures in 2015. The SMFP requires this threshold showing before additional open heart surgery programs may be approved. 12 VAC 5-230-450(A)(2). DCOPN relied only on the ALSD Report and divided the total number of reported procedures in PD 20's cardiac operating rooms by three - the number of hospitals offering adult open heart surgery standards - to find that CRMC complied with the standard. Sentara maintained that when the number of operating rooms at each existing cardiac program in PD 20 is properly considered in gauging utilization, none of the existing open heart surgical services [or programs] in PD 20 performed an average of 400 open heart procedures. AR at 1983-1985. PD 20 has a total of eight cardiac ORs across the three cardiac programs. AR at 1984.

CRMC argues vigorously that the drafters of the SMFP know how to specify when procedures should be averaged per operating room, because they did so elsewhere in the SMFP. They did not include language specifying "per room" in the standard requiring existing "services" to perform an average of 400 open and closed heart surgical procedures. CRMC cites to a comment received by the SMFP Task Force during its review and revisions to the SMFP which discussed adding the "per room" rather than "per service" standard to this regulation. The revised SMFP ultimately did not include that suggested change, indicating that the drafters rejected the per room average that Sentara contends should govern. CRMC argues that DCOPN did not err by
7 averaging the procedures by the number of services rather than the number of operating rooms. *7

The Adjudication Officer interpreted the. SMFP regulation and the use of the word "services:"

> In similar utilization calculations performed for unrelated resources covered by the SMFP that have similar utilization standards, it is my belief that "services," as used in the SMFP, is normally defined for use to calculate *iterations* or discrete instances of a reviewable resource. In relation to calculating open and closed heart procedures, in this case, ORs, and not existing programs (of varying size) would lend themselves to a reliable determination.

AR at 18. The Commissioner agreed that the word "service" in the regulation should be interpreted as a per-OR standard and that DCOPN erred in disregarding the number of ORs in PD 20 to conclude that the required average of 400 procedures had been met.

It does appear to the Court that interpreting the regulation to require 400 procedures per hospital rather than per OR would be inconsistent with utilization standards in other parts of the SMFP, including the subparagraph immediately following the one at issue: "The proposed new service will perform at least 150 procedures per room in the first year of operation 250 procedures per room in the second year of operation ...." 12 VAC 5-230-450(A)(3). Other regulated services such as general purpose ORs and diagnostic services gauge utilization on a per-unit basis.

The Court is mindful that an agency's interpretation of its governing statutes, as reflected in its regulations, is entitled to great weight. *Manassas Auto., Inc. v. Couch*, 274 Va. 82, 87 (2007). "An agency's interpretation of its own regulation is controlling unless plainly erroneous or inconsistent with the regulations being interpreted." *Mathews v. PHH Mortg. Corp.*, 283 Va. 723, 738 (2012). If the regulation were specific and clear that the

Commissioner was *not* to consider the OR average and was categorically required to look at the hospitals' average, without reference to the number of ORs in the particular hospital, perhaps the interpretation given in this case could be characterized as arbitrary and capricious. The Court does not find such clarity in the regulations. The comment to the SMFP Task Force does not lend itself to any conclusive determination of the drafters' intent.

The Commissioner interpreted her agency's own regulation to require that DCOPN consider open heart surgery utilization per OR, which it did not do in this case. The Court does not find that interpretation to be plainly erroneous or inconsistent with the regulation being interpreted. The Court finds that the Commissioner properly accepted Sentara's third allegation and its conclusion that DCOPN's report included a substantial and material
8 mistake of fact or law. *8

4) The fourth allegation

Sentara argues that the DCOPN staff report contains a substantial material mistake of fact and law in its conclusion that the CRMC project was generally consistent with the cardiac catheterization utilization standards in the SMFP. That standard provides:

> Proposals to increase cardiac catheterization services should be approved only when ... among other things, all existing cardiac catheterization laboratories operated by the applicant's facilities where the proposed expansion is to occur have performed an average of 1,200 diagnostic equivalent procedures per existing and approved laboratory for the relevant reporting period.

12 VAC 5-230-400(1).

The DCOPN Staff Report states that CRMC performed 1,374 diagnostic equivalent procedures in 2015 without identifying the number of cardiac catheterization laboratories at the hospital. The hospital has two laboratories. AR at 2404. CRMC clearly did not satisfy the 1200 procedures per laboratory standard, and DCOPN's failure to account for the number of laboratories was a mistake.

CRMC's argument regarding this allegation is strained. It admits that DCOPN erred by failing to account for the number of laboratories, but it argues that the error is not substantial or material because if its other non-cardiac procedures are included in the utilization analysis, it could show compliance with the utilization standard. See AR at 1357 (showing combined totals per peripheral/vascular, electrophysiology, and cardiac catheterization procedures).

DCOPN clearly erred in its calculation. It did not comment on the inclusion of non-cardiac procedures in the calculation; it just seemingly forgot that CRMC has two laboratories rather than one. Sentara appropriately identified the error in its Good Cause Petition. Additionally, Table 7 in the DCOPN Staff Report (AR at 2173) does include the non-cardiac procedures (without accounting for the two laboratories) and those totals still do not satisfy the 1,200 procedures per laboratory standard. Thus, CRMC's argument about the immateriality of the error is not supported.

The Commissioner's conclusion that DCOPN committed a substantial and material mistake of fact and law in
9 determining that 1,374 diagnostic procedures across two laboratories *9 satisfied the utilization standard was a substantial and material mistake of fact. The Court finds that the Commissioner properly concluded that DCOPN's report included a substantial and material mistake of fact regarding CRMC's compliance with this standard. That conclusion was supported by uncontested evidence and was not arbitrary or capricious.

5) The fifth allegation

The DCOPN Staff Report included a finding that CRMC will perform the requisite number of open heart surgical procedures in the first two years of operation without significantly reducing the utilization of existing open heart surgery services in PD 20. 12 VAC 5-230-45(A)(iii). The report included no substantiation or analysis of CRMC's claims both that it would hit the SMFP target exactly and that other providers would not be harmed.

In questioning DCOPN's acceptance of CRMC's projections without analysis, the Adjudication Officer wrote:

> In a PD with three hospital-based cardiac programs exist, i) one is nationally-recognized for excellence, and ii) of the other two, one barely peaked 400 and the other hasn't met the first-year level, experience shows that compliance with SMFP projections in a procedure-sensitive, utilization-affected area of medicine cannot be credibly shown.

AR at 22.

CRMC vigorously defends its projected volumes with multiple citations to the record regarding the aging of the population, the demand for cardiac services, and its current referrals of patients to other providers. Its citations to the record regarding those assertions do not, however, make the case as clearly as CRMC argues. For example, CRMC argues: "The record shows that CRMC's program will also reach sufficient case volumes without negatively affecting existing programs." (CRMC's Mem. in Supp. of Pet. at 21). The footnote to that sentence refers to: (i) a chart titled "Impact of New Open Heart Service in PD 20," AR at 1457, which appears to demonstrate how each "service" [not each OR] will achieve the required 400 procedures per year; (ii) a table titled "Basis for CRMC Cardiac Surgery Projection Calculations, FY 2020-21," AR at 1358, which totals the patients that CRMC diverted from its facility to receive their surgeries elsewhere; and (iii) the testimony of witness Lori Pycior-Wright, AR at 1185. The referenced testimony was given at the IFFC on December 7, 2017 before the Adjudication Officer and not at the public hearing conducted by DCOPN. It was not therefore part of
10 the record that DCOPN had *10 considered prior to reaching the conclusion that CRMC's project would not negatively affect other providers.

Assuming for the sake of argument that the same or similar testimony had been provided to DCOPN to support that conclusion, the Court notes that the witness explained that virtually all of its projected volumes are cases that would otherwise go to Sentara Norfolk General:

> With regard to Norfolk General, Norfolk General has five open heart OR's. Chesapeake is proposing to have just one, which means it will not have the capacity to affect Norfolk General's surgical volumes beyond the number of procedures that can reasonably be performed on an annual basis in a single OR.

AR at 1189. A program that would empty out one of Norfolk General's ORs hardly sounds like one without negative impact. Sentara noted in oral argument that losing the volumes that CRMC projected to achieve would adversely affect its program.

The Court has reviewed all of the citations to the record offered by CRMC and only concludes that the data offered to both support and to rebut CRMC's projections and their likely effect on other providers was sharply contested and thus in need of analysis. If the record does contain sufficient data to support DCOPN's conclusion, CRMC nonetheless does not persuade the Court that the DCOPN actually conducted the analysis that the Commissioner expected and required. "The absence of substantiation (and no probing analysis), along with the sensitivity of the clinical discipline involved, makes me see DCOPN's coverage of this section of the SMFP as allowing a substantial and material mistake of fact and law to occur, as exhibited in the DCOPN staff report. *Id*.

The Commissioner has the right to require her staff to conduct a detailed analysis of submitted data rather than simply relying upon its existence in the record. The Court concludes that the Commissioner's determination about the absence of any such analysis did constitute a substantial material mistake of fact and law and was a basis for granting good cause party status to Sentara. Her decision was supported by substantial evidence and was neither arbitrary nor capricious. *11

6) The sixth allegation

The Commissioner did not find good cause as to Sentara's sixth allegation, and the Court therefore does not address it.

7) The seventh allegation

The Commissioner agreed with Sentara that the DCOPN Staff Report failed to recognize, address, and evaluate the impact of CRMC's program on the three existing providers of open heart surgery in the planning district, all of which are located within 30 minutes driving time from CRMC. The COPN law requires consideration of the "relationship of the project to the existing health care system of the area to be served, including the utilization and efficiency of existing services and facilities." Va. Code § 32.1-102.3(B)(5). The Staff Report allotted only two lines to exploring this impact. The Commissioner determined that "the failure of the DCOPN Staff Report to explore, beyond a mere two lines in the report, the relationship of the project to existing facilities in PD 20 constitutes a substantial and material mistake of fact and law in the DCOPN Staff Report." AR at 23.

Again, CRMC defends the conclusion reached by the DCOPN staff but does not show that the Staff Report sufficiently explored and analyzed this issue. CRMC also does not indicate what evidence in the record supports the conclusion that it can hire the specialized staff needed to run an open heart surgery program without recruiting losses to existing programs. Sentara argues:

> Nationwide, specialized cardiothoracic staff is in short supply due to population trends, fewer cardiothoracic residents, training programs closing in response to unfilled positions, and a retiring cardiothoracic workforce. Given these practical challenges well-documented in the Agency Record, it is highly unlikely that CRMC would be able to secure the specialized staff necessary to operate an open heart surgery program without diverting already scarce personnel from existing providers.

(Sentara's Mem. in Opp. to Pet. at 29-30, citing AR at 1592-1608).

Again, the Commissioner may in her exercise of discretion determine that certain issues should have been considered in DCOPN's assessment of public need. The Court concludes that the Commissioner acted within her specialized competence in determining that the absence of any such analysis constituted a substantial material mistake of fact and law and was a basis for granting *12 good cause party status to Sentara. The Court thus funds that her decision in that regard was not arbitrary or capricious and that there was substantial evidence to support her conclusion.

8) The eighth allegation

Sentara's petition alleged that the DCOPN Staff Report contained a substantial material mistake of fact and law in its failure to identify for the Commissioner other factors that are relevant to or that militate against a determination of public need. AR at 1990-92. The COPN law calls on the Commissioner to consider, "at the discretion of the Commissioner, any other factors as may be relevant to the determination of public need for a project." Va. Code § 32.1-102.3(B)(2)(vi). DCOPN, however, "did not identify any other factors to bring to the

attention of the Commissioner not discussed elsewhere in this staff analysis report." AR at 2195. The Commissioner concluded that such failure constitutes a substantial and material mistake of fact and laws. AR at 23.

First, CRMC challenges the Commissioner's finding of error based on the DCOPN's failure to consider the impact of the proposal on underutilized open heart surgery providers in PD 20 and its failure to consider whether an additional program would raise quality concerns. CRMC's Mem. in Supp. of Pet. at 13-15. The Court has already noted that the Commissioner properly decided that DCOPN's failure to address the impact of CRMC's proposal on other providers constituted a substantial and material mistake of law. It is entirely within the Commissioner's specialized competence and discretion, which shall be afforded due deference, to conclude that DCOPN's failure to consider any of these factors constitutes error; and therefore, her decision was not arbitrary or capricious.

Second, CRMC claims that the Commissioner acted arbitrarily and capriciously by considering information outside the Agency Record, specifically the Adjudication Officer's Recommendation regarding Sentara's reputation and ranking as well as an assertion that past unrelated COPN decisions support a link between high utilization volumes and program quality. CRMC's Pet. at 17. The parties differ on the existence of any volume-to-quality correlation, with CRMC arguing both that no such correlation exists and that no evidence of such a correlation exists in this record.

Sentara argues that both of these assertions are within the Agency Record and correctly notes that it is entirely within the Commissioner's discretion to consider any information in the Agency Record. *13

Even if these assertions were not in the Agency Record, "the rules of evidence are relaxed in an administrative proceeding and the findings will not be reversed solely because the Commissioner considered evidence not in the record." *Johnston-Willis*, *Ltd v. Kenley*, 6 Va. App. 231, 258 (1988) (citing *U.S. v. Pierce Auto Freight*, *Lines*, *Inc.*, 327 U.S. 515, 529-30 (1946)) ("[T]he mere fact that the [agency] has looked beyond the record does not invalidate its action unless substantial prejudice is shown to result."); *Johnston-Willis*, 6 Va. App. at 258 (citing *Virginia Real Estate Com'n v. Bias*, 226 Va. 264, 270 (1983)) ("No reversible error will be found ... unless there is a clear showing of prejudice arising from the admission of such evidence, or unless it is plain that the agency's conclusions were determined by the improper evidence, and that a contrary result would have been reached in its absence").

CRMC has not demonstrated substantial prejudice or shown "that the Commissioner would have reached a contrary result in the absence of [her] consideration" of any outside evidence. *Johnston-Willis*, *Ltd v. Kenley*, 6 Va. App. 231, 258 (1988). CRMC's contentions fail to establish legal error, and the Court finds that the Commissioner's findings were not arbitrary or capricious.

CONCLUSION

Acting within her specialized competence and discretion, the Commissioner found that good cause existed with respect to seven of Sentara's eight allegations of material mistakes of fact and law in the DCOPN Staff Report . Her findings must be afforded due deference. She also made factual determinations that are supported by substantial evidence in the Agency Record. The Court cannot and does not determine that a reasonable person, considering the record as a whole, would necessarily reach different factual determinations. Therefore, the Court AFFIRMS the Commissioner's case decision granting good cause standing to Sentara.

Counsel for Sentara is directed to draft and circulate for endorsement a Final Order that incorporates the findings of this Letter Opinion and submit the same for entry within thirty days.

Sincerely,

Mary Jane Hall

Judge MJH/MAM/nm