

**DISTRICT OF COLUMBIA**  
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MJ HOME HEALTH SERVICES  
Petitioner

v.

DISTRICT OF COLUMBIA DEPARTMENT  
OF HEALTH STATE HEALTH PLANNING  
AND DEVELOPMENT AGENCY  
Respondent

Case No.: 2010-DOH-00334

**FINAL DECISION ON MJ HOME HEALTH SERVICES’  
CERTIFICATE OF NEED APPLICATION**

**I. INTRODUCTION**

On July 22, 2010, the Director of the District of Columbia Department of Health, State Health Planning and Development Agency (“SHPDA”) denied MJ Home Health Services’ (MJ or Petitioner) Certificate of Need (CON) application. On August 31, 2010, SHPDA denied MJ’s Request for Reconsideration of the July 22, 2010, denial. On September 13, 2010, MJ filed a Notice of Appeal with the Office of Administrative Hearings appealing this decision. *See* D.C. Code, 2001 Ed. §44-413.

**II. PROCEEDINGS IN THIS CASE**

After exchanging information through discovery, the parties filed extensive pretrial pleadings with voluminous attachments. Additionally, SHPDA filed an electronic copy of the

record (“Administrative Record”)<sup>1</sup> it compiled during consideration of MJ’s CON application. I convened an evidentiary hearing on October 6, 2011, at 10:30 a.m. Paul Toulouse, Esq., represented MJ. Amy Schmidt, Esq., represented SHPDA. MJ Owner Ernest Igwacho and SHPDA Director Amha Selassie testified. By agreement of the parties I may consider for purposes of this Order all documents submitted by the parties before the evidentiary hearing, including SHPDA’s Administrative Record, Mr. Igwacho’s, Ken Courage’s, and Denise Capaci’s affidavits. *See* MJ’s Motion for Summary Adjudication, exhibits 7-9. As well as the 2007 District of Columbia State Health Plan. Exhibit 300.

### **III. STANDARD OF REVIEW AND BURDEN OF PROOF**

The statute governing CON appeals provides that I “shall review the record and any additional evidence presented on behalf of the parties to the appeal [and] shall take due account of the presumption of official regularity, the experience, and specialized competence of the SHPDA, and the purposes of this chapter.” D.C. Code, 2001 Ed. § 44-413(b). This statute also provides that the District of Columbia Administrative Procedures Act (“APA”) shall govern any contested test case held by this administrative court. D.C. Code, 2001 Ed. § 44-413(c). The APA, in turn, requires that “findings of fact and conclusions of law shall be supported by and in accordance with . . . reliable, probative, and substantial evidence.” D.C. Code, 2001 Ed. § 2-509(e). Finally, although they come at this standard from different perspectives, the parties agreed that SHPDA’s decision shall not be disturbed unless it is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law. *Brown v. Watts*, 993 A.2d 529, 532 (D.C. 2010) *quoting* *Zhang v. D.C. Dep’t of Consumer & Regulatory Affairs*, 834 A.2d 97, 101 (D.C. 2003).

### **IV. FINDINGS OF FACT**

1. An overarching goal of District of Columbia health planning is “the elimination of racial and ethnic health disparities.” Exhibit 300, 2007 District of Columbia State Health Plan, page ix. In order to accomplish this goal, the U.S. Surgeon General suggested six areas of focus:

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<sup>1</sup> I actually ordered SHPDA to file an indexed copy of the record. What I did not realize, until it was too late, is that the electronic file is not indexed. So, I cannot make easy reference to a document at, for example, “Administrative Record, Tab 6.” Consequently, my references to documents from the Administrative Record will also contain the document name as it appears on the electronic record SHPDA provided.

infant mortality, breast and cervical cancer, cardiovascular disease, diabetes, immunizations, and HIV/AIDS. *Id.* The Surgeon General’s strategic plan “was for public and private organizations to develop and implement the needed changes in the health care system (access to care, mental health, injury and violence, environmental quality, and immunization). . . .” *Id.* The District of Columbia has embraced the Surgeon General’s ideas. *Id.*, at pages ix and x.

2. In order to be licensed as a home health agency, the District of Columbia Department of Health, Health Regulation and Licensing Administration (HRLA) requires agency applicants for initial licensure to first obtain a CON. 22 District of Columbia Municipal Regulations (DCMR) B3102.3. HRLA has not yet licensed Petitioner as a home health agency.

3. On September 18, 2009, MJ submitted a CON application. Administrative Record, Application part1, part2, and part3. Responding to staff concerns, MJ ultimately identified its target population as any medically-eligible client “older than 21 years of age (with no upper [age] limit).” Administrative Record, Response to Staff Questions, page 2; MJ’s Motion, exhibit 1, page 2 (SHPDA July 22, 2010, Denial of MJ CON Application); *compare* Administrative Record, Application part1, pages 24-27. After SHPDA staff analyzed the application, it recommended that the application be denied. Administrative Record, Staff Report. So, MJ preemptively withdrew its application for a “second opportunity to make the case for a new home health care agency in Washington, DC.” MJ’s Motion, exhibit 4, June 22, 2010, email from Ernest Igwacho to Director SHPDA Director Amha Selassie; Administrative Record, Letter postponing review.

4. MJ reassessed its strategy and resubmitted its application, with, among other things, a new target population (patients whose psychiatric illness complicates treatment of their physical illness, so that having a skilled home health aide would improve health outcomes) and a Quality Assurance Plan. Exhibit 100<sup>2</sup>, pages 27-32; MJ’s Motion, exhibit 1. MJ’s new application also outlined a training regime for staff focused on providing specialized services for the targeted

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<sup>2</sup> The parties agreed that the electronic copy of MJ’s additional submission was incomplete (it was missing footnotes), and that I should rely on a hard-copy provided by MJ’s counsel. But, despite the fact that I admitted it into evidence during the hearing, it appears I did not give it an exhibit number. For ease of reference, I have labeled it “Exhibit 100” and will refer to it as such throughout this Decision.

population. Exhibit 100, page 22. MJ proposed accepting “75 patients in the first year.” *Id.*, page 29. MJ filed this application with SHPDA on May 3, 2010.

5. One component of its Quality Assurance plan is the creation of an Advisory Council. Exhibit 100, pages 47-50, and 53-54. Petitioner’s new application also created a continuing education program. *Id.*, pages 50, and 121-123. Petitioner’s document establishing the Advisory Council refers to “MJ Home Health Service” three times, but in one place refers to “Ivory Home Care” services. *Id.*, page 53. Petitioner has demonstrated the ability to meet the criteria and standards for quality of care.

6. In order to establish “need” for the proposed service, SHPDA requires applicants to

discuss the need that the population to be served has for the services proposed to be offered or expanded. Explain how you reached the conclusion that there is unmet need. Include an analysis of the area and population to be served, the present and future utilization patterns of the proposed facility and services(s), and the impact of the proposal, if implemented, on the utilization of existing facilities and services in the area. Use the methodology (if any) specified in the Comprehensive Health Plan. Demonstration of an unmet need is essential to approval of an application for a CON.

Exhibit 100, page 27.

7. In a June 20, 2010, email to Director Selassie, Mr. Igwacho characterized the new submission as having “made significant changes to the original application after identifying a specific gap in home health services. We identified the gap in services among dually diagnosed patients (severe mental and medical/surgical illness) via needs assessment analysis.” MJ’s Motion, exhibit 4. The median age for this population is 45 years old.

8. “Mental disorders” rose as a cause of hospitalizations across the District of Columbia from 1997 to 2002 (from seventh to sixth). Exhibit 300, pages 22-23. Among men, “hospitalizations due to mental disorders rose in rank from fifth to third within the [same period].” *Id.*, page 23. Moreover, the concentration of men with a mental health discharge

diagnosis is heaviest in Wards 4, 5, 7, and 8.<sup>3</sup> *Id*, page 24. The same is true of women. *Id*, page 25.

9. In 2004, the top ten causes of death for District of Columbia residents by Ward was:

Cause of Death	WARD								
	<u>Totals</u>	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8
<u>Population</u>	572,059	80,014	82,845	79,566	71,393	66,548	65,457	64,704	61,532
<b>HEART DISEASE</b> <b>*Rates</b>	1,301 227.4	105 131.2	142 171.4	178 223.7	218 305.4	202 303.5	138 210.8	194 299.8	115 186.9
<b>CANCER</b> <b>Rates</b>	1,132 197.9	114 142.5	140 169.0	135 169.7	207 289.9	167 250.9	115 175.7	164 253.5	82 133.3
<b>ESSENTIAL HYPERTENSION</b> <b>Rates</b>	326 57.0	34 42.5	45 54.3	32 40.2	45 63.0	56 84.1	34 51.9	43 66.5	37 60.1
<b>HIV/AIDS</b> <b>Rates</b>	223 39.0	34 42.5	25 30.2	2 2.5	16 22.4	44 66.1	23 35.1	34 52.5	42 68.3
<b>ACCIDENTS</b> <b>Rates</b>	210 36.7	18 22.5	20 24.1	17 21.4	32 44.8	33 49.6	23 35.1	32 49.5	32 52.0
<b>CEREBROVASCULAR DISEASES</b> <b>Rates</b>	196 34.3	13 16.2	16 19.3	25 31.4	38 53.2	29 43.6	20 30.6	30 46.4	22 35.8
<b>DIABETES</b> <b>Rates</b>	187 32.7	15 18.7	13 15.7	13 16.3	25 35.0	36 54.1	20 30.6	44 68.0	21 34.1
<b>HOMICIDE</b> <b>Rates</b>	178 31.1	8 10.0	4 4.8	1 1.3	21 29.4	34 51.1	31 47.4	36 55.6	41 66.6
<b>CHRONIC LOWER RESPIRATORY</b> <b>Rates</b>	145 25.3	10 12.5	23 27.8	19 23.9	30 42.0	20 30.1	15 22.9	20 30.9	8 13.0
<b>INFLUENZA/PNEUMONIA</b> <b>Rates</b>	136 23.8	12 15.0	16 19.3	13 16.3	25 35.0	25 37.6	8 12.2	25 38.6	10 16.3

Exhibit 300, page 17 (\*the “rates” are per 100,000 population).

10. The life expectancy in the District of Columbia, by race and gender, for those born between 1989 and 1991 is:

<sup>3</sup> Analysis of health data at the ward level is “a useful guide in targeting health policies and resources. . . .” Exhibit 300, page v.

<u>White</u>		<u>African American</u>	
Male	Female	Male	Female
71.4	81.1	57.5	71.6

Exhibit 300, page 9.

11. In Fiscal Year 2008, the federal Medicare program covered approximately “73,000 D.C. residents, or about 13% of the population.” Exhibit 301, District of Columbia, Department of Health Care Finance, Medicaid Annual Report, FY 2008, page 4.<sup>4</sup> Additionally, in FY 2008, 144,910 people received Medicaid-funded health care, which constituted approximately 24.5% of the population. *Id.*; Administrative Record, 09-8-1 Response to Staff Questions. Of Medicaid recipients, the percentages by ward and ethnicity were:

African American		Hispanic			White		Unknown
85%		10%			3%		3%
Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8
10%	13%	1%	12%	14%	11%	18%	20%

Exhibit 301, page 4.

12. As Petitioner prepared its new (May 3, 2010) CON application, Mr. Igwacho spoke with DMH Director of Integrated Care Jana Berkow and her colleague, Senior Deputy Director

<sup>4</sup> I found the 2008 Fiscal Year Medicaid Annual Report on the District of Columbia, Department of Health Care Finance Website. It is the most recent published report. As these data were not adduced during the hearing, I am giving the parties until January 27, 2012, to file and serve any and all objections they have to admission of the data. D.C. Code, 2001 Ed. § 44-413(b). Otherwise, it will be admitted as exhibit 301.

for Policy Barbara Bazron, Ph.D. Both administrators told Mr. Igwacho that there is a need for a home health agency that provides specialized care for the population of District of Columbia residents with a dual diagnosis of mental illness and severe medical/surgical illness. MJ's Motion, exhibit 4. Ms. Berkow then conducted a voluntary survey of DMH's core service agencies (CSAs). MJ's Motion, exhibit 4, attachment. Of the CSAs used by DMH, four agencies responded: Community Connections (DMH's largest CSA), Green Door (DMH's second largest), Volunteers of America ("very representative of [DMH's] smaller agencies of color"), and Family Preservation (also, "very representative of [DMH's] smaller agencies of color"). *Id.*

13. As a result of her survey, Ms. Berkow learned that on the last day of FY 2009, DMH had 14,571 consumers who had billed for at least one claim during the prior 90 days. *Id.* St. Elizabeths Hospital had 351 discharges (this number may not be 351 different people as an individual may have been admitted and discharged more than once during the fiscal year), and of these discharges, 77 consumers (22%) required a home health aide. *Id.*

14. During FY 2009, Community Connections enrolled 3,820 DMH consumers. *Id.* Of these, 76 had a home health aide, but another 120 (almost 5% of its total population) required, but did not have a home health aide. *Id.* Of the total enrolled population, 497 had diabetes, 382 had HIV/AIDS, 1,031 had high blood pressure, and 649 had chronic respiratory diseases. *Id.*

15. During FY 2009, Green Door enrolled 1,913 DMH consumers. Of these, it estimated that 574 would benefit from a home health aide. *Id.* Of the total enrolled population, 151 had diabetes, 97 had HIV/AIDS, 308 had high blood pressure, and 3 had chronic respiratory disease. *Id.*

16. During FY 2009, Volunteers of America enrolled 319 DMH consumers. Of these, 4 had a home health aide and 3 more required, but did not have, a home health aide. *Id.* Of the total enrolled population, 12 had diabetes, 6 had HIV/AIDS, 63 had high blood pressure, and 1 had chronic respiratory disease. *Id.*

17. During FY 2009, Family Preservation enrolled 356 DMH consumers. Of these, 5

required, but did not have a home health aide. *Id.* Of the total enrolled population, 5 had diabetes, 10 had HIV/AIDS, 80 had high blood pressure, and 3 had chronic respiratory disease. *Id.*

18. On September 1, 2011, Ken Courage was President and Chief Operating Officer of the PIW. MJ's Motion, exhibit 7. PIW is a "short-term, acute care psychiatric hospital. . . . Each year [PIW discharges] hundreds of consumers with mixed medical and psychiatric diagnoses. . . . PIW will work with [Petitioner], by both providing referrals and receiving their clients into our care. . . . It is with much enthusiasm that PIW pledges its support of [Petitioner's] CON application to operate a home health care agency. . . . [N]o one from the SHPDA staff communicated with me (Mr. Courage) or staff at PIW in regards to my letter of support. Had they done so, I would have told SHPDA staff that to the best of my knowledge there has never been and there is presently no District of Columbia CON home health care agency with staff adequately trained to provide home health care services to District of Columbia consumers with mixed medical and psychiatric diagnoses, that there is a need for a CON home health care agency in the District of Columbia with trained staff to provide these services and in my view, [Petitioner] would fulfill that need." *Id.*, exhibit 7.

19. On August 22, 2011, Denise Capaci, LICSW, was Executive director of Anchor Mental Health and Director for Adult and Family Services division of Catholic Charities. MJ's Motion, exhibit 8. Anchor is a "core service agency [for] the Department of Mental Health and is a full service community mental health center, which provides care to more than 800 adult consumers in Washington, DC. More than 500 consumers from our facility present with severe chronic medical problems and an estimated 150 may need home care services. In an effort to improve compliance and provide comprehensive care to home bound consumers, we welcome the opportunity to work with [Petitioner]. . . . [N]o one from the state health planning and development agency of the DC department of health staff communicated with me (Ms. Capaci) or staff at Anchor Mental Health in regards to my letter of support. Had they done so, I would have told SHPDA staff that to the best of my knowledge there has never been and there is presently no District of Columbia CON home health care agency with staff adequately trained to provide home health care services to District of Columbia mentally ill patients that present with coexisting medical/surgical morbidities, that there is a need for a CON home health care agency

in the District of Columbia with trained staff to provide these services and in my view, [Petitioner] would fulfill that need.” *Id.*, exhibit 8.

20. As SHPDA has not approved Petitioner’s CON application and HRLA has not given Petitioner a home health agency license, Petitioner cannot enter into formal agreements with public and private organizations that provide ancillary or support services to its target population. But Petitioner does have existing relationships with such organizations, including La Clinica del Pueblo, Psychiatric Institute of Washington (PIW), Anchor Mental Health, and the Department of Mental Health (DMH), as well as others, that demonstrate consistency with the criteria and standards of continuity of care. Exhibit 100, page 45-47, and 146-151; MJ’s Motion, exhibit 9.

21. Petitioner provided financial documents in its application and in response to every staff request. Petitioner’s responses satisfied the Chair of the Project Review Committee (PRC). MJ’s Motion, exhibit 10 (transcript of the June 17, 2010, PRC meeting). In its denial, SHPDA’s staff concluded that Petitioner’s financial documentation “actually produces additional questions.” Based on those questions, SHPDA decided Petitioner had “not demonstrated an ability to meet the criteria and standards for financial feasibility.” MJ’s Motion, exhibit 1. But, neither subsequent to the June 17, 2010, PRC meeting, nor in its July 22, 2010, denial of Petitioner’s CON application did SHPDA ever articulate those questions, or allow Petitioner an opportunity to respond. Petitioner has demonstrated an ability to meet the criteria and standards for financial feasibility.

22. At no time prior to denying Petitioner’s CON application did SHPDA did have information specific to the population of persons with a dual diagnosis of mental illness and medical/surgical morbidities, including data on the number of District residents who are dually-diagnosed, the number of such persons served by home health care agencies, the name of home health care agencies that train their staff to treat consumers with a dual diagnosis, the number of persons with a dual diagnosis discharged from hospitals, or the number discharged who request home health care agency services. MJ’s Motion, exhibit 6.

23. SHPDA staff did conduct a needs assessment by reviewing “data on the number of District residents requiring home health care services and residents utilizing home health care.” MJ’s Motion, exhibit 1. *See* 22 DCMR B4050.6(b). Staff used the National Library of Medicine definition of “home care” to determine that home health services are accessed by ““people who

are getting older, are chronically ill and recovering from surgery or disabled.” *Id.* So SHPDA staff looked at data for three sub-sets of people: 1) the elderly; 2) those recovering from acute care services; and 3) those with disabilities. *Id.*

24. SHPDA staff analyzed discharge data from seven District of Columbia hospitals to home care agencies; trends in the percentage of the District’s elderly population; and trends in the number of people with disabilities in the District who are “self-care.” MJ’s Motion, exhibit 1. These data led to the conclusions that: (i) there is a decrease in the number of patients discharged from these seven District of Columbia hospitals to home care agencies (in 2005 there were 3,756 discharges, in 2006 there were 3,186 discharges, and in 2007 there were 2,822 discharges); (ii) the percentage of residents 65 and older in the District of Columbia declined from 1990 to 2008 by 9% (contrary to a national increase of 22%); and (iii) the number of people with disabilities who are “self-care” is not growing (based on data from 2003, 2007, and 2008). *Id.*

25. SHPDA staff also conducted a preliminary survey of local home health agencies. MJ’s Motion, exhibit 1. It used as baseline data the 2007 Edition of the District of Columbia State Health Plan, which incorporated the 1989 Edition’s chapter on Home Health Care. Exhibit 300. The 1989 Edition of the State Health Plan contained a 1986 utilization study conducted by the Georgetown University’s Department of Community and Family Medicine in collaboration with the District Government and the Capital Home Health Care Association (“Georgetown Study”).

26. The 1986 Georgetown Study concluded that at that time, 13,431 patients received home health services from 22 home health agencies. MJ’s Motion, exhibit 1. In 2010, SHPDA staff’s preliminary study concluded that in 2009 approximately 13,000 residents received home health services from 30 home health agencies (not all 30 agencies participated in the study). *Id.* Additionally, staff noted that of the 30 agencies, over the preceding five years SHPDA had approved 12 of the home care agencies and not all had completed the required procedures to become Medicare and Medicaid certified. Consequently, staff believed it was “reasonable to assume that recently opened agencies have the capacity to absorb additional patients” and there is no “need for additional home health care services.” *Id.* Finally, SHPDA staff noted that “no case has been made to SHPDA, either by acute care providers, long-term care providers, third

party payers, or Government entities, that there is a need for additional general home health care services.” *Id.* (emphasis added).

27. Based on its analysis of local hospital discharge data, a decline in the District elderly population, stability in the self-care, disabled population, and because no case had been made for additional general home care agencies, SPHDA staff concluded that Petitioner had failed to show there was a need for its services. MJ’s Motion, exhibit 1. SHPDA staff also concluded that Petitioner had failed to demonstrate an ability to meet the quality of care, continuity of care, or financial feasibility standards. *Id.* Based on these perceived deficiencies, SHPDA staff recommended that Petitioner’s CON application be denied. On July 22, 2010, Director Selassie wrote Mr. Igwacho informing him that SHPDA denied Petitioner’s CON application. *Id.* On August 31, 2010, Director Selassie denied Petitioner’s motion for reconsideration.

28. Hospital referrals to home health agencies only account for approximately 15% of all referrals. The American Community Survey, which SHPDA staff used to determine that the number of self-care disabled in the District was stable, specifically warned readers not to compare data from the 2007 and 2008 surveys, as the data points had changed. From 2003 to 2007, the number of self-care disabled in the District grew in raw numbers by 2,452. *See* MJ’s Motion, exhibit 1.

29. SHPDA analyzed Petitioner’s CON application as if it intended to be a general home health care agency. SHPDA did not focus on the fact that Petitioner’s May 3, 2010, application pared down its targeted population to District residents with a dual diagnosis of severe mental illness and medical/surgical morbidities. People with a dual diagnosis of severe mental illness and medical/surgical morbidities have specialized medical needs.

## **V. DISCUSSION**

As noted above, the parties agreed that the standard of review in this case is whether SHPDA’s denial was arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law. In a recent case, the District of Columbia Court of Appeals has noted that “If, after examining the record as a whole, we conclude that the agency’s findings are supported by substantial evidence, we must accept those findings even though the record could support a contrary finding.” *Brown v. Watts*, 993 A.2d 529, 532 (D.C. 2010) *quoting* *Zhang v. D.C. Dep’t of Consumer & Regulatory Affairs*, 834 A.2d 97, 101 (D.C. 2003). Earlier, the Court of Appeals

noted, “We do not reassess the merits of the decision, but instead determine ‘whether the findings and conclusions were arbitrary, capricious or an abuse of discretion, or not supported by substantial evidence.’” *Wash. Canoe Club v. D.C. Zoning Comm'n*, 889 A.2d 995, 998 (D.C. 2005) quoting *Dupont Cir. Citizens Ass'n v. D.C. Zoning Comm'n*, 355 A.2d 550, 560 (D.C.), cert. denied, 429 U.S. 966 (1976). “Substantial evidence is ‘relevant evidence such as a reasonable mind might accept as adequate to support a conclusion.’” *Davidson v. Office of Empl. Appeals*, 886 A.2d 70, 72 (D.C. 2005) quoting *Mills v. D.C. Dep't of Emp't Servs.*, 838 A.2d 325, 328 (D.C. 2003).

### **A. The Case in Support of Petitioner**

In the District of Columbia, poverty, race/ethnicity, morbidity, and early death all converge in the wards that also have the highest concentration of men and women discharged from a hospital with a mental health diagnosis; namely Wards 4, 5, 7, and 8. Exhibits 300, pages 9, 17, and 24; and 301, page 4. An overarching goal of District of Columbia health planning is “the elimination of racial and ethnic health disparities.” Exhibit 300, 2007 District of Columbia State Health Plan, page ix. In response to the problem of racial and ethnic health disparities, the U.S. Surgeon General proposed a broad-based solution, which the District of Columbia has embraced, “for public and private organizations to develop and implement the needed changes in the health care system (access to care, mental health, injury and violence, environmental quality, and immunization). . . .” *Id.*, at pages ix and x.

Petitioner stepped into this mix, identifying, correctly, a “gap in services among dually diagnosed patients (severe mental and medical/surgical illness).” MJ’s Motion, exhibit 4. Ken Courage, President of the Psychiatric Institute of Washington, concurred with Petitioner’s assessment that “to the best of my knowledge there has never been and there is presently no District of Columbia CON home health care agency with staff adequately trained to provide home health care services to District of Columbia consumers with mixed medical and psychiatric diagnoses, [and] that there is a need for a CON home health care agency in the District of Columbia with trained staff to provide these services . . . .” MJ’s Motion, exhibit 7. Similarly, Denise Capaci, LICSW, Executive director of Anchor Mental Health and Director for Adult and Family Services division of Catholic Charities, agreed “that to the best of my knowledge there has never been and there is presently no District of Columbia CON home health care agency

with staff adequately trained to provide home health care services to District of Columbia mentally ill patients that present with coexisting medical/surgical morbidities, that there is a need for a CON home health care agency in the District of Columbia with trained staff to provide these services.” MJ’s Motion, exhibit 8. Finally, in response to Petitioner’s interrogatories, SHPDA acknowledged knowing of no home health agency with staff trained to “served the [specialized] needs of dually diagnosed persons. . . .” MJ’s Motion, exhibit 6.

Thus, the context for SHPDA’s review of Petitioner’s CON application is District of Columbia health policy that is dedicated to improving access to health care with a special emphasis on patients with mental illness, a recognition that race/ethnicity are important factors in this equation, plus a health care system that lacks but needs a home health care agency dedicated to serve and provide specialized care to patients with a dual diagnosis of severe mental illness and medical/surgical morbidities. As SHPDA found Petitioner’s application lacking in four areas (need, quality of care, continuity of care, and financial feasibility), I will address each area in turn.

### **1. Need for the Service**

Petitioner’s evidence of need consisted of a study conducted by the District of Columbia Department of Mental Health; affidavits from PIW President Ken Courage and Anchor Executive Director Denise Capaci, the uncontested evidence that people with a dual diagnosis of severe mental illness and medical/surgical morbidities have specialized medical needs; evidence that there is currently no home health care agency with staff adequately trained to provide home health care services to such patients; and proof that the median age of these patients is 45 years.<sup>5</sup>

DMH’s study concluded that for fiscal year 2009, 77 consumers discharged from St. Elizabeths Hospital needed a home health aide, as did 120 consumers assigned to its CSA Community Connections, 3 assigned to its CSA Volunteers of America, 5 assigned to its CSA Family Preservation. Additionally, 574 consumers assigned to its CSA Green Door would “benefit” from a home health aide (which is not the same as be eligible for one). MJ’s Motion, exhibit 4, attachment. Additionally, DMH found that of Community Connection’s enrolled

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<sup>5</sup> According to the State Plan the “Need for health services are derived from an assessment of the health status of the community, or by utilization of population/service ratios.” Exhibit 300, pages 41-42. *See also* 22B DCMR 4309.8.

DMH consumers (3,820), 497 had diabetes, 382 had HIV/AIDS, 1,031 had high blood pressure, and 649 had chronic respiratory diseases; of Green Door's enrolled DMH consumers (1,913), 151 had diabetes, 97 had HIV/AIDS, 308 had high blood pressure, and 3 had chronic respiratory disease; of Volunteers of America's enrolled DMH consumers (319), 12 had diabetes, 6 had HIV/AIDS, 63 had high blood pressure, and 1 had chronic respiratory disease; of Family Preservation's enrolled DMH consumers (356), 5 had diabetes, 10 had HIV/AIDS, 80 had high blood pressure, and 3 had chronic respiratory disease. *Id.* DMH Director of Integrated Care Jana Berkow, the study's author, and her colleague, Senior Deputy Director for Policy Barbara Bazron, Ph.D, told Mr. Igwacho that there is a need for a home health agency that provides specialized care for the population of District of Columbia residents with a dual diagnosis of mental illness and severe medical/surgical illness. MJ's Motion, exhibit 4.

Further, PIW President Courage wrote that "[e]ach year hundreds of consumers with mixed medical and psychiatric diagnoses are discharged from this hospital. With the expertise of its staff, MJ will be able to fulfill the need for home health services among these consumers. PIW will work with [Petitioner], by both providing referrals and receiving their clients into our care. . . ." MJ's Motion, exhibit 7. Additionally, Anchor Executive Director Capaci wrote that "[m]ore than 500 consumers from our facility present with severe chronic medical problems and an estimated 150 may need home care services." MJ's Motion, exhibit 8.

SHPDA's primary arguments against Petitioner's evidence were that it did not contradict SHPDA's special analysis (discussed below), or otherwise constitute substantial evidence that there is a need for an additional home health agency in the District of Columbia. District's Response to Motion for Summary Adjudication, page 5. SHPDA attacked as "anecdotal evidence" the number of DMH consumers Petitioner identified as constituting unmet need. *Id.*, page 6. But SHPDA's argument does not persuade me. DMH is a District Government agency and I have no reason to give less credence to its data than I do to SHPDA's "preliminary" study, which was a premise for its conclusion that there was no need for Petitioner's services (*see* below). DMH had sufficient confidence in its numbers to publish them, and SHPDA failed to give me reason to discredit the evidence.

Petitioner's application stated that it intended to accept "75 patients in the first year." Exhibit 100, page 29. DMH's study identified 205 consumers, who, according to the testimony

of Director Selassie had specialized medical needs, and, according to DMH, required but were not receiving, specialized home health aide services.<sup>6</sup> Here alone, Petitioner established that there is ample unmet need within this subpopulation for it to remain financially viable. Exhibit 300, page 41 (one component of the Health Systems Plan administered by SHPDA is “financial viability of the proposed services”). This unmet need is in addition to the 574 consumers Green Door said would “benefit” from a home health aide (which the parties agree is not a substitute for being eligible.)

Furthermore, SHPDA’s challenge to the affidavits submitted by PIW President Courage and Anchor Executive Director Capaci missed their point. Both affiants declare that they know of no home health care agency dedicated to serve and provide specialized care to patients with a dual diagnosis of severe mental illness and medical/surgical morbidities (a point on which Director Selassie concurs). MJ’s Motion, exhibits 7 and 8. Thus, in the words of PIW President Courage, PIW will make referrals to Petitioner from the “hundreds of consumers with mixed medical and psychiatric diagnoses” discharged from PIW each year. MJ’s Motion, exhibit 7. Anchor Executive Director Capaci was more specific by projecting that “500 consumers from our facility present with severe chronic medical problems and an estimated 150 may need home care services.” MJ’s Motion, exhibit 8.

Thus, SHPDA reduced to mere anecdotal evidence the opinion of two mental health professional in the community, who direct large mental health programs, that promise to make referrals to Petitioner, and note that they make such referrals from 100s of consumers (if not 1,000) every year. One reason that SHPDA dismisses Petitioner’s evidence is because of the “detailed studies cited in the Denial” (SHPDA is referring to the special analysis it conducted and cited in its denial of Petitioner’s CON application). Although I set out my concerns about

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<sup>6</sup> The health data that DMH collected from its CSAs should have been an important component of SHPDA’s analysis, because the morbidities identified clearly result in earlier death rates for our fellow residents with mental illness, if they also happen to be poorer and a racial/ethnic minority. Exhibit 300, pages 9 and 17 (for example, for residents of Wards 3 and 8 compare the percentage on Medicaid (1% in Ward 3, 20% in Ward 8), the life expectancy for men (71.4 years in Ward 3, 57.5 years in Ward 8), the rate of hypertension (40.2 in Ward 3, 60.1 in Ward 8), the rate of HIV/AIDS (22.4 in Ward 3, 68.3 in Ward 8), and the rate of diabetes (16.3 in Ward 3, 34.1 in Ward 8). District of Columbia health policy implies that ameliorating these health needs through the provision of specialized home health aides to eligible consumers results in better health outcomes. Exhibit 300, pages ix and x.

that analysis below, suffice it to say that I disagree with SHPDA's argument that Petitioner's evidence pales in comparison to its. Given that the affidavits supplement the DMH study, I credit these affidavits.

Although I would have preferred that Petitioner had supplied more data on the numbers of consumers with severe mental illness who require home health aide services, we must not lose sight of these undisputed facts: 1) there is currently no home health agency dedicated to providing these services, so Petitioner would "corner the market;" 2) Petitioner proposed accepting only 75 patients during its first year; and 3) DMH alone identified at least 205 consumers who needed but did not have a home health aide. When these essential facts are coupled with the whole record, I conclude Petitioner presented substantial evidence of need and SHPDA's conclusion to the contrary was not supported by substantial evidence.

## 2. Quality of Care

Petitioner's evidence to support its contention that it satisfied the quality of care criteria consists of its detailed CON application and, specifically, its newly acquired nurse staffing license, quality assurance and continuing education plans, and Advisory Council.<sup>7</sup> MJ's Motion, pages 33 and 34. SHPDA acknowledges that Petitioner obtained a nurse staffing license and that that issue is moot. District's Response, page 9. In its report denying Petitioner's CON application, SHPDA acknowledged that Petitioner submitted quality assurance and continuing education plans with its May 3, 2010, application. MJ's Motion, exhibit 1, page 15. Thus, SHPDA wrote that it "is baffled as to how Petitioner interprets these as adverse findings."<sup>8</sup> *Id.*, page 10. Therefore, both sides agree that what remains is SHPDA's rejection of Petitioner's

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<sup>7</sup> According to the State Health Plan, "Quality is defined as the degree or grade of excellence which characterizes services received by an individual or group. It is measured by gradations or levels of existence, rather than by its presence or absence; and can be determined in terms of technical competency, need for the service provided, and appropriateness." Exhibit 300, page 43. *See also* 22B DCMR 4309.4 and 4309.23.

<sup>8</sup> Actually, SHPDA's position is baffling. On the one hand SHPDA is "baffled" by Petitioner's interpretation of SHPDA's action on these matters as "adverse," but then states that SHPDA found the documents to be "insufficient." District's Response, page 10. If SHPDA found the documents to be "insufficient," did it not make an adverse finding? Or, if SHPDA made a finding that the documents were insufficient, why is it baffled by Petitioner's interpretation that the finding was adverse?

proposed Advisory Council.

Petitioner's application provided a detailed response to SHPDA's questions concerning quality of care. Exhibit 100, pages 3, 13-18, 24-37, and 44-51. Petitioner's quality assurance and continuing education plans (which it failed to submit with its original application) are substantive and comport with regulatory standards. The document Petitioner used to create its Advisory Council incorrectly states in one sentence that it governs "Ivory Home Care Services," despite its many correct references to Petitioner. *Id.*, page 53. Petitioner explained that this was a "typographical and editing error arising from the use of a similar Advisory Council in an application for a home care agency of another subsidiary of petitioner in the state of Pennsylvania." MJ's Motion, page 40.

SHPDA argued that it correctly interpreted this typographical error as meaning "there would be no advisory council to monitor Petitioner's quality standards." District's Response, page 10. SHPDA's argument is a reach. The document in question clearly states it is creating an "Advisory Council" for "MJ Home Health Service." Exhibit 100, page 53. The enabling document references Petitioner by name three times. Petitioner's explanation for why "Ivory Home Care Services" appears in the section labeled "General Power" is plausible and I credit it. Further, the SHPDA's argument does not persuade me that Petitioner has no advisory council. Rather, I conclude that Petitioner does have an advisory council, but that Council needs to correct the typographical error in its enabling document.

Therefore, based on the whole record I conclude that Petitioner presented substantial evidence (including Petitioner's quality assurance and continuing education plans) of its ability to meet the criteria and standards for quality of care, and SHPDA's conclusion to the contrary was not supported by substantial evidence. *See* exhibit 300, pages 43-44.

### **3. Continuity of Care**

Petitioner's evidence to support its contention that it satisfied the continuity of care criteria is its detailed CON application, most of which SHPDA acknowledged in its July 22,

2010, denial.<sup>9</sup> Exhibit 100, pages 4-12; MJ's Motion, exhibit 1, pages 15-16. Further, Petitioner points to its existing relationships with such organizations, including La Clinica del Pueblo, Psychiatric Institute of Washington (PIW), Anchor Mental Health, and the Department of Mental Health (DMH), as well as others. Exhibit 100, page 45-47, and 146-151; MJ's Motion, exhibit 9.

In its July 22, 2010, denial, SHPDA focused on Petitioner's failure to have "partnership agreements" with the organizations that Petitioner said it had collaborative relationships with. As SHPDA has not approved Petitioner's CON application and HRLA has not given Petitioner a home health agency license and Petitioner is not otherwise an ongoing operation in the District of Columbia, Petitioner's plausible argument convinces me that it cannot yet enter into formal agreements with public and private organizations that will provide ancillary or support services to its target population. Certainly, SHPDA did not present any evidence showing that the industry norm is for formal agreements to be entered at this stage. Further, in its Response, SHPDA also argued that Petitioner's application did not provide "meaningful details such as number of staff, number of proposed clients as to how it will deliver these services or in the case of physical or occupational therapy, the location of the therapy sessions." District's Response, page 11. I do not understand the basis for this assertion, because, as Petitioner noted, its application provided these "meaningful details."

Therefore, based on the whole record I conclude that Petitioner presented substantial evidence of its ability to meet the criteria and standards for continuity of care, and SHPDA's conclusion to the contrary was not supported by substantial evidence. *See* exhibit 300, pages 44-45 (continuity of care is "measured by the ease in which individuals move between required elements of the system and the degree to which the elements are integrated").

#### 4. **Financial Feasibility**

Petitioner's evidence to support its contention that it satisfied the financial feasibility criteria is its detailed CON application, its responses to staff questions, and the affirming

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<sup>9</sup> According to the State Health Plan, "Continuity is the effective structuring, coordination and delivery of services on a continuous basis in one or more settings. . . . It is measured by the ease in which individuals move between required elements of the system and the degree to which the elements are integrated." Exhibit 300, page 44. *See also* 22B DCMR 4309.14.

comments of the Chair of the Project Review Committee (PRC).<sup>10</sup> Exhibit 100, pages 2-5, and 8-14; Administrative Record, 09-8-1 Response to Staff Questions; MJ's Motion, exhibit 10 (transcript of the June 17, 2010, PRC meeting). In its denial, SHPDA's staff concluded that Petitioner's financial documentation "actually produces additional questions." Based on those questions, SHPDA decided Petitioner had "not demonstrated an ability to meet the criteria and standards for financial feasibility." MJ's Motion, exhibit 1. But in its pleading, SHPDA argued that Petitioner's failure to meet its burden was two fold: 1) Petitioner "only supplied the supply side of funding with no reference to what the demand for services will be;" and 2) Petitioner did not provide a "basis for how it determined the cost of treatment." District's Response, page 11.

On the presumption that the "additional questions" it had were those articulated in its brief, I do not understand SHPDA's position. In assessing a CON application, District of Columbia Health Policy discounts "demand" for a service, compared to "need," and Petitioner, as set forth above, has presented substantial evidence of need. Exhibit 300, page 42 ("Demand for health services is that quantity of health services which the population is willing and able to purchase over a relevant period of time. . . Planning must be based primarily on need while taking into consideration demand and want") (emphasis added). So, it is unclear, why SHPDA argued that Petitioner had an additional obligation to address "demand" for its services.<sup>11</sup>

Further, Petitioner's application contains very detailed data setting forth the basis for how it determined the "cost of treatment." Exhibit 100, pages 2-5, and 8-14. These data were supplemented with additional data supplied in response to staff questions. Administrative Record, 09-8-1 Response to Staff Questions. Of importance to me is that much of the data used were actually generated by the federal or District governments, so they were easily verifiable.<sup>12</sup>

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<sup>10</sup> The State Health Plan does not contain a definition of "financial feasibility," although it does discuss cost (which briefly mentions "financial viability"). *But see* 22B DCMR 4309.7.

<sup>11</sup> It is also interesting that SHPDA did not, apparently, take "demand" into consideration when it assessed Petitioner's CON application. It only raised this issue during this litigation.

<sup>12</sup> The data was applicable to the application because Petitioner's primary sources of funding were to be Medicare and Medicaid; keeping in mind that in FY 2008, Medicaid and Medicare recipients constituted approximately 37% of the District's population. Exhibit 301.

With a final submission, concerns articulated by the Chair of the PRC appear to have been alleviated. MJ's Motion, exhibit 10.

Therefore, based on the whole record I conclude that Petitioner presented substantial evidence of its ability to meet the criteria and standards for financial feasibility, and SHPDA's conclusion to the contrary was not supported by substantial evidence.

### **5. Petitioner's CON is consistent with the State Health Plan**

The pertinent regulations require that "Each decision of the SHPDA, or the appropriate judicial or administrative review body, to issue a Certificate of Need shall be consistent with the State Health Plan. . . ." 22B DCMR 4309.4. As noted above, an overarching goal of District of Columbia health planning is "the elimination of racial and ethnic health disparities." Exhibit 300, 2007 District of Columbia State Health Plan, page ix. In order to accomplish this goal, the U.S. Surgeon General recommended six areas of focus: infant mortality, breast and cervical cancer, cardiovascular disease, diabetes, immunizations, and HIV/AIDS. *Id.* The Surgeon General's solution "was for public and private organizations to develop and implement the needed changes in the health care system (access to care, mental health, injury and violence, environmental quality, and immunization). . . ." *Id.* The District of Columbia has embraced the Surgeon General's suggestions. *Id.*, at pages ix and x.<sup>13</sup>

As noted previously, in the District of Columbia, poverty, race/ethnicity, morbidity, and early death all converge in the wards that also have the highest concentration of men and women discharged from a hospital with a mental health diagnosis; namely Wards 4, 5, 7, and 8. Exhibits 300, pages 9, 17, and 24; and 301, page 4. Petitioner identified correctly, a gap in services among patients with a dual diagnosis of severe mental and medical/surgical illness. MJ's Motion, exhibits 4, 7 and 8. Given that the available data establishes that their mental illness causes frequent hospitalizations, that these patients have significant co-morbidities, and that their lower incomes and average racial/ethnic background (at least in District of Columbia) all present significant barriers to their receipt of health care, I conclude that Petitioner's efforts to provide

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<sup>13</sup> The governing regulations also require SHPDA to "consider the contribution of the proposed service in meeting the health related needs of members of medically underserved groups . . . (such as low income persons, racial and ethnic minorities, women, and handicapped persons) . . ." 22B DCMR 4309.10.

home health aides with specialized training for this sub-set of the medically eligible population is not only consistent with the State Health Plan, it will help the District of Columbia reduce barriers to care that result in health disparities for persons with mental illness.

### **B. SHPDA's Special Analysis**

The pertinent regulations mandate that

in cases in which the D.C. State Health Plan does not specify need, the project shall be found to be needed by the SHPDA Director on the basis of a special analysis of District or larger area service and facility needs. Such study shall consider the appropriateness of utilization rates of the same or similar services of the applicant or other providers.

22 DCMR B4050.6(b). *See* MJ's Motion, exhibit 1.

SHPDA staff decided to use a special analysis in this case. Here, SHPDA staff used the National Library of Medicine definition of "home care" to determine that home health services are accessed by "people who are getting older, are chronically ill and recovering from surgery or disabled." MJ's Motion, exhibit 1. So SHPDA staff looked at data for these three sub-sets of people: 1) the elderly; 2) those recovering from acute care services; and 3) those with disabilities. *Id.* On the patient "need" side of the equation, SHPDA staff analyzed discharge data from seven District of Columbia hospitals to home health agencies; trends in percentage of the District's population that is elderly; and trends in number of people with disabilities in the District who are "self-care." *Id.*

On the "capacity" side of the equation, SHPDA staff conducted a preliminary survey of local home health agencies. *Id.* It used as baseline data a 1986 Georgetown Study, which concluded that at that time, 13,431 patients received home health services from 22 home health agencies. Exhibit 300. In 2010, SHPDA staff's study concluded that in 2009 approximately 13,000 residents received home health services from 30 home health agencies (not all 30 agencies participated in the study). *Id.* Additionally, staff noted that SHPDA has approved 12 home health agencies over the preceding five years and not all had completed the required procedures to become Medicare and Medicaid certified. Consequently, staff believed it was "reasonable to assume that recently opened agencies have the capacity to absorb additional patients" and there is no "need for additional home health care services." *Id.* Finally, SHPDA

staff noted that “no case has been made to SHPDA, either by acute care providers, long-term care providers, third party payers, or Government entities, that there is a need for additional general home health care services.” *Id.* (emphasis added).

Petitioner challenged SHPDA’s special analysis as flawed and inapplicable to its CON application because SHPDA’s conclusions were directed at an agency that provided “general home health” services; not a home health agency with the targeted population and specialized services Petitioner envisioned. Additionally, Petitioner argued that SHPDA’s special analysis: 1) overemphasized the impact that hospital discharges have on the home health agency business; 2) misidentified the elderly as a focus of Petitioner’s targeted population; and 3) incorrectly compared the American Community Surveys from 2007 and 2008 to conclude that the number of people with a disability that “self-care” was decreasing.

Petitioner’s uncontested evidence was that hospital referrals to home health agencies account for approximately 15% of all referrals. Regardless, “mental disorders” rose as a cause of hospitalizations across the District of Columbia from 1997 to 2002 (from seventh to sixth). Exhibit 300, pages 22-23. Among men, “hospitalizations due to mental disorders rose in rank from fifth to third within the [same period].” *Id.*, page 23. Moreover, the concentration of men with a mental health discharge diagnosis is heaviest in Wards 4, 5, 7, and 8. *Id.*, page 24. The same is true of women. *Id.*, page 25. Thus, despite SHPDA’s special analysis regarding general home health care services, the District of Columbia’s health data establishes that mental health problems continue to drive hospitalizations, and a mental health diagnosis at discharge is prevalent in those wards of the District that have the highest rates of Medicaid coverage and preventable death. Exhibits 300 and 301. These data raise serious doubts about the applicability and reliability of SHPDA’s conclusions regarding hospital referrals to Petitioner’s CON application.

Additionally, SHPDA relied on a 9% decrease in residents 65 and older in the District of Columbia from 1990 to 2008 (compared to a national increase of 22%), as evidence that there is not need for additional home health care services. Petitioner’s uncontested evidence was that the median age for the targeted population (patients with a dual diagnosis of severe mental illness and medical/surgical morbidities) was 45 years. Thus, even if SHPDA’s data does establish that the population of residents 65 and older in the District of Columbia has declined (and may

continue to decline), there is no obvious link between this fact and Petitioner's application to serve a targeted, younger population with specialized services.

Finally, SHPDA relied on Census Bureau data released in the American Community Survey to show that the number of people with a disability that are "self-care" is "not growing." MJ's Motion, exhibit 1. Necessarily, SHPDA concluded that there was no data to support a finding that need existed for additional home health care services. Petitioner argued that SHPDA was misplaced to rely on the American Community Surveys for 2003, 2007, and 2008 to establish that this population did not grow. Specifically, Petitioner acknowledged that the Census Bureau study found there were 11,883 such residents in 2003, 14,335 in 2007, and 12,417 in 2008. *Id.* But, it also presented uncontested evidence that the 2008 Survey used different data points than the 2003 and 2007 Surveys, such that the Census Bureau specifically warned readers that they could not compare the data from 2008 with earlier Surveys. Based on this warning, because SHPDA never examined this data closely, the comparable data in the Surveys show that the number of people with a disability that are "self-care" grew from 2003 to 2007 by 2,452.

Lastly, SHPDA studied home health agencies in the District of Columbia. On the patient need side, SHPDA determined that approximately 13,000 residents received home health agency services in 2009. MJ's Motion, exhibit 1. On the provider capacity side, SHPDA conducted a survey of home health agencies that have CONs and are certified Medicaid providers (which is a smaller number than home health agencies licensed by HRLA). SHPDA determined that there were 30 such home health agencies. SHPDA then compared these numbers to the Georgetown Study and determined that patient need had remained relatively flat; while provider capacity had expanded (the number of providers grew from 22 in 1986 to 30 in 2010). *Id.* Additionally, SHPDA also considered:

- 1) that 20 of the 30 providers responded to its survey and the results established that demand can be met by the existing provider community (SHPDA multiplied the number of providers that responded by an average number of patients and added the sum of the number of providers that did not respond by a smaller average number of patients);
- 2) that it had approved 12 home health agencies over the preceding five years and not all had completed the required procedures to become Medicare and Medicaid certified; and

- 3) that “no case has been made to SHPDA, either by acute care providers, long-term care providers, third party payers, or Government entities, that there is a need for additional general home health care services.” *Id.*

Consequently, staff believed it was reasonable to presume that recently opened agencies could absorb more patients, and that the provider community as a whole was not at capacity. MJ’s Motion, exhibit 1.

Petitioner’s primary contention, as noted above, is that SHPDA’s study of the provider community was based only on home health agencies that provide general services (as compared to Petitioner’s plan to provide specialized services to a targeted population). Additionally, Petitioner argued that SHPDA’s conclusion that outside parties are not arguing for additional home health agencies is based on two errors: 1) there is evidence of a push for specialized home health agencies from DMH’s CSAs, PIW, and Anchor; and 2) SHPDA, again, failed to look at Petitioner’s plan to provide specialized services to a targeted population. SHPDA did not have information specific to the population of persons with a dual-diagnosis (those with mental illness and medical/surgical morbidities), including the number of persons served by home health care agencies. MJ’s Motion, exhibit 6. This information gap prevents SHPDA’s study of the provider community from being dispositive or even helpful in analyzing Petitioner’s CON application.

During his testimony, Director Selassie said that SHPDA was not attentive to the fact that Petitioner had shifted its focus from the broad population of medically-eligible persons, to the subset of those medically-eligible who also have a severe mental health diagnosis (in other words, they have a dual diagnosis). I think this failure is one reason, but not the only, that SHPDA decided to deny Petitioner’s application, or at least deny the application in the manner and with the special analysis data that it did. I conclude SHPDA’s special analysis does not constitute substantial evidence that there is no need for an additional home health agency targeting the subset of those medically-eligible who also have a severe mental health diagnosis in the District of Columbia. To the extent there are other points SHPDA argued in support of its contention that its special analysis is substantial evidence that are not specifically addressed herein, I have considered and rejected these points.

**VI. Conclusion**

For the reasons set forth above, I conclude there was not substantial evidence for SHPDA's denial of Petitioner's CON application. In that regard, SHPDA's denial was arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law. I reverse SHPDA's denial of Petitioner's CON application and its denial of Petitioner's request for reconsideration.

On this 13<sup>th</sup> day of January 2012, it is hereby

**ORDERED**, that the District of Columbia, State Health Planning and Development Agency's denial of Petitioner MJ Home Health Services' Certificate of Need application is **REVERSED**; and it is further

**ORDERED**, that the District of Columbia, State Health Planning and Development Agency shall issue Petitioner MJ Home Health Services a Certificate of Need, in accord with Petitioner's application; and it is further

**ORDERED**, that no later than **January 27, 2012**, any party shall file and serve any and all objections to the admission of the document entitled *District of Columbia 2008 Fiscal Year Medicaid Annual Report* (or any portion thereof); it is further

**ORDERED**, that unless an objection is filed, the *District of Columbia 2008 Fiscal Year Medicaid Annual Report* is **ADMITTED** into evidence as exhibit 301; it is further

**ORDERED**, that the appeal rights of any person aggrieved by this Order are stated below.

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Jesse P. Goode  
Administrative Law Judge