73454-7

73454-7

No. 73454-7-I

(King County Superior Court No. 15-2-04698-5)

IN THE COURT OF APPEALS, DIVISION I
OF THE STATE OF WASHINGTON

PROVIDENCE HEALTH & SERVICES – WASHINGTON, D/B/A PROVIDENCE REGIONAL MEDICAL CENTER EVERETT; PROVIDENCE HEALTH & SERVICES – WASHINGTON, D/B/A PROVIDENCE SACRED HEART MEDICAL CENTER; and SWEDISH HEALTH SERVICES, D/B/A SWEDISH MEDICAL CENTER/FIRST HILL,

Petitioners/Appellants,

v.

DEPARTMENT OF HEALTH OF THE STATE OF WASHINGTON,

Respondent.

UNIVERSITY OF WASHINGTON MEDICAL CENTER,

Intervenor.

APPELLANTS' OPENING BRIEF

Peter S. Ehrlichman, WSBA 6591
Shawn Larsen-Bright, WSBA 37066
DORSEY & WHITNEY LLP
701 Fifth Avenue, Suite 6100
Seattle, WA 98104-7043
Telephone: (206) 903-8800
Fax: (206) 903-8820
Attorneys for Petitioners/Appellants

E

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Regulations

Other Authorities

I. INTRODUCTION AND RELIEF REQUESTED

This administrative appeal concerns whether the University of Washington Medical Center ("UWMC") will be given special, preferential treatment and exempted from the normal requirements of the Department of Health ("Department") Certificate of Need ("CON") process for approving new hospital beds, or whether UWMC will be held to the same standards as all other hospitals, as required by law. The agency action at issue is the Department's erroneous decision to "make an exception" and grant UWMC a CON for unneeded beds. This decision was made even though the legal standards applied by the Department in every other acute care bed case required the CON to be denied. The Department's decision was unprecedented and without basis in law or fact. It should be reversed.

In 2012, UWMC finished construction on a new building (the "Montlake Tower") without obtaining Department approval. UWMC understood from the outset that a CON would be required before it could add acute care hospital beds to its new building. It also knew that there was no community need for additional beds, but it decided to shell in the entire building anyway. Once it did so, UWMC wanted to speed up the timetable for acute care bed use of the space it had built, despite the lack of community need. UWMC applied for a CON seeking the right to add 79 acute care beds to its Tower (the "Application"), with the expectation that it could convince the Department to approve the beds notwithstanding the community's bed surplus and lack of need for the foreseeable future.

The Department's CON Program ("Program") spent a year

collecting data and evaluating the Application. The Program Analyst and the Department's financial expert, who were charged with conducting the evaluation, correctly determined that the Application *failed* the four CON statutory review criteria (need, financial feasibility, cost containment, and structure and process of care), in part because there was no community need projected for new beds according to the methodology always applied by the Department. Accordingly, the Analyst prepared an extensive written evaluation concluding that the Application should be *denied.* At the last minute, however, the Analyst's boss's boss, Bart Eggen, unilaterally ordered the Analyst to award a CON to UWMC. Eggen had not taken part in the evaluation process, nor had he reviewed *any* of the Application materials, the documents or data submitted in opposition, or any other materials. Without any further analysis, the Program's "no" was summarily changed to a "yes" and the Application was approved, despite failing the legal standards universally applied to all previous applications.

Petitioners/Appellants Providence Health & Services–Washington and Swedish Health Services ("Petitioners") requested an adjudicative proceeding to review and reverse the Program's flawed decision. At the hearing, the Program completely abandoned and made no effort to defend its written decision. Instead, it deferred entirely to UWMC to try to justify issuance of the CON. Since the Application failed under the standards always applied by the Department, UWMC asked the Presiding Officer to affirm the CON under a purported "alternative" analysis mentioned in the long-defunct State Health Plan. This "alternative," which has been

referred to in this case as "Criterion Two," had *never* been used by the Department in the 34-year history of the CON Program. In fact, it was not even considered in the Program's year-long evaluation of the Application. Nonetheless, the Department's Presiding Officer acceded to UWMC's request and affirmed Eggen's directive to issue the CON, relying upon "Criterion Two." In essence, without any legal authority, the Presiding Officer ruled that UWMC was so "unique" that the Department would not apply the normal rules to its Application.

Petitioners sought administrative review by the Department. The Review Officer affirmed the Presiding Officer's decision in its entirety with little further analysis. Both the Presiding Officer and the Review Officer improperly focused on the desires and perceived institutional needs of UWMC itself, such as UWMC's inflated claims of overcrowding. But individual institutional needs are *not* part of the statutory framework for evaluating CON applications, nor are they a legal basis for issuing a CON. To the contrary, as the Department has itself confirmed in prior decisions: "Determining the need for acute care hospital beds looks to the need for additional acute care beds *in the service area and not whether the individual facility needs more beds.*"[1] Furthermore, UWMC failed to present substantial evidence to support issuance of the CON even under the invalid "alternative" standard it espoused. Both the standards used by

[1] *In re CON Decision on Providence Sacred Heart Med. Ctr. Proposal to Add 152 Acute Care Beds to Spokane County ("In re Sacred Heart")*, Final Order (2011) (AR2441-99), Finding of Fact No. 1.32 (emphasis added) (AR2465-66).

the Department to evaluate the Application, and its assessment of the Application against those standards, were materially flawed and wrong.

In its race to approve new beds for a fellow state-funded entity, the Department has thrown out its year-long evaluation of the Application, controverted its own longstanding policy and practice, and disregarded the governing statutory and regulatory requirements. Its decision, if allowed to stand, would effectively forever give UWMC a de facto exemption from the health care planning framework established by the legislature and applied consistently by the Department for decades. It has granted a CON for 79 new beds even though there is no need for more beds projected out into the future under the usual methodology and even though the Application failed the review criteria as always applied. This is not a case where a state agency has conducted a legitimate, lawful analysis entitled to deference and affirmance; instead, the Department simply made an exception contrary to Washington law, arbitrarily and capriciously, and without substantial evidence. The decision should be reversed.

II. ASSIGNMENTS OF ERROR

1. The Department erred in approving UWMC's Application for a CON to add 79 new acute care hospital beds to its current license.

2. The Department erred in entering its Findings of Fact, Conclusions of Law, and Initial Order dated September 12, 2014 (the "Initial Order"). *See* Appendix A (AR3119-56).

3. The Department erred in entering its Findings of Fact, Conclusions of Law, and Final Order dated January 26, 2015 (the "Final

Order"), including Finding of Fact 1.1 and Conclusion of Law 2.4, which affirms and adopts in full all Findings of Fact and Conclusions of Law set forth in the Initial Order. *See* Appendix B (AR3493-507). For ease of reference, herein the Findings of Fact in the Initial Order will be referred to as the "Findings" and the Conclusions of Law in the Initial Order will be referred to as the "Conclusions."

4. The Department erred in entering Finding 1.3.[2]

5. The Department erred in entering Finding 1.4.

6. The Department erred in entering Finding 1.6.

7. The Department erred in entering Finding 1.7.

8. The Department erred in entering Finding 1.8.

9. The Department erred in entering Finding 1.11.

10. The Department erred in entering Finding 1.12.

11. The Department erred in entering Finding 1.13.

12. The Department erred in entering Finding 1.14.

13. The Department erred in entering Finding 1.15.

14. The Department erred in entering Finding 1.17.

15. The Department erred in entering Finding 1.18.

16. The Department erred in entering Finding 1.19.

17. The Department erred in entering Finding 1.20.

---

[2] The Initial Order contains extensive footnotes. For the avoidance of doubt, assignments of error include all footnotes associated with the identified Findings. In addition, several of the "Findings" are very lengthy, including a few that span multiple pages. It is not practicable, in the page limits available here, for Petitioners to specifically parse out each erroneous aspect of each Finding and thus, they assign error to each Finding as a whole. For reference, a chart setting forth specific statements in the Initial Order to which Petitioners have taken specific exception is set forth at AR3275-84.

18. The Department erred in entering Finding 1.21.

19. The Department erred in entering Finding 1.22.

20. The Department erred in entering Finding 1.25.

21. The Department erred in entering Finding 1.26.

22. The Department erred in entering Finding 1.29.

23. The Department erred in entering Finding 1.30.

24. The Department erred in entering Finding 1.31.

25. The Department erred in entering Finding 1.32.

26. The Department erred in entering Finding 1.33.

27. The Department erred in entering Conclusion 2.3.

28. The Department erred in entering Conclusion 2.9.

29. The Department erred in its discussion set forth in the Initial Order and Final Order that was not numbered or identified as any Finding or Conclusion (*see* Initial Order, pp. 6-13; Final Order, pp. 2-12).

30. The Department erred in refusing to allow Petitioners to introduce actual 2012 Comprehensive Hospital Abstract Reporting System ("CHARS") statistical data while yet allowing UWMC to rely upon and introduce inaccurate statements and projections concerning the 2012 data.

III. ISSUES PERTAINING TO ASSIGNMENTS OF ERROR

Did the Department err in granting UWMC a CON for 79 new acute care hospital beds? Specifically:

1. The methodology that has always been used by the Department to determine whether there is need for new acute care beds establishes that there is no need for the 79 beds requested by UWMC, and,

in fact, shows that there is already a substantial surplus of beds well into the future. Under established law and practice, the Application thus fails the "need" criterion (WAC 246-310-210). Nonetheless, the Department held that "need" existed under a new analysis, referred to as "Criterion Two," which has never been used before and is inconsistent with prior Department decisions and CON law. Did the Department err in concluding that the need criterion could be satisfied through Criterion Two? (Assignments of Error 1-13, 27-29).

2. If Criterion Two is allowed to be used as a standard to evaluate whether need exists for additional beds, did the Department err in concluding that UWMC had proven actual community need despite the lack of evidence? (Assignments of Error 1-13, 27-29).

3. UWMC's Application omitted $34,000,000 in capital costs related to the proposed addition of beds, contrary to law. As a result, no evaluation of the true capital cost of UWMC's project has ever been performed by the Department to determine whether it satisfies the financial feasibility and cost containment criteria in WAC 246-310-220 and WAC 246-310-240. Moreover, the Department has always held that these criteria are not satisfied where, as here, there is no numeric need for beds. Did the Department err in concluding that UWMC's Application nonetheless satisfied the financial feasibility and cost containment criteria as required by law? (Assignments of Error 1-5, 14-19, 22-29).

4. Even if it was not legal error to apply Criterion Two in finding the need criterion was satisfied, did the Department err in

concluding that UWMC's Application also satisfied the *other* required CON review criteria, given that there is not substantial evidence to find: (a) its project is the superior alternative to address any purported need, and that other alternatives are not available or practicable (WAC 246-310-240(1)); and (b) it will not result in duplication or fragmentation of care (WAC 246-310-230(4))? (Assignments of Error 1-5, 20-29).

5. Longstanding, consistent Department policy requires the Department to use the most accurate, up-to-date statistical data available in reviewing CON applications (in this case, 2012 CHARS data). Did the Department err in refusing to consider this accurate data, as proffered by Petitioners, while considering inaccurate projections or portions of the same data proffered by UWMC? (Assignment of Error 30).

IV. STATEMENT OF THE CASE

A. CON Regulatory Framework And The Bed Need Methodology

As noted above, this case arises from UWMC's request for a CON to add 79 new acute care hospital beds. Under Washington law (RCW Chapter 70.38, WAC Chapter 246-310), CON applications for acute care beds are analyzed using four review criteria, which *all* must be satisfied to obtain approval. *See* WAC 246-310-210 (need); WAC 246-310-220 (financial feasibility); WAC 246-310-230 (structure and process of care); WAC 246-310-240 (cost containment). The applicant must prove that the proposed project is needed by the community, will foster containment of health care costs, is financially feasible, and will benefit the structure and process of care delivery in the community. *Id.* This framework aids in

managing health planning in a comprehensive manner that considers community interests rather than the interests of any particular facility, avoiding duplication of services, and controlling costs and inefficiencies. Indeed, an applicant's own institutional wants or needs are not supposed to be part of any of the review criteria. *Id.*

For health planning and CON purposes, the Department divides the state into regions called "service" or "planning" areas. UWMC is located in the North King Planning Area ("Planning Area"), along with several other hospitals, including Petitioner Swedish's Ballard campus ("Swedish/Ballard"), and UWMC's sister facility, UW Medicine Northwest Hospital ("UW/Northwest"), which is near Northgate. AR3515-16. Virtually all of the services provided in the Planning Area are duplicated at multiple facilities therein. AR4261; RP1079-86.

Since the enactment of the CON statute in 1979, the Department has begun its analysis in matters like this one by applying a multi-step numeric need methodology (the "Methodology"), which forecasts the number of beds actually needed in the applicable planning area.[3] Indeed, the Department has conceded that it has used the Methodology in *every* prior evaluation of the need for new acute care beds. *See* AR3029. This has ensured a "predictable, transparent, and consistent" process for applicants throughout Washington and for the Department.[4]

---

[3] *See, e.g., In re: CON Decision by Dep't of Health re: Valley Med. Ctr. et al. ("In re Valley")* (AR2362-439), Final Order (2012), Findings of Fact 1.13, 1.14 (AR2375).

[4] *In re Valley*, Finding of Fact 1.14, footnote 8 (AR2375).

In general terms, the Methodology utilizes (1) patient hospital utilization data, (2) population projections, (3) adjustments for patient in-migration and out-migration into and out of the planning area, and (4) the existing inventory of acute care beds, to calculate the numerical need for, or surplus of, beds in a planning area as of the planning target year (seven years in the future). AR4722-30. Historically, the Department has denied any CON application where the Methodology does not show a need for new beds. *See* RP820, 831-35, 838.

B. UWMC Builds A New Tower And Wants To Fill It With Unneeded Acute Care Hospital Beds

In 2008, the University of Washington Regents approved the construction of the Montlake Tower, a new medical building, to take place in two phases. AR3519, 3784. Phase 1 included the construction of a five-story hospital building at a cost of $170 million. AR3748, 3783. Phase 2 was planned as a future vertical expansion, including a shell for three additional floors. *Id.* UWMC understood that a CON would be required before it could add new acute care beds to these three additional floors, and anticipated that CON approval would be sought in the latter part of this 2010 decade. AR3519; RP72. In 2010, however, the Regents decided to complete Phase 2 early, and approved a $34,000,000 capital expenditure to shell in the three additional floors. AR3783-84.

The new three-floor shell was completed by October 2012. AR3519-20. At that point, UWMC faced a dilemma of its own making. Having chosen to prematurely shell in three additional floors, UWMC was

then strongly motivated to try to prematurely occupy the empty floors by filling them with additional acute care beds (meaning patients and revenues), even though the community had no need for additional hospital beds. Thus, in November of 2012, years earlier than it had originally planned, UWMC applied for a CON to add 79 surplus acute care beds to its Tower. *Id.* Notably, UWMC's Application represented that the total capital cost of the project to add 79 beds was $70,771,363, which omitted the $34,000,000 in incurred construction costs for the brand new three-floor shell, one-third of the actual capital cost. AR3550.

C. The Program Analyst Who Evaluated The Application Determines That It Fails The CON Review Criteria

The Department, led by CON Program Analyst Bob Russell, engaged in a thorough, year-long evaluation of the Application, ending in November of 2013. AR4712-58. The process included multiple screenings of the Application by the Program, a public hearing, and the submission of extensive written analyses and statements by UWMC, Petitioners, and other interested persons. *See, e.g.*, AR3743-832, 3842-46, 3991-4077, 4464-523. The public comment rebuttal period ended on July 11, 2013. AR4781-82. The Program continued to collect and analyze information until late October of 2013, including conducting bed space surveys of Swedish/Ballard and UW/Northwest to aid the Department's calculation of community bed need under the Methodology. AR4788-89, 4829-90, 4894-902, 5097-105.

At the end of this lengthy process, Russell determined that there

was no need for the requested 79 beds. AR4758. Russell reached this conclusion using the same Methodology the Department has always used to evaluate whether there is a need for new hospital beds. RP880, 1251. Russell found that there was a substantial *surplus* of beds through 2018, which was the target year for planning purposes. AR4758. In other words, while UWMC *wanted* new beds, there was *no community need* for UWMC's project for the foreseeable planning horizon. *Id.*

In addition, the Department's financial expert, Ric Ordos, who was the *only* person in the Department to analyze whether the Application satisfied the financial feasibility and cost containment criteria, concluded in his written report to the Program that the Application *failed* the criteria, in part because there was no numeric need. AR4765-69; RP1249-50. This decision was completely consistent with past Department analysis. Historically, the Department has uniformly concluded that the addition of numerically unneeded beds cannot be financially feasible or promote cost containment as required by law. RP819-20, 831-35, 838.

Consequently, based upon his own analysis of no need and Ordos's conclusions, Russell drafted an evaluation denying UWMC's Application and the requested CON. RP880, 1249-51. His bottom line was that UWMC failed to prove the project satisfied the four review criteria. *Id.*

D. The Department Supervisor Who Did Not Review Anything In The Record Orders The Failed Application To Be Approved

The Application was found by Department experts to fail the review criteria and thus it should have been denied. However, just before

the Program's decision was to be issued, Bart Eggen (Executive Director, Community Health Systems), who was Russell's boss's boss, unilaterally directed Russell to reverse the decision – to change "no" to "yes." RP880-81, 1257. Eggen made this directive even though – as he later admitted on the stand – he never reviewed the Application or even a single piece of paper in the record. RP881-86. Russell complied with Eggen's directive without reviewing any additional documents or engaging in any further analysis; he simply made modest revisions to portions of his written evaluation to change its conclusion. RP1257. The Program issued its final evaluation on November 5, 2013 (the "Evaluation"), awarding a CON to UWMC just as Eggen had directed. AR4712-58.

Importantly, the altered Evaluation does not cite any authority for ignoring the requirement of numeric need under the Methodology or for issuing a CON despite the Application failing the standards always previously used by the Department. *Id.* Nor does the Evaluation mention the "Criterion Two" analysis urged by UWMC. *Id.* Indeed, Russell admitted that the Program just decided to "make an exception," without "analyzing, evaluating, or passing judgment on whether" UWMC satisfied Criterion Two or any other purported "alternative" criteria. RP1257-58.

The Program's actions were unprecedented and inconsistent with Department practice in numerous respects. This is the *first* time that: (1) the Program approved a CON for acute care beds in the absence of need shown by the Methodology *always* used by the Department; (2) the Program found that an application satisfied the cost containment and

financial feasibility criteria despite there being no numeric need; (3) the Program disregarded the findings of the Department's expert on financial feasibility and cost containment, who had *failed* the Application; and (4) the Analyst responsible for the evaluation was overruled at the last minute by a superior and directed to approve an application that had been found to fail the traditional CON review criteria. RP831-35, 838, 846, 926-27.

E. There Is No Need For UWMC's Proposed New Beds Under The Department's Uniformly Applied Methodology

There is no dispute that application of the Methodology shows that there is no numeric need for the 79 requested beds. The Program's calculation confirmed that there was a *surplus* of beds in the 2018 target year. AR4758. Likewise, even UWMC's own skewed calculation does not remotely support a community need for 79 more beds. Findings 1.9, 1.10 (noting that calculations by the Program and UWMC show no numeric need for the requested 79 beds); RP797-98 (UWMC's consultant testifying that she did not care about the bed surplus). And both of these calculations actually *understated* the inventory of available beds.[5]

A correct application of the Methodology shows a *surplus of 59*

[5] The calculations of the Program and UWMC are flawed in several respects. The most significant flaw is that they undercounted available beds by approximately 40 beds, resulting in an understated surplus. The Program included 166 beds at UW/Northwest, while UWMC included 172 beds. AR3753, 4758. In fact, UW/Northwest had 206 available beds according to UW/Northwest's own accurate internal bed inventory. AR5107; RP269-73. These errors are discussed at length in Petitioners' administrative briefing but are not particularly material for this appeal given the Department's decision to abandon the Methodology. Regardless, if the Department applied the standard Methodology using its own calculation, the Application would have to be denied (just as Russell had initially concluded). RP1249-51.

beds in the Planning Area in the target year of 2018, *before* adding UWMC's requested 79 beds. AR1874. The Methodology further shows a *continuing surplus* of beds out to at least 2021. *Id.* In other words, there is no need for *any* additional beds during the planning period or at any time through the decade. Indeed, allowing UWMC to proceed with its 79-bed project would result in a bed surplus of at least 140 beds in the target year of 2018, with an enormous continuing surplus well into the next decade. AR1875. This would be the equivalent of adding another entire hospital, empty, to a planning area that is already fully served.

F. The Presiding Officer Affirms The Issuance Of The CON On Improper And Unprecedented Grounds

Petitioners requested an adjudicative proceeding to contest the Program's decision because UWMC's Application does not satisfy the four review criteria and should be denied.[6] *See, e.g.*, AR1-62. Following discovery, an evidentiary hearing was conducted before the now-retired Presiding Officer (Frank Lockhart) on June 16-20, 2014. AR993.[7]

---

[6] In a footnote, the Presiding Officer made a factual error, to which Petitioners object and assign error. He stated: "The three Petitioners . . . are all located outside of the North King Planning Area." Initial Order, footnote 1. This is not true. Petitioner Swedish is located in the North King Planning Area by virtue of the fact that its Ballard hospital campus (Swedish/Ballard) is located there. AR3516. In any event, Petitioners are affected parties, were given affected party status by the Department, participated in all administrative proceedings, and neither UWMC nor the Program have argued otherwise.

[7] Petitioners, as the parties who initiated the adjudicative proceeding, requested to present their case first. The Presiding Officer denied their request and allowed UWMC to go first, without restriction. He also limited the hearing to five days, over Petitioners' objection. UWMC called five witnesses and was permitted to present its case from Monday to mid-day Thursday, leaving Petitioners only the rest of Thursday and Friday in which to put on their case. The order and time limitations prevented Petitioners from calling several witnesses and compressed the examination of the witnesses Petitioners were able to call. The deck was stacked against Petitioners from the outset.

Notably, the Program did not call any witnesses or otherwise try to support its Evaluation or evaluation process. No effort was made to convince the Presiding Officer that the Program had gotten it right.[8] Instead, UWMC focused on trying to have the Presiding Officer apply a new, "alternative" analysis, "Criterion Two," which was not considered by the Program or even mentioned in the Evaluation. *See* AR2817-53 (UWMC argument focusing on Criterion Two); AR4712-58. As discussed below, "Criterion Two," which was found in the long-defunct State Health Plan, has *never* been used by the Department and is inconsistent with the need Methodology always applied. *See infra* Section V.B. UWMC focused on this "alternative" approach before the Presiding Officer because otherwise the absence of numeric need for new beds would be an insurmountable obstacle to approval.

During the hearing, the Presiding Officer contravened settled Department policy by refusing to use the most recent available statistical data in evaluating the Application (2012 CHARS data). RP1025-26. However, while Petitioners were limited to using 2011 CHARS data, the Presiding Officer allowed UWMC to present its inaccurate estimates and

[8] As the Department has conceded, the evidence at adjudicative hearings is typically limited to "what was presented to the Program during the review of the application." AR366. But the Presiding Officer did not focus on the evidence presented to the Program or give any real consideration to the Program's Evaluation or process. Instead, the Presiding Officer disregarded the Evaluation and the undisputed facts about the disturbing manner in which the Program changed its decision at the last-minute, calling it simply part of the "process." Initial Order, footnote 44. In doing so, the Presiding Officer missed the point, which was that the Program's decision was not based on a legitimate "process," but was instead an improper and unfounded executive directive completely inconsistent with prior Department practice, precedents, and CON law.

projections allegedly based upon current 2012 data. RP1038. It was error to refuse to admit the actual, accurate data. Even the Program asked the Presiding Officer to reconsider, to no avail. RP1030.

Following post-hearing briefing, the Presiding Officer issued the Initial Order. *See* Appendix A (AR3119-56). The Presiding Officer largely ignored the Evaluation and the work of the Department's experts, and adopted UWMC's positions essentially in their entirety. *See id.* With respect to the need criterion, the Presiding Officer refused to apply the Methodology applied in all prior CON matters, which showed no need. Findings 1.6-1.12. Instead, he held that UWMC would be treated as "unique" and that, for the first time ever, the Application would be evaluated under Criterion Two. *Id.* He then concluded that UWMC had shown an institutional need for more beds, principally based on its inflated claims of overcrowding at its current facility. *Id.*

With respect to financial feasibility, the Presiding Officer acknowledged that UWMC had omitted $34,000,000 in capital costs from its Application, but concluded that financial feasibility was satisfied despite the fact that no analysis of the project's true costs had ever been performed by the Department. Findings 1.16-1.22. With respect to the cost containment and structure and process of care criteria, the Presiding Officer merely made conclusory findings that the criteria were met without undertaking any analysis of the issues. Findings 1.23-1.33.

G. The Review Officer Affirms The Presiding Officer's Decision

Petitioners timely sought administrative review of the Initial

Order. AR3221-84. On January 26, 2015, the Review Officer issued the Final Order, upholding the Initial Order with little further analysis. *See* Appendix B (AR3493-507). The Final Order affirmed all of the reasoning in the Initial Order and adopted all Findings and Conclusions in the Initial Order as the final decision of the Department. *Id.*

H. Petitioners Seek Judicial Review

Petitioners timely filed a petition for judicial review in King County Superior Court. CP41-170. All parties jointly requested an order certifying the case for direct review by this Court under RCW 34.05.518, which was granted. CP174-77. The parties then filed a joint motion for discretionary review, which was granted by this Court on June 4, 2015.

V. ARGUMENT

The Department's decision marks a stunning departure from its uniform interpretation of applicable CON law. In all prior acute care bed cases, the Department has used the Methodology to determine need. It has also consistently held that the institutional needs of a particular hospital – even a premier facility uniquely providing complex care – do not support a finding of *community* need. Likewise, in all prior cases, the Department has held that all project capital costs must be included and analyzed; that the financial feasibility, cost containment, and structure and process of care criteria cannot be satisfied absent numeric bed need; and that decisions should be made using the most accurate statistical data. The Department abandoned all of these well-settled principles to get to "yes."

The disturbing reality of this case is that the Department decided

what result it wanted – to give its fellow state agency permission to build out its Tower – and then did what was necessary to reach that result: it unlawfully and arbitrarily swept aside and disregarded decades of its decisions, standard practices, and legal interpretations under the applicable CON statutes and regulations. Without any legal authority whatsoever, the Department simply treated UWMC as above the law. Its approach was procedurally improper, factually baseless, and contrary to law.

While Petitioners dispute virtually all aspects of the Department's decision, this appeal focuses on five principal deficiencies. First, there is no legal or factual basis for the Department's decision to abandon the need Methodology and instead to assess UWMC's project based on Criterion Two – legally ineffectual language that has never been used before and that is inconsistent with the review criteria as uniformly interpreted and applied over the past several decades. Second, even if Criterion Two could be considered, the evidence in the record cannot support a conclusion of need. Third, the record cannot support a conclusion that UWMC has satisfied the financial feasibility and cost containment criteria in light of the lack of numeric need for the project and the Department's failure to include $34,000,000, one-third of the project's actual capital cost, in its analysis. Fourth, the record cannot support a conclusion that UWMC has proven that its project is the most superior alternative to address any purported need or that its project will not result in duplication or fragmentation of care, as required by law. Finally, the Department erred in refusing to admit accurate statistical data while permitting

UWMC to introduce inaccurate estimated projections of that data, resulting in a record and decision prejudicially based on false information.

A. Standard Of Review

The standards for judicial review in CON cases are well-settled and stem from the Washington Administrative Procedure Act, RCW 34.05 *et seq.* ("APA"). *See, e.g., King County Pub. Hosp. Dist. No. 2 v. Dep't of Health*, 178 Wn.2d 363, 372, 309 P.3d 416 (2013). It is the function of the courts to "ensure[] that administrative agencies follow the law and appropriate procedures." *Children's Hosp. & Med. Ctr. v. Dep't of Health*, 95 Wn. App. 858, 868, 975 P.2d 567 (1999); *cf. Wash. State Hosp. Ass'n v. Dep't of Health*, 183 Wn.2d 590, 363 P.3d 1285 (2015) (holding that Department rule violated governing statute).

Under the APA, the Court should reverse the Department if it (1) employs improper procedure, (2) has "erroneously interpreted or applied the law," or has issued an order that is (3) "inconsistent with a rule of the agency," (4) "not supported by evidence that is substantial," or (5) is "arbitrary or capricious." RCW 34.05.570(3).

For issues of law, including interpretation of the agency's regulations, the Court's review is de novo. *Kadlec Reg'l Med. Ctr. v. Dep't of Health*, 177 Wn. App. 171, 178, 310 P.3d 876 (2013). The Court may "substitute its interpretation of the law for that of the agency," *Dist. No. 2*, 178 Wn.2d at 372, and must "ensure that the agency applies and interprets its regulations consistently with the enabling statute." *Cobra Roofing Serv., Inc. v. Dep't of Labor & Indus.*, 122 Wn. App. 402, 409, 97

P.3d 17 (2004). Likewise, the "process of applying the law to the facts" is "a question of law and is subject to de novo review." *Tapper v. Employment Sec. Dep't*, 122 Wn.2d 397, 403, 858 P.2d 494 (1993).

Factual findings are reviewed for substantial evidence in the record. *Dist. No. 2*, 178 Wn.2d at 372. Procedural errors are reviewed de novo. *K.P. McNamara Northwest, Inc. v. Dep't of Ecology*, 173 Wn. App. 104, 121, 292 P.3d 812 (2013). In addition, the Court will reverse any action that is arbitrary or capricious, meaning that it was "the result of willful and unreasoning disregard of the facts and circumstances." *Dist. No. 2*, 178 Wn.2d at 372 (quotations omitted); *see also Children's*, 95 Wn. App. at 874 (finding Department decision to be arbitrary and capricious).

B. The Criterion Two Language Is Not A Lawful Basis For A Finding Of Need For UWMC's Proposed 79 New Beds

Despite the lack of numeric need for UWMC's 79-bed project, the Department held that the Application satisfied the need criterion (WAC 246-310-210). It based this decision on the claimed institutional needs of UWMC, applying the Criterion Two language from the long-defunct State Health Plan. Findings 1.6-1.12. In doing so, the Department rejected the legal analysis it had uniformly applied for decades in favor of inconsistent, legally ineffectual language that had never once been used in the history of the CON program. If allowed to stand, this would be the *first time* that the Department did not use the Methodology to determine need for acute care beds. This decision was an error of law, arbitrary and capricious, and unsupported by substantial evidence in the record.

1. The Criterion Two Language Is Inconsistent With Applicable Law And Must Be Rejected.

The Department's use of Criterion Two as the legal standard for determining need constitutes an error of law. The CON statute provides that the need criterion assesses "[t]he need that *the population* served or to be served" has for the proposed services (here, new acute care beds). RCW 70.38.115(2) (emphasis added). Likewise, the applicable regulation provides that need is assessed by considering whether "[t]he *population* served or to be served *has need* for the project *and other services and facilities of the type proposed are not or will not be sufficiently available or accessible to meet that need.*" WAC 246-310-210(1) (emphasis added). Thus, the law focuses not on the institutional interests or "needs" of the applicant, but rather on the need of the population to be served, which the Department has always defined as the geographic planning area. Indeed, consistent with the plain language of the statute and regulation, the Department has previously made clear that institutional interests are *not to be considered* in assessing need. The Department has stated that it "looks to the need for additional acute care beds in the service area" and does not consider "whether the individual facility needs more beds."[9] It has further stated that the analysis of need "is not a determination whether the [applicant] meets the requirements but whether the proposed additional beds are needed in the [applicable] service area."[10]

Criterion Two does not consider the service area's needs or the

---

[9] *In re Sacred Heart*, Finding of Fact 1.32 (AR2465-66).
[10] *Id.*

availability of services at other facilities, as required by law. *See* Finding 1.6. Instead, it focuses on *institutional interests*. The Department based its decision principally on UWMC's (inflated) claims of overcrowding *at its facility*, despite the substantial surplus of other available beds. Findings 1.8-1.12.[11] Its reasoning – that such institutional factors could be considered because UWMC provides some complex services – is contrary to its past decisions. The Department has specifically held that the fact that a hospital uniquely provides complex services is *not proof of need.*[12] It was legal error, and arbitrary and capricious, for the Department to apply a standard contrary to its prior, consistent interpretation of the law.

Moreover, the unprecedented use of Criterion Two undermines the predictability and transparency promoted by the Department's decades-old use of the Methodology to determine need. This usual approach ensured a "predictable, transparent, and consistent" process.[13] As the Department has stated, the "predictability afforded by the consistent use of the [Methodology] argues for its continued use in measuring acute care bed need."[14] Consistency avoids the risk of improper decision-making of the sort that occurred here, where the Department applied the Methodology

---

[11] In her prefatory "analysis," which was not part of the Department's Findings or Conclusions, the Review Officer asserted that the applicable population for UWMC's Application was the entire population of the state. Final Order, p. 9. But there is simply no evidence in the record to support either the notion that the applicable population is the entire state or that the statewide population somehow has need for the 79 beds. This novel proposition was raised for the first time in the Review Officer's Final Order.

[12] *In re Sacred Heart*, Finding of Fact 1.32 ("Sacred Heart provides care in areas that other hospitals do not . . . . [T]his reason alone does not reduce the existing surplus of hospital beds for all other types of health care.") (AR2465-66).

[13] *In re Valley*, Finding of Fact 1.14, footnote 8 (AR2375).

[14] *In re Valley*, Finding of Fact 1.14 (AR2375).

but then subsequently changed the rules to reach a different result. The unreasoned application of a new, subjective standard wholly inconsistent with decades of consistent analysis is a perfect example of legally erroneous, and arbitrary and capricious conduct.[15]

It is additionally troubling that Criterion Two was not even used by the Program in its analysis and was used by the Department, for the first time ever, only in the adjudicative phase. The Department's belated application of a new standard at that late stage in order to arbitrarily favor a fellow state body undermines trust and respect in the CON process, even beyond violating the critical principles of consistency and transparency.

2. The Criterion Two Language Is Not A Standard That Can Be Relied Upon By The Department.

The Department attempted to justify its application of Criterion Two by claiming that, although contrary to its longstanding interpretation of applicable law, Criterion Two was a "standard" that it could apply. The Department was wrong. WAC 246-310-200(2) permits the Department to consider "standards," in its evaluation of the review criteria, that are nationally recognized or developed by professional organizations or others with recognized expertise. Criterion Two does not fall within any of those categories. It is never-used, legally ineffectual language from a document, the State Health Plan, that has been defunct for 25 years.

---

[15] The law disfavors exceptions to the normal process of CON decision-making. *Cf. Swedish Health Svcs. v. Dep't of Health*, No. 72612-9, 2015 WL 5098744, at *6 (Wash. App. Aug. 31, 2015) (holding that the Department may not use "special circumstances" to avoid the requirements of the governing regulations).

The State Health Plan was created as part of the enactment of the CON statute. The version containing the Criterion Two language originated in 1987. Originally, the State Health Plan was to be used in considering CON applications.[16] In 1989, however, the legislature phased out the use of the State Health Plan, and as of June 30, 1990, it was repealed entirely.[17] The Department was authorized to adopt the provisions of the State Health Plan as regulations but never did so. Accordingly, as of June 30, 1990, the Plan ceased to have any role in the Department's review of CON applications. In particular, the Criterion Two language was never used when the State Health Plan was in effect and, like the rest of the Plan, currently has no legal authority whatsoever.[18]

The Department contends that Criterion Two is nonetheless a "standard" that may be considered under WAC 246-310-200(2).[19] Finding 1.7. It is not. The Department cannot rely upon a "standard" unless it exists. The plain language, common sense reading of the regulation indicates that it is referring to actual standards that are valid, existing, and current; any other reading would lead to absurd results. Criterion Two is not a valid, existing, or current standard. It was never

---

[16] *See* Laws 1979, 1st Ex. Sess., Ch. 161, Sec. 11 (former RCW 70.38.115(2)(a)); Laws 1980, Ch. 139, Sec. 8 (former 70.38.115(5)).

[17] Laws 1989, 1st Ex. Sess. Ch. 9, Sec. 610 (former RCW 70.38.919).

[18] The Department has pointed out that the Methodology also appears in the State Health Plan. But there is a stark contrast between the Department's uniform use of the Methodology for decades, before and after the State Health Plan was in effect, and the Department's reliance here on forgotten language that has never before been used.

[19] The Department also erroneously cited to RCW 70.38.115(5), which allows the Department flexibility as to the "[c]riteria adopted for review" of CON applications. This provision is irrelevant. Criterion Two has never been "adopted" as a review criteria.

used when the State Health Plan was in effect, and the Plan itself was the product of a very different health planning environment and a regulatory framework the Washington legislature decreed out of existence a quarter century ago. Although copies of the State Health Plan are available as historical curiosities, the stray Criterion Two language has no legal existence or effect and provides no valid basis for a Department decision.

Even if Criterion Two could be a "standard," the Department could not apply that standard unless it had disclosed the standard *prior* to evaluating the application. WAC 246-310-200(2)(c) states that "the Department shall identify the criteria and standards it will use during the screening of a certificate of need application." *Id.* The purpose of this requirement is clear: it provides advance notice to the applicant and interested persons of the ground rules for the Department's evaluation, which enables the parties to participate meaningfully in the process. It precludes the Department from using new or unexpected standards at the last minute, which is exactly what happened here. The Department had never identified Criterion Two as a "standard" for evaluating this or any other CON application. Indeed, the Program here did not use or even mention Criterion Two. Finding 1.11; *see* AR4712-58. Criterion Two was first used by the Department in the adjudicative proceeding. Again, this is precisely the sort of ad hoc, arbitrary and capricious decision-making that the statute and regulations are intended to avoid.

3. There Is No Basis For Applying Criterion Two Here.

The Department expressly acknowledged that it gave UWMC's

Application "special consideration." Final Order, p. 9. Critically, however, there is absolutely no authority, statutory or regulatory, that authorizes the Department to accord UWMC "special" treatment. The Department did not cite any authority because there is no such authority.

Nor is there any support in the record for giving UWMC "special consideration." Asserting that UWMC is "unique," the Department stated that it believed departing from the Methodology and relying on Criterion Two was appropriate because UWMC purportedly has high "in-migration" of patients from outside the Planning Area and because its beds are purportedly not "fungible" with other beds.[20] Finding 1.12. This reasoning is inconsistent with prior Department decisions[21] and without record support. The Methodology itself takes in-migration into account; all services required by all patients coming to UWMC are fully accounted for in the calculation. RP961-64, 990. Moreover, the record establishes that UWMC's beds *are* fungible: the vast majority of the services

[20] UWMC touted its "uniqueness" through a variety of overstated, conclusory assertions and hyperbole. However, other than the undisputed but irrelevant fact, cited by the Department, that UWMC is affiliated with the state's only allopathic medical school (which by law does not give it any special CON status), the record does not support a conclusion that UWMC is in any way "unique." UWMC joins company with several other premier medical facilities in the state, but it is in no way singular. Indeed, the reality is that UWMC is *not* unique in its case mix or provision of complex services, and in fact does not even have the highest case mix index in the state. RP1091-93, 1122; AR4005-16, 4490-91. Petitioners presented these facts to the Department, but because they were not supportive of the Department's end goal, UWMC's unsupported assertions were nonetheless adopted. AR1811-75 (Post-Hearing Statement); AR3079-116 (Reply).

[21] As noted above, the Department has previously determined that providing unique services does not support a finding of need where, as here, there is a surplus of beds for all other care. *In re Sacred Heart*, Finding of Fact 1.32. Notably, the Review Officer attempted to distinguish *In re Sacred Heart* by pointing out that it was not decided under Criterion Two. But that tautology is the entire point: the Department is acting contrary to law by deciding this case in a manner totally inconsistent with *In re Sacred Heart*.

provided by UWMC are duplicated elsewhere. AR4261; RP1079-86. The Department's decision to apply Criterion Two is not only contrary to law and arbitrary and capricious, but lacks substantial evidence as well.[22]

C. The Record Does Not Support A Finding Of Community Need For the Project Even Under Criterion Two

As stated above, if the Methodology that is always used is applied here, UWMC's Application fails for lack of need. Even if the Criterion Two language could be applied here as an alternative need analysis, and it cannot, the evidence in the record does not support granting the CON because there is not substantial evidence of community need regardless.

1. The Record Does Not Contain The Comparative Data Required Under The Criterion Two Language.

First and foremost, UWMC cannot be found to have shown need under Criterion Two because it failed to provide the necessary *comparative evidence* about other facilities. Criterion Two specifically requires *comparisons* with other providers, on factors such as (1) staff with "greater training and skill," (2) "a wider range of important services," or (3) programs with "evidence of better results" than "neighboring and comparable institutions." *See* Finding 1.6. The Criterion Two language

[22] The Department appears to have mistakenly believed, contrary to the evidence, that UWMC's in-migration resulted from patients seeking high complexity care unavailable elsewhere. In fact, the vast majority of patients who in-migrate do so for non-complex care. RP940-41, 1167. The highly complex services touted by UWMC in its Application are only a small portion of the services it provides; more than 90% of its patient days are for services in other, less complex areas. AR4287-88, 4300. Thus, although UWMC gets most of its patients from outside the Planning Area, virtually all of those patients could be cared for by many other facilities, both in and out of the Planning Area.

also states that an applicant must prove that "neighboring and comparable institutions" have "higher costs, less efficient operations or lower productivity." *Id.* Here, all the record shows is certain (often inaccurate) information about *UWMC's* attributes, without any competent evidence about the relevant attributes of other facilities. UWMC simply did not submit any such evidence. Critically, the Department did not make *any* findings comparing UWMC to other providers, as expressly required by Criterion Two, nor could it do so given the absence of any such evidence in the record. There is no legal or factual basis for finding that the Application satisfies Criterion Two.

2. The Department's Criterion Two Findings Are Arbitrary, Capricious, And Lack Substantial Evidence.

In summary fashion, the Department held that three Criterion Two requirements were satisfied. Finding 1.8. The evidence is otherwise.

First, the Department found that the project would "significantly improve[e] the accessibility or acceptability of services for underserved groups." *Id.* However, there are no factual findings supporting this conclusion, nor is there any record support for it. The Department noted that UWMC is among the highest providers (not the highest) of services to Medicaid recipients in King County. Finding 1.8f. This is largely true but it is also irrelevant. UWMC's provision of care to underserved groups is not unique, AR3931-33, and has nothing to do with whether *the project* will "significantly improve" accessibility of services. There is absolutely no such evidence. The Department appears to have reasoned simply that

UWMC provides care to underserved groups and could expand its care with more beds. Interpreted in that way, however, this factor is meaningless – every major hospital provides substantial services to underserved groups and thus, under the Department's reasoning, every such hospital would always satisfy this factor.

Second, the Department found that the project would "allow[] expansion or maintenance of an institution which has staff who have greater training or skill, or which has a wider range of important services, or whose programs have evidence of better results than do neighboring and comparable institutions." Finding 1.8. Again, there are no specific factual findings to support this conclusion, and the record is completely devoid of the comparative evidence required by Criterion Two. There is no evidence in the record about the "training or skill" of the staff at comparable institutions, nor is there any evidence that they have worse results than UWMC. There *is* evidence about the range of services provided at UWMC and a few other facilities, but it actually shows that the "range of important services" at UWMC is *not* "wider" than that of other institutions. There is nearly complete overlap between the services offered at UWMC and those offered at other nearby institutions. AR4261, 6321-30, 6335, 6345-46, 6354; RP1079-86. Certainly, there are a few specialized services that UWMC provides in greater number than other facilities, just as there are specialized services that other facilities provide in greater numbers than UWMC. AR4005-16. This unsurprising fact does not suggest that 79 additional beds are *needed* by the community.

Importantly, the Department's key "findings" are premised on the *mistaken* and unsupported belief that there are many patients who can *only* obtain care from UWMC and who are unable to access that care "because of a lack of beds." Finding 1.8e. That presumption, which is foundational to the decision, is simply not true. In fact, except for a few specialized services affecting only a *tiny* number of patients, all of the services available at UWMC are duplicated elsewhere, and patients who can only receive care from UWMC are *not* being turned away. RP219-20.[23]

Finally, the Department found that the project would "allow[] expansion of a crowded institution which has good cost, efficiency, or productivity measures of its performance while underutilized services are located in neighboring and comparable institutions with higher costs, less efficient operations, or lower productivity." Finding 1.8. Once again, the record is devoid of any evidence to support such a finding. There is *no evidence* about the "costs, efficiency, or productivity" of any institution other than UWMC. Indeed, the Program *admitted* that UWMC had not provided any evidence that it has "good cost, efficiency, or productivity measures" or that "neighboring or comparable institutions have higher

[23] The Department stated: "For many patients with complex medical needs in Washington State, and in the 5 state WWAMI region, there may not be other treatment options available." Finding 1.8e. This "finding" *dramatically* overstates UWMC's uniqueness. The Department cited to a portion of the transcript (RP80-82) discussing how UW/Northwest could not service certain organ transplant patients. But other facilities provide transplants, and the number of patients who need solid organ transplant services is *miniscule*, amounting to a few hundred of UWMC's more than 16,500 patients each year. AR3518, 4006-09. While those few patients have limited options for care, the remaining 98%+ of UWMC's patients have a variety of other options. There is *absolutely no record support* for the notion that the 79 beds are needed because patients with need for services only available at UWMC are not able to access those services.

costs, less efficient operations or lower productivity." RP894-95. Thus, the Department's finding is totally unsupported by the record.

Furthermore, the evidence does not support a finding that UWMC is "crowded," which is *also* required under this Criterion Two provision. The Department alleges that UWMC is at "maximum effective capacity." Finding 1.8d. That finding is wrong. UWMC's 71% occupancy rate is below the Department's recommended occupancy rate (of 75%), and other hospitals operate at greater occupancy levels. AR3929. The Department found "persuasive" the fact that UWMC initially could not find a bed for a small number of patients (93 in 2011, 138 in 2012, and 43 in the first third of 2013), although there is no data comparing these figures to other facilities, which also sometimes decline transfers. Finding 1.8e. But it is critical to recognize that these numbers are miniscule in the context of UWMC's overall services – amounting to *far less than 1%* of UWMC's patient population. AR3518. Moreover, there is no evidence of any negative impact on patients. UWMC does *not* turn away patients who cannot be served by other hospitals or who have emergent needs. RP219-20. The patients for whom a transfer was initially denied would be admitted into UWMC at a later time, admitted into another UW Medicine facility, or would simply obtain the care they needed elsewhere.

In summary, the evidence does not support a finding that UWMC's Application satisfies the Criterion Two requirements. Petitioners challenged UWMC to cite specific evidence to support its claims regarding those requirements and it was (and will be) unable to do so.

D. The Record Does Not Support The Conclusion That UWMC Met The Financial Feasibility And Cost Containment Criteria

In addition to finding need, to approve the Application the Department must also show that UWMC has proven that its project satisfies the financial feasibility and cost containment review criteria. The Department's conclusion that these criteria were satisfied constituted an error of law, was arbitrary and capricious, and lacked substantial evidence.

First, in all prior applications by providers, where – as here – the Methodology shows no numeric need for new beds, the Department has concluded that the application does not satisfy the financial feasibility and cost containment criteria. Application of that longstanding Department interpretation here requires that UWMC's license be denied.

Second, *no* complete financial analysis of the true cost of the project has ever been performed. Rather, only *part* of the project's costs was ever reviewed by the Department's financial expert Ordos; his work was based solely on the $70,000,000 cost to build out the space and did *not* take into account the additional $34,000,000 cost for constructing the three-floor shell in which the beds would be located, which UWMC omitted from its Application in violation of legal requirements. Nor can such an analysis be belatedly performed now on this record, as UWMC's material omission rendered the financial documentation submitted by UWMC incomplete, inaccurate, and invalid. The Department's erroneous decision to nonetheless find the financial feasibility and cost containment criteria satisfied is not just unsupported but pernicious, as it incentivizes

applicants to "game" the system with inaccurate financials.[24]

1. The Project Fails Financial Feasibility And Cost Containment Because There Is No Need.

To begin with, the project fails the cost containment and financial feasibility criteria for the simple reason that there is no numeric need for more beds. It has been the Department's longstanding, consistent interpretation of its regulations that these criteria are not satisfied where there is no need under the Methodology. The reason is simple and logical: the Department has no basis for concluding that a project will be financially feasible and promote cost containment when there is no numeric need for the beds. Ric Ordos, the Department's financial expert, who has always assessed these criteria, could not recall *any* prior instance – out of 200 or more CON applications he has reviewed, over 25 years – in which an applicant failed to show numeric need but was found to have satisfied the cost containment criterion. RP817-20, 831-32. Likewise, Ordos stated that to his knowledge there has *never* been a prior instance in which an applicant was found to have satisfied the financial feasibility criterion despite a lack of numeric bed need. RP834-35, 838. Applying

[24] Beyond the $34,000,000 omission, UWMC's project financials are not credible for the *additional* reason that they were premised on overly optimistic growth projections. The Application used a projected growth rate *four times greater than UWMC's actual growth rate.* AR3523, 4017-18. Even the Program could not accept UWMC's "very optimistic" projections, finding that they "may not be achievable." AR4733. UWMC's own finance witness testified that the project would "break even" by the target year of 2018 *only* if UWMC experienced growth exponentially greater than its historic growth. RP378. The Department ignored these deficiencies, while falsely stating that Petitioners "did not take issue" with them. Finding 1.17; *see* AR1850-52 (Petitioners' Post-Hearing Statement rebutting UWMC's "unrealistic and inflated growth rates"). For this reason as well, the Application fails to satisfy the financial feasibility criterion.

these principles consistently here requires denial of UWMC's Application. *Cf. Dist. No. 2*, 178 Wn.2d at 372 (discussing Department's conclusion that the financial feasibility, cost containment, and structure and process of care criteria fail where there is no numeric bed need). The Department's decision otherwise is legally erroneous, and arbitrary and capricious.

2. The Project Fails Financial Feasibility And Cost Containment Due To UWMC's $34,000,000 Omission.

a. The Department Has Not Analyzed The Real Costs Of UWMC's Project.

It is undisputed that (1) UWMC spent $34,000,000 to "shell-in" the three floors of the Montlake Tower in which the 79 new beds would be located and (2) UWMC failed to include that $34,000,000 in the capital expenditure it reported in its Application, as it stated that the capital cost was $70,771,363 when the actual cost is $104,771,363. UWMC admitted these facts and the Department acknowledged them. Findings 1.17, 1.18.

It is also beyond dispute that the only review of project financials ever performed by the Department relied upon the inaccurate $70,771,363 figure reported by UWMC. The record is clear that Department expert Ordos was the *only* person to analyze whether UWMC's Application satisfied the cost containment and financial feasibility criteria, and that he used the inaccurate figure in his analysis.[25] RP819-20, 823-24, 1249-50;

[25] Ordos used the inaccurate $70,771,363 figure in key aspects of his analysis. First, he used the figure to calculate the relationship of the total capital cost of the project to UWMC's assets, designated assets, and equity. AR4766. Second, he used the figure to calculate the total capital cost per bed. AR4769. Both aspects of the analysis are wrong because of UWMC's material understatement of actual project costs.

AR4765-69. In other words, the Department has *never* actually evaluated whether the Application satisfies these criteria based on the true capital cost of the project. *Id.*

b. Excusing UWMC From The Financial Analysis Would Be Unlawful And Improper.

The Department attempts to avoid this fatal defect in its analysis by concluding that the omitted $34,000,000 somehow did not need to be included in the capital costs it reviewed. This conclusion is contrary to law. It is telling that the Department fails to cite the governing statute, which makes clear that *all* construction costs must be included in an applicant's capital expenditure estimate because they are not "chargeable as an expense of operation or maintenance." RCW 70.38.025(2); *see also* WAC 246-310-010(10). UWMC's stated capital expenditure of $70,771,363 indisputably did not comply with legal requirements. The Department downplays the problem by asserting that "in one sense [Petitioners] are correct" that the $34,000,000 "should have been included," but fails to acknowledge that the "sense" in which this is true is that it is *required by law*. Finding 1.18.

The Department asserted that including the $34,000,000 was unnecessary because the cost was incurred just before the Application was filed. Findings 1.20, 1.21. The Department did not cite any legal authority or precedent in support of this extraordinary position. This failure is not surprising, as the Department's position is contrary not only to the law, *see* RCW 70.38.025(2), but also to the fundamental premises of

good faith and transparency that lie at the heart of the CON framework.

In fact, the Department's reasoning is an invitation to manipulation and deception. If the Department's finding is allowed to stand, future CON applicants will be incentivized to incur costs prior to submitting their applications so they can exclude them from the reported capital costs for the project. This will improperly enhance the likelihood a project will satisfy the financial feasibility and cost containment criteria, because the applicant will be able to artificially make it appear that the project is less expensive and the financial projections more favorable than is actually the case. The integrity of the entire CON evaluation process will be undermined if applicants are permitted to "game" the system in this way. Thus, the Department's decision here is not just contrary to law; it also has serious, troubling implications for the fundamental integrity, validity, and transparency of the CON process.

c. That UWMC May Have At Some Point In Time "Disclosed" The $34,000,000 Is Insufficient.

The Department also attempts to excuse UWMC's $34,000,000 omission on the grounds that UWMC "disclosed" the expenditure in prior dealings with the Program or in correspondence after the Application had been submitted. Findings 1.18, 1.19. But mere "disclosure" is not the issue. The issue is whether the Department has at any point *evaluated* the true cost of the 79-bed project in determining whether it satisfies the financial feasibility and cost containment criteria. Indisputably, it has not.

The "disclosures" cited by the Department did not involve any

evaluation of the omitted $34,000,000. The Department stated that the Montlake Tower project was disclosed in a prior application concerning UWMC's neonatal intensive care unit. Findings 1.18, 1.19. But that application plainly did not include review of the $34,00,000; the total capital cost for that application was around $5,000,000. AR5219-47, 5249-50; RP1251. Likewise, the Department stated that the Montlake Tower project was disclosed in a determination of non-reviewability by the Program in 2008. Finding 1.19. But, again, that review had nothing to do with the $34,000,000; it concerned *only* Phase 1 of the project – the $34,000,000 Phase 2 had not even been approved by the U.W. Regents yet – and the Program specifically stated that any future bed additions would need further CON review. AR3783-84, 5208-09. Finally, the Department noted that UWMC "disclosed" the $34,000,000 in a response to the Program's Application screening questions. Findings 1.18, 1.19. This is true but irrelevant, because the record is clear that the Department *never* evaluated or approved that amount. AR4716, 4742, 4769; RP1256. Even the CON itself confirms this, as the "approved capital expenditure" is $70,771,363, even though the actual capital expenditure is $104,771,363. AR4763. None of the purported "disclosures" rectify the basic problem that no analysis of the true capital cost of the project has ever taken place.

d. UWMC's Inaccurate Financial Documentation Cannot Be Rehabilitated After The Fact.

Recognizing that it has never analyzed the true cost of the project, the Department attempts to rehabilitate UWMC's inaccurate financial

documentation by baldly asserting that "the inclusion of the [$34,000,000] shell costs in the budget would not have made a difference in the operating costs of the project." Finding 1.21. The Department cites nothing in the record as support for this finding, and there is no such record support.[26]

The plain fact is that a finding that UWMC's project satisfies the financial feasibility and cost containment criteria cannot be supported on this record. UWMC's incomplete, inaccurate, and invalid financial information is insufficient to allow such a determination to be made.[27] The testimony of Ric Ordos, the Department's financial expert, and Helen Shawcroft, a UWMC Senior Administrator who testified for UWMC about the finances of the project, powerfully illustrates this point.

At the hearing, Ordos confirmed (1) that when he performed his analysis, he was unaware that $34,000,000 had been omitted from UWMC's capital costs, and (2) that no analysis was ever performed of UWMC's financial projections using the full capital cost of the project. RP823-28, 868-69. In light of UWMC's suggestion in the hearing that the $34,000,000 was "included" somewhere within its financial statements, Ordos was asked at the hearing if he could identify where the missing

---

[26] The Department asserts that the "thrust of WAC 246-310-220 is the reasonableness of the financing." Finding 1.21. This "finding of fact" is unsupported by evidence and misstates the law. The reasonableness of financing is just one of the financial feasibility subcriteria (the third of three). WAC 246-310-220. Moreover, the subcriterion that typically receives the Department's primary focus is *not* financing, but rather, whether the immediate and long-range capital and operating costs can be met. AR4739-43, 4766-68. That issue has never been analyzed using complete information.

[27] Even if there was a basis in the record for such an after-the-fact analysis, and there is not, it would be improper and unfair for the Department to undertake such an analysis without affording Petitioners the opportunity to review, test, cross-examine, and/or offer expert opinion on any such post-hoc analysis.

$34,000,000 might be found. He responded: "No, I can't. I can tell you where it would be if it – in normal accounting practice, but to actually point to it specifically, *it is not possible*." RP864-65 (emphasis added). He confirmed that he could not locate the hidden $34,000,000 or even tell whether it was included at all. RP865-66.

Similarly, UWMC's own witness, Shawcroft, testified that she could not identify any amount in UWMC's financials related to the $34,000,000 unless she could review "significant backup" documentation. RP418-21. That "backup" is not in the record.

An analysis of financial feasibility and cost containment has not been conducted and cannot be conducted in the absence of accurate and reliable information, which is not in the record. The Presiding Officer tried to sweep this fatal deficiency under the rug by making the bald assertion that inclusion of the $34,000,000 shell costs "would not have made a difference" in the analysis. Finding 1.21. But this assertion is completely unsupported by the evidence in the record, and does not and cannot take the place of the required financial analysis. There is no legal or factual basis for a conclusion that UWMC has satisfied the financial feasibility and cost containment criteria. The Department's decision sends a clear message that applicants can make things up about the numbers and it will not matter so long as the Department wants the project to be approved.

E. The Record Does Not Support The Conclusion That UWMC's Application Satisfies Key Additional Review Criteria

1. UWMC Has Not Proven Its 79-Bed Project Is The "Superior Alternative."

As part of the cost containment criterion, applicants must prove that "superior alternatives" to the proposed project, "in terms of cost, efficiency, or effectiveness, are not available or practicable." WAC 246-310-240. UWMC has not made such a showing, nor has the Department made any such finding. The Department merely acknowledged that UWMC, unsurprisingly, decided that its project was *its* best alternative and that the "Program concurred." Finding 1.29. However, the Program did no analysis and the record reveals no basis for finding that UWMC's $100+ million, 79-bed project is actually the superior alternative.[28]

In fact, the record establishes that UWMC's project is *not* the superior alternative. First and foremost, it is not the superior alternative because there is *no need.* It has long been the Department's legal position that a project for which there is no numeric need cannot satisfy this criterion. RP828-829, 832; *see also* AR4768 (Ordos explaining that "the need methodology does not support an additional 79 beds and so an additional 79 beds is not an appropriate option"). Doing nothing is a superior alternative when there is no need for the project. RP829.

Even if there was need (and there is not), there is no evidence in

[28] This is the *only* instance where the Department relied on the Program. This is notable because the Program did not conduct *any* analysis of this issue, and the only person who did, Ordos, found that UWMC's project was *not* the superior alternative. AR4765-69; RP828-29, 1249-50.

the record that no alternatives exist to meet that need. In fact, one superior alternative would be to better use UWMC's sister facility, UW/Northwest. UW/Northwest is an award-winning facility that provides a full array of general medical services as well as many complex services. RP309-16. UW/Northwest is near UWMC, has unused capacity, and provides virtually all of the services offered by UWMC and needed in the Planning Area. AR3929-30, 4287, 6321-30, 6335, 6345-46, 6354; RP1079-86. UWMC argues that UW/Northwest is not capable of handling its most complex patients, but those patients constitute a *tiny* fraction of UWMC's services. AR3518, 4005-16, 4287, 4300, 4522. The vast majority of UWMC's services are *not* highly specialized, and 92% of its services *are already duplicated* at UW/Northwest. AR6345; RP1080-81.

Since there is no numeric need for more beds, the "need" claimed by UWMC is based on its desire to accommodate growth. However, UWMC's overall growth is modest; historically, it has been about 1% per year. AR4017. Its growth in the complex services it highlights is likewise modest, amounting to about *two beds* per year. RP1101-04. Adding 79 new beds to a fully served community is hardly the superior alternative for addressing this modest growth, particularly when UW/Northwest sits half-empty a few miles away. UWMC's desire to add beds to serve more complex patients could be readily accommodated by a modest movement of less complex services from one UW Medicine facility (UWMC) to another (UW/Northwest) that is already performing the same services and has idle capacity. Such a move would be far superior to spending tens of

millions of dollars to add dozens of surplus beds, according to the standards consistently applied by the Department in every case prior to this one. There is no competent evidence in the record that UWMC's massive, expensive project is the "superior alternative."

2. UWMC Has Not Proven Its 79-Bed Project Will Not Cause Fragmentation Of Services.

The final review criterion, structure and process of care, requires the applicant to prove that the project "will promote continuity in the provision of health care" and will "not result in an unwarranted fragmentation of services." WAC 246-310-230(4). The record does not support the Department's conclusion that this criterion was satisfied.

First of all, the Department's decision is inconsistent with the regulation. The Department has consistently interpreted the regulation such that when there is no numeric need for more beds, the addition of beds cannot satisfy the structure and process of care criterion because it results in duplication and fragmentation of care – even where the applicant uniquely provides complex services unavailable elsewhere.[29] The Department's conclusion here is directly to the contrary.

Furthermore, the *sole* factual premise on which the Department based its structure and process of care decision is unsupported by the record. The Department reasoned that this criterion was satisfied because

---

[29] *See, e.g., In re Sacred Heart*, Finding of Fact 1.33 ("The addition of more beds in light of surplus of availability [in other service area hospitals] would create an unnecessary duplication of services. Such an unnecessary duplication creates a fragmentation of services. A fragmentation of services does not promote continuity of care.") (AR2466).

"UWMC's project would not create a surplus of the type of beds (i.e., services) that these particular beds would be used for." Finding 1.25. This statement, made without any record citation, suggests that the beds would be limited to services unavailable elsewhere, which is absolutely not true. UWMC sought 79 unrestricted beds and the CON that was issued contains no such limitations or conditions. AR3520, 4763. Some of the beds are expected to be used for ICU, but the bulk of the beds will be available for any general medical/surgical purpose. *Id.* Based on UWMC's current bed usage, virtually all of the beds will be used for medical services duplicated at other hospitals in the Planning Area. AR4261; RP1079-86. Thus, the Department's ruling on fragmentation of care is both contrary to the regulation and unsupported by the record.

F. The Department's Refusal To Use Accurate Data Contravened Department Policy And Materially Prejudiced Petitioners

The Department improperly refused to use the most accurate, up-to-date data (2012 CHARS data) to evaluate UWMC's Application, while allowing UWMC to present inaccurate projections of that same data. This ruling contravened the Department's long-established standard practice and is highly prejudicial to Petitioners because it has created an inaccurate and unreliable record. These issues were preserved at the hearing and detailed in Petitioners' post-hearing Offer of Proof. AR2707-47.

1. The Department Departed From Its Long-Established Policy Of Utilizing The Most Recent Available Data.

Prior to and at the hearing, Petitioners requested that the

Department follow its standard policy and evaluate UWMC's Application utilizing the "most recent available" data as of the date on which the Program issues its CON evaluation (2012 CHARS data).[30] This would ensure that any decision would be based on the most accurate and up-to-date information as of the date of the Department's Evaluation, rather than on outdated data. UWMC opposed the use of accurate data, which showed that many of the factual assertions in its Application were false. *See* AR2707-47. But the Program *supported* Petitioners' request, confirming that it "should be allowed in." RP1030. As the Program acknowledged, the request to use accurate, updated data was consistent with the Department's standard practice in other proceedings. *Id.* For example, in one recent matter the Department explained:

> The Program's *standard practice* is to supplement the statistical information provided by applicants with newer statistical information (if available) that is obtained during the evaluation of an application. The Program's stated reason for supplementing the statistical information is to ensure the most up-to-date or current information is used when evaluating the application.

In re Valley, Finding of Fact 1.8 (emphasis added) (AR2373).

In this case, 2012 CHARS data became available to the public as of July 9, 2013 – nearly four months prior to the date on which the CON Program issued its Evaluation (November 5, 2013) and before the public

---

[30] *See, e.g., Dep't Evaluation of MultiCare Health Sys. Application* (2011) (AR2256-88) pp. 8, 10 (using "the most current data available" and "the last full year of available CHARS data"); *Dep't Evaluation of Auburn Reg. Med. Ctr., MultiCare Health Sys., and Valley Med. Ctr. Applications*, pp. 13, 16 (2010) (AR2141-214) (same).

comment period "closed." AR4719, 5203-04. However, when applying the Methodology to UWMC's Application, the Program incorrectly used 2011 CHARS data, which it later acknowledged was a *mistake*. AR4723; RP1030. Accordingly, the Program joined Petitioners in requesting that 2012 CHARS data be admitted at the hearing.

The Department refused. The stated rationale for this departure from practice and exclusion of data was: "[N]ew data that comes in after the public comment period; that comes in too late for the parties to properly incorporate it into its application; or that comes in too late for the Program to properly integrate it into its evaluation, are disruptive to the CN process." Finding 1.12, footnote 43.

This ruling is error. To begin with, it is factually incorrect to state that the 2012 CHARS data came in "too late," in view of the Department's standard practice. The data was released on July 9, 2013, before the end of the public comment period (July 11, 2013) and four months before the Program finished its analysis and released its Evaluation (November 5, 2013). RP844-45; AR4719. The Program itself has confirmed that 2012 CHARS was the correct data set to use in evaluating the Application. RP1030. More importantly, the notion that the use of up-to-date, accurate data would be "disruptive" to the CON process is not just entirely without factual basis in the record, it also directly contradicts *what the Department has actually been doing and saying for years*. The Department's decision is thus not only inconsistent and unprincipled; it also contravenes and undermines the process that the Department, CON applicants, and affected

parties have been relying upon for decades. The Department's departure from its standard practice should be reversed, and the Application should be evaluated using the correct data set (2012 CHARS).

2. The Department's Decisions On The Use Of 2012 Data Were Contradictory And Prejudicial To Petitioners.

It would have been bad enough had the Department simply deviated from standard Department policy and precluded all use of 2012 CHARS data, but its procedural rulings were far worse. Inconsistently, UWMC was allowed to – and did – present "evidence" about 2012 CHARS data both in its Application and during the hearing. Specifically, UWMC was allowed to introduce its purported annualizations and projections of 2012 CHARS data, even though the actual data was excluded. RP1025-26, 1038. Even after ruling that Petitioners could not offer evidence of 2012 CHARS data, the Department nonetheless refused to strike UWMC's 2012 references from the record. *Id.* In other words, the Department freely allowed UWMC to introduce "evidence" and make representations about what the 2012 CHARS data set *might* show, while prohibiting Petitioners from rebutting UWMC with the actual data. *Id.* It is legal error, improper procedure, and an abuse of discretion for the Department to exclude 2012 CHARS data, and that error was substantially compounded by allowing one party (UWMC) to introduce evidence on a topic at the hearing while precluding the other party (Petitioners) from having a full and fair opportunity to introduce rebuttal evidence on the same topic, contrary to basic notions of fairness and due process.

The Department's rulings in this regard were highly prejudicial to Petitioners. As detailed in Petitioners' post-hearing Offer of Proof, there were *many* instances, in both documents and testimony, where UWMC used purported 2012 data in support of its case. AR2707-47 (Offer of Proof, which is hereby incorported herein). In its written Application and rebuttal materials, UWMC presented and relied heavily on partial or purportedly "annualized" 2012 CHARS data, which Petitioners intended to rebut with the actual, accurate 2012 data. *Id.* But they were precluded from doing so by the Department. *Id.* Likewise, during the hearing, UWMC presented testimony regarding purported partial and annualized 2012 CHARS data, which again Petitioners intended to rebut with the same data set but were precluded from doing so. *Id.* The topics about which 2012 CHARS data would be relevant included many of the crucial issues in the case, and admitting the full year data would have enabled Petitioners to fully and fairly rebut assertions made by UWMC. *Id.*

By way of two examples only, while touting its growth as a justification for more beds, UWMC claimed that its number of acute patient discharges *increased* in 2012 (AR3792); the real data, however, showed they *declined* in 2012. AR2710. Similarly, while UWMC claimed it was "preposterous" that UW/Northwest could serve many UWMC patients (AR4605), the actual data showed that in 2012 – just as in 2011 – UW/Northwest continued to provide about 92% of the same services as UWMC (contradicting the notion that UWMC could not shift some less-critical patients to another of its facilities). AR2711. These are

only two examples among many where 2012 CHARS data belies UWMC's assertions on material issues of fact. *See* AR2707-47.

In effect, the Department allowed UWMC to insert into the record a wide variety of misleading or inaccurate assertions concerning 2012 data, while prohibiting Petitioners from rebutting those assertions with the actual data. Once in the record, the only fair process would have been to permit Petitioners to respond. The Department's rulings regarding 2012 data were erroneous, prejudicial, and material, and should be reversed.

VI. CONCLUSION

The Department granted the Application based on a legal rationale and factual analysis that is unprecedented in the Department's history and inconsistent with the Department's prior uniform interpretation of the CON statutory review criteria. The Department's reasoning is contrary to law and arbitrary and capricious, its material factual findings lack substantial record evidence, and the impact of its decision here has profound adverse consequences reaching far beyond this case. Any level of predictability, consistency, and transparency in the Department's CON review process has been seriously undermined by a decision that fundamentally holds that the normal rules that always apply will be ignored if the Department simply decides, without notice, to ignore them.

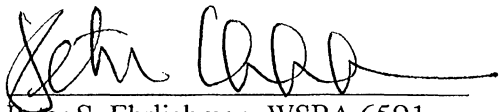
It is particularly disturbing that this process has been used by one state agency to award another state entity a de facto exemption, by administrative decree, from the rules that apply to all other participants in the state health care system. This outcome is not just inherently unfair, it

is also unsupported by either the law or the evidentiary record in this case.

It cannot reasonably be disputed that application of the relevant statutes and regulations as the Department has always applied them would result in denial of UWMC's Application, just as the Department's experts originally concluded. Simply ignoring or changing the rules to get to a different result is not a proper basis for administrative decision-making. Here, the end did not justify the means. The decision should be reversed.

Accordingly, and for the reasons set forth herein, Petitioners respectfully request entry of an order reversing the Department's decision approving UWMC's CON Application, denying the Application, and revoking the CON (#1516). In the alternative, Petitioners request entry of an order reversing the decision, remanding the Application to the Department to apply its standard evaluation methodology and 2012 CHARS data to the Application, and staying the effectiveness of CON #1516 until all proceedings on the Application are final in all respects.

Respectfully submitted this 28th day of September, 2015.



Peter S. Ehrlichman, WSBA 6591
Shawn Larsen-Bright, WSBA 37066
DORSEY & WHITNEY LLP
701 Fifth Avenue, Suite 6100
Seattle, WA 98104-7043
-and-
Stephen Pentz, WSBA No. 14089
3213 West Wheeler Street, #45
Seattle, WA 98199
Attorneys for Petitioners/Appellants

APPENDIX “A”

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE SERVICE UNIT

In Re: CERTIFICATE OF NEED APPLICATION OF UNIVERSITY OF WASHINGTON MEDICAL CENTER TO ADD 79 ACUTE CARE BEDS, Applicant, PROVIDENCE HEALTH & SERVICES – WASHINGTON, D/B/A PROVIDENCE REGIONAL MEDICAL CENTER EVERETT, PROVIDENCE HEALTH & SERVICES – WASHINGTON, D/B/A PROVIDENCE SACRED HEART MEDICAL CENTER, and SWEDISH HEALTH SERVICES, D/B/A SWEDISH MEDICAL CENTER/FIRST HILL, Petitioners.	Master Case Nos. M2013-1393 (Lead) M2013-1394 M2013-1395 FINDINGS OF FACT, CONCLUSIONS OF LAW, AND INITIAL ORDER

APPEARANCES:

Petitioners: Providence Health & Services-Washington,
d/b/a Providence Sacred Heart Medical Center, and
d/b/a Providence Regional Medical Center Everett (Providence), and
Swedish Health Services, d/b/a Swedish Medical Center/First Hill (Swedish), by
Stephen Pentz, PLLC, per
Stephen Pentz, Attorney at Law, and by
Dorsey & Whitney, LLP, per
Peter Ehrlichman, Shawn Larsen-Bright, and Amy Sterner, Attorneys at Law

Intervenor: University of Washington Medical Center (UWMC), by
Freimund Jackson & Tardif, PLLC, per
Jeff Freimund, Attorney at Law

Department of Health Certificate of Need Program (Program), by
Office of the Attorney General, per
Richard A. McCartan, Assistant Attorney General

PRESIDING OFFICER: Frank Lockhart, Health Law Judge

The Presiding Officer conducted a hearing on June 16-20, 2014, regarding UWMC's Certificate of Need (CN) Application to add 79 acute care beds to its existing hospital in Seattle, which is currently licensed for 450 acute care beds.

OVERVIEW

In 2005, UWMC began planning to expand its existing Seattle facility. Construction of an eight-story tower began in 2007 and was completed in 2012. The last three stories of the tower were "shelled-in" for future use.

In November of 2012, UWMC applied for a CN to add 79 acute care beds to its facility. The initial estimated capital expenditure of this project was $70,771,363.

On November 5, 2013, after evaluation, the Program awarded the CN to UWMC. Providence Health and Services (doing business as Providence Sacred Heart Medical Center and Providence Regional Medical Center Everett) and Swedish Health Services, were granted "affected person" status by the Program, and requested adjudicative proceedings to contest the CN award to UWMC. The three applications for hearing were consolidated and the three petitioners, represented by associated counsel, are identified collectively as "Petitioners" herein.[1] UWMC was granted Intervenor status.

[1] The Program's evaluation (AR 1218 *et seq.*) does not state the basis on which the Petitioners were granted "affected person" status. The three Petitioners (all affiliated with Providence Health) are all located outside of the North King County Planning Area, which would normally preclude them from either participating as affected persons or requesting a hearing on the Program's decision. (*See e.g.*, Prehearing Order No. 3, Order of Dismissal, *In Re HealthVest*, M2014-277.) However, one of the Petitioners, Swedish Health Services, d/b/a Swedish Medical Center/First Hill, also operates Swedish Ballard Hospital under the same hospital license, and Swedish Ballard Hospital is in the planning area. The issue of the Petitioner's standing was never challenged, and the issue of whether having one hospital in a planning area is sufficient to give standing to an affiliated/co-owned/co-licensed hospital outside the planning area was not raised. The assumption, therefore, for purposes of this Order, is that the Petitioners do have standing at the administrative level to challenge the award of the CN to UWMC. Whether they have appellate standing is another question.

ISSUE

Does UWMC's application to add 79 acute care beds to its 450-bed acute care hospital in Seattle (North King County hospital planning area) meet the relevant CN criteria in WAC 246-310-210, WAC 246-310-220, WAC 246-310-230, and WAC 246-310-240?

SUMMARY OF PROCEEDINGS

At the hearing, UWMC presented the testimony of:

1. Stephen Zieniewicz, UWMC's Executive Director.
2. April Delgado, Director of UW Medicine's Transfer Center.
3. Cynthia Hecker, Northwest Hospital's Executive Director.
4. Helen Shawcroft, UWMC's Senior Associate Administrator.
5. Jody Corona, UWMC's consultant.

The Petitioners presented the testimony of:

1. Richard Ordos, Department of Health (DOH) Hospital and Patient Data Section, Center for Health Statistics.
2. Bart Eggen, Executive Director, Office of Community Health Systems, DOH.
3. Dr. Frank Fox, Petitioners' consultant.
4. Robert Russell, DOH Certificate of Need (CN) Program

At the prehearing conference of May 30, 2014, the Presiding Officer admitted the following exhibits for hearing (*See* Prehearing Order No. 4):

Program Exhibits

Exhibit D-1: The Application Record consisting of documents related to the Application.

Exhibit D-2: The Supplemental Application Record, consisting of 12 documents (pages SUP 1-204) as described in Prehearing Order No. 3, to wit:

a. Appendix 10B to the Evaluation.

b. The final version of the Department's September 2013 survey of acute care beds at UW Medicine/Northwest.

c. Zip codes used by the Department to define the North King Planning Area.

d. Internal Department memorandum regarding UWMC's Application.

e. Floor plans of UW Medicine/Northwest.

f. Photographs taken during survey of UW Medicine/Northwest.

g. June 27, 2013 letter from Janis Sigman to "Affected and Interested Persons."

h. February 14, 2013 letter from Petitioners to the Department.

i. May 8, 2013 letter from Petitioners to the Department, enclosing an Excel file. (Note that the excel file listing diagnostic groups is printed out and place at the end of the Supplemental Application Record).

j. May 15, 2013 public comments submitted by Petitioner Providence.

k. May 15, 2013 public hearing key speakers' comments submitted by Petitioners.

l. May 15, 2013 letters of support for Petitioners' opposition to the UWMC Application.

Exhibit D-3: A nine-page final worksheet of the Department's bed count at the Swedish Ballard hospital.

UWMC's Exhibits

The Applicant was allowed to use the Application Record (Exhibit D-1 and D-2) as if it was its own exhibit.

Petitioners' Exhibits

In addition to being allowed to use the Application Record (Exhibit D-1 and D-2) as if it was its own exhibit, the following Petitioners' Exhibits were admitted at the prehearing conference of May 30, 2014.

Exhibit P-1: May 2013 internal bed count of UW/Northwest.

Exhibit P-2: The UW Medicine and UW/Northwest Affiliation Agreement.

Exhibit P-3: August 26, 2013 email from Brad Wendt, Construction Manager, UW/Northwest, to Susan Upton, Senior Plans Reviewer, Construction Review Services, regarding the Department's September 2013 survey of acute care beds at UW/Northwest.

Exhibit P-4: July 9, 2013 email from Richard Ordos, HPDS Supervisor, DOH, attaching CHARS 2012 Full Year data files.

Exhibit P-7: UWMC 2011 Acute Care Hospital License Application filed with the Washington State DOH, Revenue Section.

Exhibit P-8: UW/Northwest 2012-2014 Washington State DOH Hospital Acute Care License.

Exhibits Admitted at Hearing

The following exhibits had been reserved (*See*, Prehearing Order No. 4), but were admitted at the hearing.

Exhibit A-2: The Washington State Health Plan, Volume 2.

Exhibit A-3: UWMC's 2010 Neonatal ICU CN Application.

Exhibit P-5: April 7, 2008 letter from UWMC to Janis Sigman requesting a certificate of need applicability determination regarding phase one of the construction of Montlake Tower.

Exhibit P-6: May 5, 2008 letter from Karen Nidermayer, CN Program, to UWMC regarding a determination of non-reviewability for phase one of the construction of Montlake Tower.

Exhibit P-9: DOH Evaluation of the Application Submitted by University of Washington Medical Center Proposing to Add Intermediate Care Level 2 and Neonatal Intensive Care Level 3 Bed Capacity at the Hospital (October 8, 2010).

Exhibit P-10: DOH CN #1429 (October 28, 2010).

Closing Arguments

Pursuant to RCW 34.05.461(7), and by agreement of the parties, closing arguments were filed by brief.

Citations to the Application Record

All citations to the Application Record herein are in footnote form, citing to the Bates Stamp page number, as in "AR 343." All citations to the transcript of the administrative hearing are cited to the page number, as in "TR 99."

PRELIMINARY DISCUSSION

On its face, this case would appear to be simple. A single facility wants to add additional beds to its existing hospital location. No other facility applies for the CN. The CN is granted to the applicant. Several competitors contest the award of the CN.

However, under the surface there are several complex issues that touch upon the foundation of the CN process and require some preliminary discussion.

1. The purpose of the CN process.

The Washington State Legislature created the CN process in 1979 when it enacted RCW 70.38, the State Health Planning and Resources Development Act, which was enacted in response to the federal National Health Planning and Resources Development Act of 1974 (Pub. L. No. 93-641 93-641, 88 Stat. 2225, repealed 1986).

One of the purposes of the federal law was to control health care costs. Congress was concerned "that the marketplace forces in this industry failed to produce efficient investment in facilities and to minimize the costs of health care." *National Gerimedical Hospital & Gerontology Ct. V. Blue Cross of Kansas City*, 452 U.S. 378, 386, 69 L.Ed.2d 89, 101 S.Ct. 2415 (1981).

However, another purpose of the CN process is to increase the accessibility of health care to the public. As the Washington Supreme Court has stated:

> [T]the legislature has made clear its intent to "promote, maintain, and assure the health of all citizens in the state, provide accessible health services, health manpower, health facilities." RCW 70.38.015(1). That, in our judgment, is the overriding purpose of the CN program. While we agree with Overlake and Evergreen that controlling the costs of medical care and promoting prevention are also priorities, we believe that these goals are of secondary significance because, to a large extent, they would be realized by promotion and maintenance of access to health care services for all citizens. *Overlake Hosp. Assoc. v. Dept. of Health*, 170 Wash.2d 43, 239 P.3d 1095 at 1101. (Wash. 2010).

Obviously, there could be situations where promoting access to care could conflict with controlling costs (i.e., where increasing access raises costs or controlling costs reduces access). And there are a number of other goals in the CN process that also can conflict with cost control (e.g., providing services to medically underserved

groups regardless of ability to pay; serving the special needs of medical research projects designed to meet a national need, etc.). This is why, with the majority of factors in the CN evaluation, the regulations list factors to be considered, not factors that must be met, e.g., "The determination of need for any project shall be based on the following criteria . . . " (Emphasis added.) *See, inter alia,* WAC 246-310-210. Even the description of the individual factors in the regulations indicates most are factors to be weighed, for example:

> A determination that a proposed project will foster cost containment shall be based on the following criteria:
>
> (1) Superior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable . . .
>
> WAC 246-310-240

Deciding a "superior alternative" necessarily involves weighing and comparing factors. Therefore, rather than describing the CN evaluation as a mechanical granting of business licenses, it is more accurate to understand the CN process as the management of health care growth for the state. This is why the statutes and regulations are written in such a way as to provide a list of factors to weigh in deciding whether to grant a CN or not.

2. The need for legal fictions

However, as described in other CN decisions,[2] because the list of factors to be considered and weighed is so expansive, the agency[3] employs certain "legal fictions" in

[2] *See* Findings of Fact, Conclusions of Law, and Final Order, *In Re Puget Sound Kidney Ctr.* M2012-1073.

order to make CN determinations in a logical and consistent way. Nothing pejorative is meant by the term "legal fiction" – it simply denotes the use of a procedure or the assumption of a fact used as a basis for deciding a legal question necessary to dispose of a matter. These legal fictions include the "snap-shot in time," the planning area, and the State Health Plan.

a. The snap-shot in time

Many participants in the CN process colloquially refer to the Application Record (all the documents that were submitted during the time that the Program considered an application for a CN) as the "snap-shot in time," meaning, *what facts were considered in making a particular CN decision?* However, the origin and correct language is "snapshot of facts" and it comes from *University of Washington Medical Ctr. v. Dept. of Health*, 164 Wash.2d 95, 187 P.3d 243 (2008) which stated:

> The threshold question before the court is whether Judge Caner abused her discretion when she imposed the December 31, 2003 evidentiary cutoff in the remand hearing. The department argues that Judge Caner appropriately exercised her discretion to exclude irrelevant evidence. *See* RCW 34.05.452(1) ("The presiding officer may exclude evidence that is irrelevant, immaterial, or unduly repetitious."). At oral argument, the department suggested that the decision to grant a certificate of need is made on a "snapshot" of facts around the time the application is filed. *Id* at 103.

In that case, the Washington Supreme Court ruled that it is within the health law judge's discretion to determine the scope of admissible evidence. While "snap-shot in

[3] Whether it is the Program that makes the CN decision; or in cases that go to hearing, the Presiding Officer; or in cases that go to administrative review, the Reviewing Officer, the decision-maker in each case stands in the position of the agency. *See DaVita v. Dept. of Health*, 137 Wash.App. 174, 151 P.3d 1095, (Wash.App.II 2007).

time" is the convenient phrase that is often used to describe this scope, it has nothing to do with time. It is simply an evidentiary ruling as to what evidence comes in or is excluded. This evidentiary discretion is necessary, first, to maintain the statutory goals of allowing meaningful public input on the evidence that forms the basis for the CN decision, and secondly, for not hindering the speed with which a decision can be made. *Id* at 104. As explained in *In Re Puget Sound Kidney Ctr.* (M2012-1073), the snap-shot rule

> "is an absolutely vital rule to managing CNs because the data never stops pouring in. There is always more up-to-date data. If the Application Record remained open to capture the most recent data, there would never be a point that a CN could be granted because there's always more recent data available. So there has to be an arbitrary end point beyond which one does not consider more recent data."

The problem that arises in many cases, as it did in this case, is in the area of "need." Pursuant to WAC 246-310-210, applicants for CNs must demonstrate a need for the proposed services. Parties, for understandable business reasons, want to continue to recalculate need formulas and spreadsheets, often using data that was not available during the time of the Application Record, or using new mathematical assumptions that change the numeric outcomes, all in an effort to justify their particular positions. Without a way to limit that practice of constant recalculation, CN decisions could never be made, hence the legal fiction of limiting the decision to a certain snapshot of facts. The snapshot of facts is, in essence, an evidentiary ruling that makes a final decision possible.

b. The planning area

For purposes of deciding CNs, the state is divided into 54 planning areas. These planning areas serve the same purpose as the snap-shot in time – the planning areas are snap-shots in place, a necessary legal fiction that allows for an analysis of CN data within a pre-set geographical limit. In some CN cases, the methodology used to determine health care need (need-methodology) in a particular planning area makes the mathematical assumption that no prospective patient in that planning area would leave the planning area to seek treatment elsewhere, and that no patient outside of the planning area would come into the planning area to seek treatment. In other CN cases, the need-methodology does take into account patients who might migrate in from other planning areas to seek treatment. In the instant case, because of UWMC's unique position (as the teaching hospital for Washington's only medical school; as part of a state agency; and as a nationally recognized multi-state-wide provider of complex patient care), the permeability of the planning area was of great importance. Again, the purpose of the CN process is to try and have a logical approach that involves stakeholders and the public in a way that allows for a timely decision that balances access to health care while controlling health costs. This process necessarily gives great discretion to the agency responsible for the ultimate decision.

c. The State Health Plan

The Program uses the Hospital Bed Need Forecasting Method contained in the 1987 Washington State Health Plan in order to calculate hospital bed need. As the Program states in each of its hospital bed CN evaluations, "though the State Health

Plan was 'sunset' in 1989, the department has concluded that this methodology remains a reliable tool for predicting the baseline need for acute care beds in most circumstances."[4] Normally, the application of the State Health Plan is an uncontested matter, but in this particular case, a key passage in the State Health Plan was hotly contested and is pivotal to the CN decision.

3. The adjudicative hearing

Finally, it is important to remember that the adjudicative review for a CN case is not a de novo hearing, wherein the parties receive a whole new hearing and can retry their case. Rather, it is a type of de novo review. *University of Washington Medical Ctr. v. Dept. of Health*, 164 Wash.2d 95, 187 P.3d 243 (2008). In a de novo review, the presiding officer reviews the record from the underlying proceeding but is not bound by the underlying decision. However, inherent in the de novo review is the ability of the presiding officer to examine all the evidence presented to the underlying decision maker (in this case, the Program), even if the Program excluded that evidence from its decision.[5] Furthermore, in CN cases, the courts have given the presiding officer broad discretion to admit, or not admit, evidence that came into existence after the Application Record closed. *University of Washington Medical Ctr.* 164 Wash.2d at 104. However, that broad discretion does not turn the de novo review into a de novo hearing. As the Court in *University of Washington Medical Ctr.* stated:

---

[4] AR 1227.

[5] *See, Folsom v. Burger King*, 135 Wash.2d 658, 663, 958 P.2d 301 (1998); *Davis v. Baugh Indus. Contractors, Inc.*, 159 Wash.2d 413, 416, 150 P.3d 545 (2007); *University of Washington Medical Ctr. v Dept. of Health*, 164 Wash.2d 95, 187 P.3d 243 (2008).

> Both the statutes and the administrative rules clearly contemplate that the decision will be made quickly; ideally, 90 days from the application's filing. RCW 70.38.115(8); WAC 246–310–160(1). Requiring the health law judge to admit evidence created long after this period of time would undermine the statutory objective of expeditious decision making and prevent meaningful public input on that evidence. A request for an adjudicative hearing does not begin the application process anew; the adjudicative proceeding is part of the entire certificate of need petition process established by chapter 70.38 RCW.

With the above discussion in mind, we turn to the unique issues of this case.

I. FINDINGS OF FACT

1.1 The University of Washington Medical Center (UWMC) is the teaching hospital for the University of Washington School of Medicine in Seattle.[6] It is part of a state agency, governed by the University of Washington Regents, whose members are appointed by the Governor. UWMC operates the fifth largest training program in the United States for physicians, dentists, and other health professionals[7] and provides a comprehensive range of complex health services in the areas of cardiac surgery, high-risk pregnancy, oncology, solid organ transplant, and other tertiary and quaternary services.[8] UWMC has a number of distinctions, including being ranked as the number one hospital in Washington by U.S. News & World Report;[9] being named the nation's first Magnet Hospital for Excellence in Nursing Care by the American Nurses

[6] AR 7. While there are naturopathic/homeopathic/alternative schools of medicine in Washington, the University of Washington Medical School is the only allopathic medical school in the five-state WWAMI region (Washington, Wyoming, Alaska, Montana, and Idaho).

[7] AR 43.

[8] Tertiary care "is a level of medical care available only in large medical care institutions. It includes techniques and methods of therapy and diagnosis involving equipment and personnel not economically feasible in a smaller institution because of underutilization." Taber's Cyclopedic Medical Dictionary. Quaternary care is an advanced level of specialized tertiary care only found in national medical centers.

[9] AR 11.

Credentialing Center;[10] being the academic medical center for the WWAMI region;[11] and being the only hospital in Washington that provides all types of solid organ transplants.[12]

1.2 At the time of this application (November 2012), UWMC was licensed for 450 beds.

1.3 In 2005, UWMC began planning for a new eight-story tower to house patients and services. In 2007, the Regents approved the construction project. The original plan was to build five floors and then add the remaining three floors later, but when the economic recession hit, the construction environment became more favorable and UWMC was able to "shell-in" the remaining three floors of the tower at a substantial savings during the first phase of the project rather than wait until later.[13] The cost of the shell (approximately 34 million dollars) was paid for in full out of UWMC reserve funds.[14] In April 2010, while the tower was still under construction, UWMC applied for a CN to expand its Level IIIB neonatal service (to be housed in the lower section of the tower). The projected capital costs of the tower, including the shell, were included in that application.[15] Construction of the eight-story tower was completed in 2012, and UWMC

[10] AR 50.

[11] TR 43.

[12] TR 44.

[13] TR 349-351. UWMC's Senior Associate Administrator estimated that the cost savings to UWMC for completing the entire tower during phase one of the construction was 13 million dollars. TR 351.

[14] TR 350.

[15] AR 243, TR 348-350.

opened their replacement Neonatal Intensive Care Unit and a new inpatient oncology/medical/surgical unit in the lower floors of the tower.[16]

1.4 In November of 2012, UWMC applied for a CN to add 79 acute care beds to its facility, in essence to fill the part of the tower that had been shelled-in. The initial estimated capital expenditure of this project was $70,771,363. At the time of its CN application, UWMC had 445 beds set up, of which 50 beds were dedicated to neonatal intensive care, 16 to inpatient psychiatric care, and 19 to rehabilitation, leaving 360 beds available for acute care.

1.5 In order to qualify for a CN, an applicant must show compliance with WAC 246-310 and demonstrate that the proposed project (a) is needed; (b) is financially feasible; (c) will meet certain criteria for structure and process of care; and (d) will foster containment of health care costs.

WAC 246-310-210 "Determination of Need"

1.6 Pursuant to WAC 246-310-210, an applicant for a CN must demonstrate a need for the proposed services. Normally, that need for additional beds (numeric need) is established using the Hospital Bed Need Forecasting Method contained in the 1987 Washington State Health Plan, and is focused on the numeric need within the planning area. However, from the very beginning,[17] in their original application, UWMC cited the section in the State Health Plan that allows for deviation from examining only need

[16] AR 10.

[17] AR 28.

within the planning area as the criteria for meeting the Determination of Need requirement. Criterion 2 in Volume II of the State Health Plan states:

> CRITERION 2: Need for Multiple Criteria
>
> Hospital bed need forecasts are only one aspect of planning hospital services for specific groups of people. Bed need forecasts by themselves should not be the only criterion used to decide whether a specific group of people or a specific institution should develop additional beds, services or facilities. Even where the total bed supply serving a group of people or planning area is adequate, it may be appropriate to allow an individual institution to expand.
>
> Standards:
>
> b. Under certain conditions, institutions may be allowed to expand even though the bed need forecasts indicate that there are underutilized facilities in the area. The conditions might include the following:
>
> - The proposed development would significantly improve the accessibility or acceptability of services for underserved groups; or
> - The proposed development would allow expansion or maintenance of an institution which has staff who have greater training or skill, or which has wider range of important services, or whose programs have evidence of better results than do neighboring and comparable institutions; or
> - The proposed development would allow expansion of a crowded institution which has good cost, efficiency or productivity measures of its performance while underutilized services are located in neighboring and comparable institutions with higher costs, less efficient operations or lower productivity.
> - In such cases the benefits of expansion are judged to outweigh the potential costs of possible additional surplus.

In its application, UWMC argued that the need criteria could be met looking at either the bed need within the planning area or the demand from outside the planning area. (UWMC argued that within the North King planning area there would be a need for 112 additional beds by the year 2021.[18] The issue of need within the planning area is discussed in Paragraph 1.9 below.) However, given the fact that 89% of UWMC's patient days come from patients who reside outside of the planning area, it makes no sense to determine "need" only in terms of the 11% of UWMC's patient days that come from residents within the North King planning area. UWMC's situation in Washington State is unique and is exactly the type of CN application that Criterion 2 of the State Health Plan envisioned.

1.7 At hearing, in prehearing briefs, and in its closing brief, Petitioners argue that Criterion 2 of the State Health Plan cannot be used in CN evaluations, but they are incorrect. RCW 70.38.115(5) does give the Program discretion when applying the evaluative criteria.[19] WAC 246-310-200(2)(a)(ii) and (b)(ii) allow the use of other standards and criteria. Criterion 2 is a balanced, logical approach to evaluating cases like this, and furthermore, is completely harmonious with the Washington Supreme Court's opinion in *Overlake Hosp. Assoc. v. Dept. of Health, Op. cit.*, which promotes accessibility as one of the overriding purposes of the CN program.

---

[18] AR 25.

[19] RCW 70.38.115(5) states: "Criteria adopted for review in accordance with subsection (2) of this section [criteria for the review of certificate of need applications] may vary according to the purpose for which the particular review is being conducted or the type of health service reviewed." The Petitioners' argument in its closing brief that reliance on Criterion 2 of the State Health Plan would violate the Administrative Procedures Act is a spurious argument.

1.8 In support of a finding that UWMC meets the WAC 246-310-210 need criteria via the application of Criterion 2 of the State Health Plan, the Presiding Officer finds the following persuasive:

a. 89% of UWMC's patient days come from outside the North King planning area.[20] Even the Petitioner's expert acknowledged this.[21]

b. UWMC provides a higher percentage of state-wide care for such tertiary and quaternary areas as cardiology, high risk pregnancy, oncology, and organ transplants than other providers in the state. The actual percent amount was hotly disputed at hearing. UWMC provided a table[22] of 17 selected complex DRGs[23] that showed that UWMC provides more than 50% of all state-wide care for those types of patients. (The Petitioners' complaint was that the DRGs were "cherry-picked" to show only the complex diagnoses on which UWMC provided the most service, but the percentage of care that UWMC provided to those diagnoses was not contested. In fact, the Petitioners conceded that UWMC's total share of highly complex cases is higher than other providers.[24] The Petitioners' public comments also acknowledged that UWMC provided the most organ transplants in the state, and provided oncology care to more inpatients than any other hospital in the state.[25])

c. 10% of UWMC's patient days come from persons who live outside the state. The population of the WWAMI region (Washington, Wyoming, Alaska, Montana, and Idaho) was more than 10.5 million in 2010, and has a projected growth of 11% over the next decade. The population of 65 and

[20] AR 7, TR 47.

[21] TR 1167

[22] AR 26.

[23] DRGs are Diagnostic Related Groups, an accepted system of classifying hospital cases.

[24] AR 418-9.

[25] AR 420-422.

older in the WWAMI region is projected to grow 36% over that same time frame.[26]

d. UWMC is at maximum effective capacity. Its average midnight occupancy rate (the lowest census point of the day) for its 365 acute care beds is 75%. The Program has previously determined that a 75% occupancy rate is the optimal percentage for efficient utilization of services.[27] An occupancy rate above 75% begins to compromise access to service and indicates need for additional beds.[28] UWMC's occupancy rate for its ICU beds, for example, is in the 90th percentile.[29]

e. For many patients with complex medical needs in Washington State, and in the 5 state WWAMI region, there may not be other treatment options available. UWMC's affiliated hospitals and other community hospitals do not have the technology, equipment, or physician support to provide adequate or safe care for these particular complex medical patients.[30] Yet those patients are being denied access to UWMC because of a lack of beds.[31] The

---

[26] AR 35.

[27] AR 429 & Exhibit A-2, page C-37.

[28] In a typical CN application, an occupancy rate over 75% in a particular facility would not necessarily mandate additional beds if there are other comparable-use beds in the planning area. One of the Petitioners' main arguments was that there are beds available at Valley Medical Center and Northwest Hospital. However, this case is not a typical CN application. When it comes to highly specialized and complex medical cases, hospital beds between facilities are not fungible. UWMC's occupancy is higher than Valley Medical Center and Northwest Hospital, and will continue to rise, because of the nature of the services that UWMC provides (TR 77). In an effort to reserve bed space for complex cases, UWMC has relocated several of its non-complex case types (non-complicated hip and joint replacements, general hernia surgeries, midwifery, and its Multiple Sclerosis center) to affiliated hospitals. (TR 78-79; TR 173) Yet, UWMC's occupancy rate remains at 75%. The impact of relocating non-complex cases to other facilities is that UWMC's beds are filled with more complex cases, and its "case-mix index" (its percentage of complex medical cases) increases. (TR 62 & 79). Petitioners argued at hearing that UWMC's case mix actually decreased (TR 103-105), but this argument was based on their claim that the 2011 CHARS data showed a lower case mix compared to UWMC's chart. The fact that two different entities come to different numeric figures does not prove a "decrease". Even assuming Petitioners' claim that UWMC was selecting only their most complex cases to illustrate the increase in the case mix does not invalidate UWMC's point that those particular cases are increasing. Despite their claim that UWMC does not need additional beds, Petitioners concede that UWMC has the highest share of highly complex cases (AR 505-506).

[29] TR 78.

[30] TR 80-82.

[31] TR 188

University of Washington Transfer Center handles requests by WWAMI physicians for patient transfers into UWMC. In 2011 there were 93 patients who were turned away because there was no bed available; in 2012 there were 138 patients turned away because no bed was available; and in first four months 2013, January through April, there were 43 patients who could not be accommodated because of a lack of beds at UWMC.[32] These are primarily complex cardiology patients, cardiac surgery, general surgery, oncology, and organ transplant cases.[33] These transfer requests came from over 150 different hospitals, including transfers from the Petitioners.[34]

f. UWMC provides the highest percentage of inpatient care to Medicaid recipients of any hospital in King County, except for its affiliated hospital, Harborview.[35]

g. In addition to providing medical care to patients, UWMC provides training to physicians as the 5 state WWAMI's only teaching hospital. There are 1,318 residents and fellows in training at UWMC.[36] The Accreditation Council for Graduate Medical Education requires a minimum volume of cases occur at a hospital to maintain accreditation.[37]

As indicated, the Presiding Officer does find that Criterion 2 of the State Health Plan can, in certain cases, allow an applicant to satisfy the WAC 246-310-210 "need criteria." This is one of those cases. The above enumerated items indicate that UWMC meets the Criterion 2 requirements of:

- significantly improving the accessibility or acceptability of services for underserved groups; or

---

[32] AR 584, TR 185.

[33] TR 185.

[34] AR 641-642. For example, from January 2011 through April 2013, Providence-Everett transferred 152 patients to UWMC.

[35] AR 29.

[36] TR 82.

[37] AR 1108.

- allowing expansion or maintenance of an institution which has staff who have greater training or skill, or which has wider range of important services, or whose programs have evidence of better results than do neighboring and comparable institutions; or

- allowing expansion of a crowded institution which has good cost, efficiency or productivity measures of its performance while underutilized services are located in neighboring and comparable institutions with higher costs, less efficient operations or lower productivity.

1.9 As indicated, in its application UWMC did argue that it met both the Criterion 2 need requirements and also the more traditional need analysis methodology used under WAC 246-310-210 to determine need in the planning area. In terms of the latter, UWMC provided three different versions of its numeric calculation: the original calculation in its application, a second calculation during the screening process, and a third calculation during the rebuttal process. The second calculation was identical to the original calculation but incorporated information related to bed availability at Swedish Ballard that was not available at the time of UWMC's original application. The third version revised the second calculation by assuming fewer available beds at Northwest Hospital. The Program accepted the second calculation as a more accurate version of UWMC's original calculation, but rejected the third calculation as untimely.[38] UWMC's second calculation predicted a shortage in the planning area of 12 beds by 2018 and a shortage of 64 beds by 2021.

[38] AR 1225-1226

1.10 The Program then ran its own numeric calculation but came up with different figures. The Program's calculations showed a 9 bed surplus in the planning area by 2018 and a shortage of 39 beds by 2021.

1.11 Although the Program did not refer to Criterion 2 by name, in essence what it did next was to look at UWMC's application under the Criterion 2 requirements[39] and concluded that "allocating the projected patient days to all the hospitals in the North King planning area as the methodology does, will not provide an accurate allocation of the needed beds in the North King planning area."[40] This is because the other hospitals in the planning area "do not have the facilities, personnel, or other resources to provide the needed services."[41] The Program determined that "the occupancy levels for UWMC especially in their intensive care units indicate a need for beds"[42] and concluded that UWMC had met the criteria for establishing need.

1.12 The Presiding Officer agrees with the Program's conclusion but makes it explicit that this is a Criterion 2 case. In this case, there is simply no way not to apply Criterion 2 of the State Health Plan to the analysis. Were the Presiding Officer to only accept the traditional need analysis methodology, the Presiding Officer would deem UWMC's second calculation (made during the screening process) as the most accurate

[39] AR 1234-1239.

[40] AR 1238.

[41] AR 1239

[42] AR 1239

calculation within the "snapshot of time."[43] But that calculation, as accurate as it was at the time it was offered, only showed a need for 12 beds at UWMC starting in 2018, and that simply does not square with the fact that UWMC is already turning away over 100 patients a year, patients who need complex medical care, because of a lack of beds. And the reason those two figures do not square with each other is because the traditional needs analysis fails to take into account not only that 89% of UWMC's patients come from outside the planning area, but also that UWMC's beds are not fungible with other beds in the planning area.[44] Hence the need for the Criterion 2 analysis.

1.13 In addition to establishing bed need, UWMC also fulfilled the other sub-criteria that WAC 246-310-210 provides for consideration. UWMC proved that its

[43] The Program was correct in not considering revisions to statistical calculations that occurred during the rebuttal phase. Likewise, the Presiding Officer rejects the Petitioners' use of the 2012 CHARS statistical data that only became available during the last few days of an extended rebuttal period. (TR 1007-1026). Thus, the Petitioners' Post Hearing Offer of Proof Regarding 2012 CHARS data is denied. For the reasons outlined in the Preliminary Discussion of this Order, new data that comes in after the public comment period; that comes in too late for the parties to properly incorporate it into its application; or that comes in too late for the Program to properly integrate it into its evaluation, are disruptive to the CN process, and except for extraordinary exceptions, should be excluded from the CN decision.

[44] Throughout the adjudication process, the Petitioners made the argument that UWMC's specialized services and special status as part of a state agency do not entitle it to special treatment. And while that is a rhetorically-appealing argument, it is false rhetoric. In the mission of managing the state's health care system, the CN Program is allowed to take into account the individual attributes or needs of an applicant if it furthers the betterment of the health care of the people of Washington. The Petitioners also attempted, at hearing and in their closing briefs, to prove that the Program's evaluation of UWMC's application was flawed by showing that the Program's first reviews of UWMC's application were negative, or by showing that there were differences of opinion among the Program's staff early in the evaluation regarding the suitability of the application. This litigation approach at hearing is not favored. In any evaluation, there are going to be differences of opinions, and there may be times when senior members of an evaluation team overrule subordinates. The process of rendering an agency decision is just that – a process. In the CN process, it is the final agency opinion that matters, not earlier drafts of that opinion. The same is true when comparing a current agency CN decision to a previous CN decisions involving other parties, other facts, and other planning areas. The management of health care growth for the state requires that the agency have the flexibility to make decisions for each application based on the facts of that particular application.

patient population has need for its services and that those services are not sufficiently available elsewhere, satisfying WAC 246-310-210(1). UWMC proved that all residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, the elderly, Medicare patients, Medicaid patients, and medically indigent patients would have adequate access to its services, satisfying WAC 246-310-210(2).[45]

1.14 UWMC also satisfied WAC 246-310-210(3) and (4) sub-criteria by substantiating its special needs as a teaching hospital and as providing services to patients outside of the planning area. These two WAC subsections resonate with RCW 70.38.115(2)(d) which requires the Program to consider the impact of a CN application on existing training programs for medical interns and residents. As previously indicated, UWMC is the fifth largest training program in the United States for physicians, dentists, and other health professionals; has over 1,300 residents and fellows in training; is the only allopathic medical school in the state; and is the academic medical center for the five-state WWAMI region. Increasing UWMC bed capacity not only fills a patient need, but also fulfills and enhances a training need.

1.15 Based on the Application Record and the testimony at hearing, the Presiding Officer finds that UWMC meets the need determination of WAC 246-310-210.

WAC 246-310-220 "Financial Feasibility"

1.16 Pursuant to WAC 246-310-220, an applicant for a CN must demonstrate that the project is financially feasible. Specifically, an applicant must demonstrate that

[45] TR 83-86, AR 32, AR 83-87, and AR 1239-1240.

the capital and operating costs can be met; that the costs of the project will probably not result in an unreasonable impact on the costs for health services; and that the project can be appropriately financed.

1.17 In its application, UWMC estimated its capital expenditure as $70,771,363 for this project. The Program used those figures for its evaluation and determined (a) that the project was appropriately financed,[46] (b) that UWMC's projections of meeting its operating costs by the end of the third year were reasonable,[47] and (c) that the costs of the project would not have an unreasonable impact on health care costs.[48] The Petitioners did not take issue with the Program's conclusions based on the figures that UWMC provided, but rather, they took issue with the figures that UWMC provided. Specifically, they objected that the cost of the building shell (approximately 34 million dollars) was not included in UWMCs capital expenditure forecasts.

1.18 The Petitioners argue that the 34 million dollars that UWMC paid for the shell should have been included as part of the construction costs, and in one sense they are correct. Had UWMC's building project been completed in 2 phases, as originally approved by the Board of Regents in 2008, the cost of the shell would have stood clearly separate from the initial cost of the tower construction. However, as previously indicated, UWMC was able to take advantage of conditions in the construction environment due to the recession and was able to complete the shell during the original

[46] AR 1245.

[47] AR 1242.

[48] AR 1244.

phase 1 of the project. But UWMC was always transparent about this. Within the first eight pages of their application, UWMC stated:

> The physical shell for the beds proposed in this application was constructed as part of UWMC's Montlake Tower inpatient bed tower project. A draft supplemental Environmental Impact Statement (EIS) (which supplements UW's existing Campus Master Plan EIS) was issued May 20, 2008 and a final supplemental IES was issued on December 23, 2008. Documentation of these filings is included as Exhibit 2.[49]

Later, in response to the Program's screening questions about the tower, UWMC wrote:

> Please note that UWMC provided all of the cost, financing and depreciation/interest expense associated with the larger tower (including the shell) in our April 2010 CN application requesting approval for an expanded Level IIIB neonatal service. In that CN, we stated that the cost of the Montlake Tower (Phases 1 and 2) which was projected to be operational in September of 2012, was $204,000,000. We also provided a copy of the signed UW Financing Agreement and noted that the financing was secured on July 15, 2009. Finally, at Table 7 of the NICU application, we provided the capital cost per day associated with the entirety of the Montlake Tower project.[50]

To further document the shell costs, UWMC attached to its answer to the Program's screening questions, the minutes from the January 21, 2010 Board of Regents meeting in which the Board approved the 34 million dollar expenditure for the shell.[51]

1.19 Furthermore, prior to their 2010 application for the neonatal CN, UWMC had filed, in 2008, a request for determination of non-reviewability with the Program in

---

[49] AR 10.

[50] AR 243.

[51] AR 268, 270, and 278.

which they also disclosed the costs of the shell.[52] In essence then, UWMC disclosed, or made reference to, the costs of the shell at three different junctures: in their 2008 request for non-reviewability; in their 2010 NICU (neonatal) CN application; and in this application.

1.20 Furthermore, the Program acknowledged in their evaluation that the shell had been built and paid for prior to the application, to wit:

> The physical shell for the beds proposed in the application submitted by UWMC was constructed as part of UWMC's Montlake Tower inpatient bed tower project.[53]

1.21 This is not a case where an applicant deliberately tries to obfuscate, disguise, or hide building costs. Nor can the omission of the shell costs from the application's budget be classified as a mistake. Rather, it was a not-unreasonable assumption for UWMC to believe that because it had included the shell costs in its neonatal CN application, and had discussed that fact in this application process, it would not have to list the shell costs again in this capital expenditure budget. The thrust of WAC 246-310-220 is the reasonableness of the financing. In this case, the inclusion of the shell costs in the budget would not have made a difference in the operating costs

---

[52] TR 352-355. A request for determination of non-reviewability, also known as a certificate of need applicability determination, is a request for a written decision from the Program that a specific project (in this case the building of the Montlake Tower) does not need a CN. Basically, in that request, UWMC described the building project and the costs, and the Program determined that no CN was needed for the building. *See* Exhibits P-5 and P-6.

[53] AR 1243. It may well have been the case that the different Program advisors and analysts who worked on different aspects of UWMC's application did not connect that the cost of the shell, having been previously paid, was not included in the UWMC's capital expenditure budget, but that does not mean they were not aware of the cost. Nor does it mean that UWMC, having disclosed the costs, was mandated to include those costs in their capital expenditure budget. E.g., the financial analyst for the Program testified that he was aware that the shell was already built and paid for (TR 1253), and while he did not become

of the project. The shell itself was not financed - it was paid in full out of UWMC's reserves.[54] Only the shell was built. None of the inside construction was done. The inside construction costs, equipment costs, site supervision, and financing costs, totaling $70,771,363, were detailed in UWMC's capital expenditures in their application.[55] While it would have been the better practice to have shown the cost of the shell in the capital expenditure budget with an explanation, the fact that UWMC was open about the shell costs is sufficient to deem those costs as acknowledged by the applicant.[56]

1.22 Based on Paragraphs 1.15 through 1.18 above, UWMC met all the criteria in WAC 246-310-220.

WAC 246-310-230 "Structure and Process of Care"

1.23 The criteria for structure and process of care, spelled out in WAC 246-310-230, includes five areas that must be considered when reviewing a CN Application, to wit: adequate staffing, appropriate organizational structure and support, conformity with licensing requirements, continuity of health care, and the provision of safe and adequate care.

---

aware until later that the cost of the shell was not included in UWMC's capital expenditure budget, he also testified that it was not required to be included in such a budget (TR 1255).

[54] TR 345 and 351.

[55] TR 75, AR 1245.

[56] Showing the shell costs in the capital expenditure budget with an explanation would have been the better practice because CN applications need to be completely transparent. Because the Program depends on applicants to be honest and forthright in their applications, those applicants who deliberately hide construction costs, or who make avoidable mistakes in their pro formas are traditionally denied CNs. The practice of denying CNs to such intentional misrepresentations or avoidable mistakes will continue. However, as indicated, the Presiding Officer finds here that UWMC's actions were reasonable.

1.24 As pointed out in the Program's evaluation,[57] UWMC is well positioned to attract, train, and retain staff due to its reputation as a nationally recognized provider of high quality tertiary and quaternary services, its status as a Magnet Hospital for Nursing Excellence, and its position as a research and teaching facility. Because this project is an expansion of already existing services, the underlying structure, staffing, agreements, and transfer agreements are already in place.[58]

1.25 The Petitioners argue in their closing brief that approval of UWMC's application would lead to duplication and fragmentation of services, but their argument is based on the false assumption that hospital beds are all fungible and that UWMC's project would create a surplus of beds. The Presiding Officer finds that UWMC's project would not create a surplus of the types of beds (*i.e.* services) that these particular beds would be used for – in fact, these beds would fill a need that already exists. Thus, this project would promote and further continuity of care with UWMC's partners and patients, the majority of whom are outside of the North King planning area.

1.26 The Presiding Officer finds that UWMC's project satisfies the requirements of WAC 246-310-330.

WAC 246-310-240 "Cost Containment"

1.27 The final criteria for analyzing the viability of a CN Application is a determination of cost containment, as described in WAC 246-310-240, which includes

[57] AR 1248-1249.

[58] AR 50-52.

an analysis of whether there are superior alternatives to the proposed project in terms of cost, efficiency, or effectiveness.

1.28 UWMC's proposal is to add 79 beds in two separate phases. The first phase is the completion of two of the shelled floors and would add 56 beds, including a new 24 bed intensive care unit. The second phase, to be completed two years after the completion of the first phase, would include the completion of the final shelled floor and would add another 23 acute care beds.[59]

1.29 UWMC considered a variety of alternatives, including phasing in the beds at different times, phasing in internal construction at different times, but determined that any alternative to the existing proposal would be significantly more costly and disruptive to patient care.[60] The Program concurred with that analysis.[61]

1.30 Two of the other sub-criterion of WAC 246-310-240 (reasonable cost, scope, and method of construction; and impact on health care costs) were met under the financial feasibility criterion of WAC 246-310-220.

1.31 For the reasons discussed in Paragraph 1.8, the project would be an improvement on the delivery of health services that would promote cost effectiveness (another sub-criterion for WAC 246-310-240) for the residents of the North King Planning area and Washington State.

---

[59] AR 1247.

[60] AR 54.

[61] AR 1250-1251.

1.32 Thus, the Presiding Officer finds that UWMC's project satisfies the requirements of WAC 246-310-240.

1.33 The Presiding Officer finds that UWMC's application meets the criteria for CN set forth in WAC 246-310-210, WAC 246-310-220, WAC 246-310-230, and WAC 246-310-240. For this reason, UWMC's application for CN is granted.

II. CONCLUSIONS OF LAW

2.1 The Department of Health is authorized and directed to implement the certificate of need program. RCW 70.38.105(1). Increasing the number of acute care beds requires a certificate of need. WAC 246-310-020. The applicant must show or establish that its application meets all of the applicable criteria. WAC 246-10-606. The Program issues a written analysis which grants or denies the certificate of need application. The written analysis must contain sufficient evidence to support the Program's decision. WAC 246-310-200(2)(a). Admissible evidence in certificate of need hearings is the kind of evidence on which reasonably prudent persons are accustomed to rely in the conduct of their affairs. RCW 34.05.452(1). The standard of proof is preponderance of the evidence. WAC 246-10-606.

2.2 The Presiding Officer (on delegated authority from the Secretary of Health) is the agency's fact-finder and decision maker. *DaVita v. Department of Health*, 137 Wn. App. 174, 182 (2007) (*DaVita*). The Presiding Officer engages in a de novo review of the record. *See University of Washington Medical Center v. Department of Health*, 164 Wn.2d 95 (2008) (citing to *DaVita*). The Presiding Officer may consider the

Program's written analysis in reaching his decision but is not required to defer to the Program analyst's decision or expertise. *DaVita*, 137 Wn. App. at 182-183.

2.3 In acting as the Department's decision maker, the Presiding Officer reviewed the application record. The Presiding Officer also reviewed the hearing transcripts and the closing briefs submitted by the parties pursuant to RCW 34.05.461(7). The Presiding Office applied the standards found in WAC 246-310-200 through 246-310-240 in evaluating both parties' applications.

2.4 WAC 246-310-200 sets forth the "bases for findings and actions" on CN Applications, to wit:

> (1) The findings of the department's review of certificate of need applications and the action of the secretary's designee on such applications shall, with the exceptions provided for in WAC 246-310-470 and 246-310-480 be based on determinations as to:
>
> (a) Whether the proposed project is needed;
>
> (b) Whether the proposed project will foster containment of the costs of health care;
>
> (c) Whether the proposed project is financially feasible; and
>
> (d) Whether the proposed project will meet the criteria for structure and process of care identified in WAC 246-310-230.
>
> (2) Criteria contained in this section and in WAC 246-310-210, 246-310-220, 246-310-230, and 246-310-240 shall be used by the department in making the required determinations.
>
> (a) In the use of criteria for making the required determinations, the department shall consider:
>
> (i) The consistency of the proposed project with service or facility standards contained in this chapter;

(ii) In the event the standards contained in this chapter do not address in sufficient detail for a required determination the services or facilities for health services proposed, the department may consider standards not in conflict with those standards in accordance with subsection (2)(b) of this section; and

(iii) The relationship of the proposed project to the long-range plan (if any) of the person proposing the project.

(b) The department may consider any of the following in its use of criteria for making the required determinations:

(i) Nationally recognized standards from professional organizations;

(ii) Standards developed by professional organizations in Washington State;

(iii) Federal medicare and medicaid certification requirements;

(iv) State licensing requirements;

(v) Applicable standards developed by other individuals, groups, or organizations with recognized expertise related to a proposed undertaking;

2.5 WAC 246-310-210 defines the "determination of need" in evaluating CN Applications, to wit:

The determination of need for any project shall be based on the following criteria, except these criteria will not justify exceeding the limitation on increases of nursing home beds provided in WAC 246-310-810.

(1) The population served or to be served has need for the project and other services and facilities of the type proposed are not or will not be sufficiently available or accessible to meet that need. The assessment of the conformance of a project with this criterion shall include, but need not be limited to, consideration of the following:

(b) In the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities similar to those proposed;

(2) All residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly are likely to have adequate access to the proposed health service or services. The assessment of the conformance of a project with this criterion shall include, but not be limited to, consideration as to whether the proposed services makes a contribution toward meeting the health-related needs of members of medically underserved groups which have traditionally experienced difficulties in obtaining equal access to health services, particularly those needs identified in the applicable regional health plan, annual implementation plan, and state health plan as deserving of priority. Such consideration shall include an assessment of the following:

(a) The extent to which medically underserved populations currently use the applicant's services in comparison to the percentage of the population in the applicant's service area which is medically underserved, and the extent to which medically underserved populations are expected to use the proposed services if approved;

(b) The past performance of the applicant in meeting obligations, if any, under any applicable federal regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal financial assistance (including the existence of any unresolved civil rights access complaints against the applicant);

(c) The extent to which medicare, medicaid, and medically indigent patients are served by the applicant; and

(d) The extent to which the applicant offers a range of means by which a person will have access to its services (e.g., outpatient services, admission by house staff, admission by personal physician).

(3) The applicant has substantiated any of the following special needs and circumstances the proposed project is to serve.

(a) The special needs and circumstances of entities such as medical and other health professions schools, multidisciplinary clinics and specialty centers providing a substantial portion of their services or resources, or both, to individuals not residing in the health service areas in which the entities are located or in adjacent health service areas.

(b) The special needs and circumstances of biomedical and behavioral research projects designed to meet a national need and for which local conditions offer special advantages.

(c) The special needs and circumstances of osteopathic hospitals and nonallopathic services.

(4) The project will not have an adverse effect on health professional schools and training programs. The assessment of the conformance of a project with this criterion shall include consideration of:

(a) The effect of the means proposed for the delivery of health services on the clinical needs of health professional training programs in the area in which the services are to be provided; and

(b) If proposed health services are to be available in a limited number of facilities, the extent to which the health professions schools serving the area will have access to the services for training purposes

2.6 WAC 246-310-220 sets forth the "determination of financial feasibility" criteria to be considered in reviewing CN Applications, to wit:

The determination of financial feasibility of a project shall be based on the following criteria.

(1) The immediate and long-range capital and operating costs of the project can be met.

(2) The costs of the project, including any construction costs, will probably not result in an unreasonable impact on the costs and charges for health services.

(3) The project can be appropriately financed.

2.7 WAC 246-310-230 sets forth the "criteria for structure and process of care" to be used in evaluating CN Applications, to wit:

> A determination that a project fosters an acceptable or improved quality of health care shall be based on the following criteria.
>
> (1) A sufficient supply of qualified staff for the project, including both health personnel and management personnel, are available or can be recruited.
>
> (2) The proposed service(s) will have an appropriate relationship, including organizational relationship, to ancillary and support services, and ancillary and support services will be sufficient to support any health services included in the proposed project.
>
> (3) There is reasonable assurance that the project will be in conformance with applicable state licensing requirements and, if the applicant is or plans to be certified under the medicaid or medicare program, with the applicable conditions of participation related to those programs.
>
> (4) The proposed project will promote continuity in the provision of health care, not result in an unwarranted fragmentation of services, and have an appropriate relationship to the service area's existing health care system.
>
> (5) There is reasonable assurance that the services to be provided through the proposed project will be provided in a manner that ensures safe and adequate care to the public to be served and in accord with applicable federal and state laws, rules, and regulations. The assessment of the conformance of a project to this criterion shall include but not be limited to consideration as to whether:

2.8 WAC 246-310-240 sets forth the "determination of cost containment" criteria to be used in evaluation a CN Application, to wit:

> A determination that a proposed project will foster cost containment shall be based on the following criteria:

(1) Superior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable.

(2) In the case of a project involving construction:

(a) The costs, scope, and methods of construction and energy conservation are reasonable; and

(b) The project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.

(3) The project will involve appropriate improvements or innovations in the financing and delivery of health services which foster cost containment and which promote quality assurance and cost effectiveness.

2.9 Based on the above Findings of Fact and Conclusions of Law, the Presiding Officer determines that UWMC's application meets the criteria for CN set forth in WAC 246-310-210, WAC 246-310-220, WAC 246-310-230, and WAC 246-310-240. Therefore, the CN is awarded to UWMC.

III. ORDER

A Certificate of Need is APPROVED for the University of Washington Medical Center to add 79 acute care beds to its Seattle facility pursuant to its application and in conformity with requirements set by the Program.

Dated this 12 day of September, 2014

Frank Lockhart

FRANK LOCKHART, Health Law Judge
Presiding Officer

NOTICE TO PARTIES

When signed by the presiding officer, this order shall be considered an initial order. RCW 18.130.095(4); Chapter 109, law of 2013 (Sec. 3); WAC 246-10-608.

Any party may file a written petition for administrative review of this initial order stating the specific grounds upon which exception is taken and the relief requested.

WAC 246-10-701(1). A petition for administrative review must be served upon the opposing party and filed with the adjudicative clerk office within 21 days of service of the initial order. WAC 246-10-701(3).

"Filed" means actual receipt of the document by the Adjudicative Clerk Office. RCW 34.05.010(6). "Served" means the day the document was deposited in the United States mail. RCW 34.05.010(19).The petition for administrative review must be filed within 21 calendar days of service of the initial order with:

Adjudicative Clerk Office
Adjudicative Service Unit
PO Box 47879
Olympia, WA 98504-7879

and a copy must be sent to the opposing party. If the opposing party is represented by counsel, the copy should be sent to the attorney. If sending a copy to the Assistant Attorney General in this case, the mailing address is:

Agriculture and Health Division
Office of the Attorney General
PO Box 40109
Olympia, WA 98504-0109

Effective date: If administrative review is not timely requested as provided above, this initial order becomes a final order and takes effect, under WAC 246-10-701(5), at 5:00 pm on 10/16/2014. Failure to petition for administrative review may result in the inability to obtain judicial review due to failure to exhaust administrative remedies. RCW 34.05.534.

Final orders will be reported to the National Practitioner Databank (45 CFR Part 60) and elsewhere as required by law. Final orders will be placed on the Department of Health's website, and otherwise disseminated as required by the Public Records Act (Chap. 42.56 RCW) and the Uniform Disciplinary Act. RCW 18.130.110. All orders are public documents and may be released.

For more information, visit our website at:
http://www.doh.wa.gov/PublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/Hearings.aspx

APPENDIX "B"

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
OFFICE OF THE SECRETARY

In the Matter of: CERTIFICATE OF NEED APPLICATION OF UNIVERSITY OF WASHINGTON MEDICAL CENTER, Applicant, vs. PROVIDENCE HEALTH & SERVICES – WASHINGTON, D/B/A PROVIDENCE REGIONAL MEDICAL CENTER EVERETT, PROVIDENCE HEALTH & SERVICES – WASHINGTON, D/B/A PROVIDENCE SACRED HEART MEDICAL CENTER, and SWEDISH HEALTH SERVICES, D/B/A SWEDISH MEDICAL CENTER/FIRST HILL, Petitioners.	Master Case Nos. M2013-1393(lead) M2013-1394 M2013-1395 FINDINGS OF FACT, CONCLUSIONS OF LAW, AND FINAL ORDER

APPEARANCES:

Petitioners: Providence Health and Services – Washington,
d/b/a Providence Sacred Heart Medical Center, and
d/b/a Providence Regional Medical Center Everett, by
Dorsey and Whitney, LLP, per
Peter Ehrlichman, Shawn Larsen-Bright, and Amy Sterner, Attorneys at Law, and
Swedish Health Services, d/b/a Swedish Medical Center/First Hill, by
Stephen Pentz, PLLC, per
Stephen Pentz, Attorney at Law

Intervenor: University of Washington Medical Center, by
Freimund Jackson and Tardif, per
Jeff Freimund, Attorney at Law

Department of Health Certificate of Need Program, by

Robert W. Ferguson, Attorney General, per
Richard A. McCartan, Assistant Attorney General

PROCEDURAL HISTORY ON REVIEW

This matter comes before the Review Officer for administrative review of the Findings of Fact, Conclusions of Law, and Initial Order (Initial Order) dated September 12, 2014, of the Presiding Officer, Frank Lockhart, Health Law Judge. The Presiding Officer issued the Initial Order after a contested administrative hearing held June 16-20, 2014, to address the certificate of need (CN) application filed by the University of Washington Medical Center (UWMC) to add 79 acute care beds to its existing hospital in Seattle, Washington.

As noted in the Initial Order, UWMC began planning to expand its existing Seattle facility in 2005. Construction of an eight-story tower began in 2007 and was completed in 2012. The last three stories of the tower were shelled-in for future use. Related to this construction project, in approximately 2010, UWMC successfully requested a CN to convert 18 acute care beds to use as neonatal intensive care unit (NICU) beds. The net result was a reduction of available acute care beds from 378 to 360[1] in October of 2012.

In November of 2012, UWMC applied for the CN currently at issue. On November 5, 2013, after evaluation, the Certificate of Need Program (Program) determined UWMC's application should be granted. CN #1516 was issued to UWMC on November 18, 2013. Providence Health and Services, doing business as Providence Sacred Heart Medical Center and Providence Regional Medical Center Everett (Providence), and Swedish Health Services, doing business as Swedish Medical Center/First Hill (Swedish), collectively

[1] In addition, there were five acute care beds not set-up, for a total of 365. AR 10.

identified as "Petitioners" herein, were granted "affected person" status by the Program.[2] Petitioners requested adjudicative proceedings to contest the award of the CN to UWMC, and UWMC was granted intervenor status.

The Initial Order approved the CN for UWMC to add 79 acute care beds and was served on the parties on September 15, 2014. Petitioners filed a Petition for Administrative Review on October 6, 2014. UWMC and the Program each filed a Response on October 27, 2014.

The Review Officer reviewed the entire record including, but not limited to, the Petition and both responses, application record, supplemental application record, hearing transcript, written closing arguments and rebuttals of all parties, and Petitioners' Offer of Proof Regarding Petitioners' Evidence Concerning 2012 CHARS Data.

PETITION FOR REVIEW

Petitioners request that the Review Officer "reject the Initial Order in its entirety" and enter a final order denying UWMC's application and "revoking the erroneously granted" CN. In the alternative, Petitioners request a stay of the CN, if affirmed, to "allow the completion of all administrative and judicial review in this case." Finally, Petitioners request oral argument prior to the issuance of a final order pursuant to RCW 34.05.464(6). Pet. at 3

Petitioners cite seven specific grounds upon which exception is taken:

1) The Initial Order's determination that UWMC satisfied the need criterion.

2) The Initial Order's determination that UWMC satisfied the financial feasibility

[2] As noted in the Initial Order, the record does not state the basis for the Program's grant of "affected persons" status to Petitioners. The Review Officer adopts the presumption that Petitioners have standing to challenge the award of the CN to UWMC for purposes of this administrative proceeding. The Review Officer takes no position as to whether they have appellate standing beyond this review.

criterion.

3) The Initial Order's determination that UWMC satisfied the structure and process of care criterion.

4) The Initial Order's determination that UWMC satisfied the cost containment criterion.

5) The Initial Order's determination that UWMC satisfied all applicable review criteria and that UWMC is awarded the CN it requested.

6) The Presiding Officer's determination that Petitioners would not be allowed to present evidence concerning 2012 CHARS data.

7) The "myriad specific statements set forth in the Initial Order as being contrary to law, Department policy or practice, and/or the record in this case."

At the heart of Petitioners' argument is the contention that it is inappropriate to use any criteria to determine bed need other than the numeric need methodology generally used by the Program. In addition, Petitioners believe UWMC's failure to list 34 million dollars used to build the shell of the last three floors renders the application and subsequent analysis deficient.

UWMC's RESPONSE

UWMC refutes each of Petitioners' grounds for exception and argues that a preponderance of the evidence supports the decision of the Program to grant the CN and the Presiding Officer's approval in the Initial Order. Therefore, it requests that the CN be approved and the request for a stay be denied.

THE PROGRAM'S RESPONSE

The Program's response supports the decision of the Program to grant the CN and the Presiding Officer's approval in the Initial Order. The Program also requests that the stay be denied.

REVIEW OFFICER'S ANALYSIS

Petition for Review

1. Determination of need.

Petitioners cite 7 grounds upon which exception is taken. The first and primary objection is to the Initial Order's determination that UWMC satisfied the need criterion.

Petitioners present the somewhat puzzling argument that the Program cannot use the Criterion 2 methodology to establish need because it is "stray language" contained in the "defunct, legally nonexistent" 1987 State Health Plan that was sunset in 1990. Pet. at 13. Instead, the Program must continue to use the numeric need methodology established in the very same document which, when applied, shows no need for additional acute care beds. Pet. at 14.

The State Health Plan (SHP) was developed in 1987 by the State Health Coordinating Council under the provisions of the State Health Planning and Development Act (chapter 70.38 RCW). The SHP has two parts. Volume 1 reviews the health status of state residents at the time and presents health principles, goals, objectives and strategies. Volume 2 presents health service performance standards, including methods for forecasting the need for beds at various types of health care facilities that were designed specifically to meet requirements for state review of proposed projects.

The Hospital Bed Need Forecasting Method in Volume 2 of the SHP contains thirteen "Criteria and Standards" in subsection (c) as well as a detailed numeric need methodology in subsection (d). Criterion 2 acknowledges that hospital bed need forecasts are only one aspect of planning, and it may be appropriate to allow a facility to expand even if the total bed supply is adequate if certain conditions exist that show the benefits of expansion outweigh the potential costs of possible bed surplus.

The 1987 SHP was sunset in 1990. However, it has continued to be used as an evaluative tool by the Program, applicants, and interested parties. As noted by the Presiding Officer in the Initial Order, the Program states in each of its hospital bed evaluations that the department has concluded that this methodology remains a reliable tool for predicting baseline need for acute care beds in most circumstances. AR 1227. Normally, the application of the SHP is an uncontested matter.

Criteria for the review of CN applications shall include consideration of "the need that the population served or to be served by such services has for such services." RCW 70.38.115(2)(a). Thus, the focus is the on the needs of the population to be served. In most cases, the population being served consists of local residents of the planning area in which the proposed services will be offered, whether that planning area spans multiple counties or portions of a single county. Therefore, it is generally appropriate to use the numeric need methodology found in the SHP because it focuses on the needs of planning area residents.

But use of the numeric need methodology for acute care beds in the SHP is not mandated in law or rule. In addition to the needs of the population to be served, RCW 70.38.115 directs consideration of additional factors that may impact need such as the

accessibility of the proposed services to all residents of the area served; the need for and the availability in the community of services and facilities for physicians and their patients; the impact on existing and proposed institutional training programs for physicians, students, interns and residents; and the level of charity care provided.

The CN rules state that the population served or to be served must have need for the project and other services and facilities of the type proposed are not or will not be sufficiently available or accessible to meet that need. WAC 236-310-210(1). As with the statute, the focus is on the people who will use the services and no specific methodology to determine need is identified. To aid in determining need, the Program may consider standards set by national and Washington state professional associations, as well as standards developed by other individuals, groups, or organizations with recognized expertise related to the proposed undertaking. WAC 246-310-200.

The 1987 SHP contains standards developed by a group with recognized expertise in health planning. The fact that it was sunset in 1990 does not render those standards void. To the contrary, those standards continue to be used by the Program, applicants, and interested parties to this day. The consideration of Criterion 2 to determine need is not invalid merely because it is contained within the 1987 SHP.

Petitioners rely heavily on the fact that Criterion 2 "has never once been applied, in the 35-year history of the CON statutory framework." Pet. at 13. Assuming, but not finding, this is true does not render its use improper as long as that use was not arbitrary or capricious. An "arbitrary and capricious" act means "willful and unreasoning action in disregard of facts and circumstances." *Washington Waste Sys., Inc. v. Clark County*, 115

Wash.2d 74, 81, 794 P.2d 508 (1990). "Though the agency's discretion is unfettered at the outset, if it announces and follows ... a general policy by which its exercise of discretion will be governed, an irrational departure from that policy ...[as opposed to an avowed alteration of it] could constitute action that must be overturned as 'arbitrary, capricious, [or] an abuse of discretion.' " *Torres–Valdivias v. Holder*, 766 F.3d 1106, 1114 (2014) citing *INS v. Yueh–Shaio Yang*, 519 U.S. 26, 32, 117 S.Ct. 350, 136 L.Ed.2d 288 (1996). Where there is room for two opinions, an administrative action is not arbitrary or capricious if the agency rendered its decision honestly and with due consideration, even if a reviewing court believes that the agency reached an erroneous conclusion. *Freeman v. State*, 178 Wash.2d 387, 403, 309 P.3d 437 (2013); *Porter v. Seattle Sch. Dist. No. 1*, 160 Wash.App. 872, 880, 248 P.3d 1111 (2011).

Here, the decision of the Presiding Officer was rendered with due consideration to the extensive arguments of all parties. Importantly, there was no surprise to the parties. UWMC referenced its reliance on Criterion 2 in its CN application dated November 2, 2012. AR 28. Criterion 2 was also referenced in UWMC's answers to the Program's second screening questions dated March 28, 2013. AR 242. This placed all parties on notice that need might be evaluated using factors other than use of the numeric need methodology and allowed the issues to be fully and fairly debated. Petitioners' written public comments dated May 15, 2013, acknowledged this by stating "While the Department has some latitude in evaluating other indicators of "need" in unique applications, we do not believe that UWMC's application warrants special consideration, since it is not unique." AR 417, AR 504.

The record is replete with arguments from both sides regarding why UWMC's application does or does not merit special consideration. The Review Officer is persuaded that it does for the same reasons detailed in Finding of Fact 1.8 in the Initial Order. Two facts are particularly compelling. First, UWMC has the distinction of being attached to the only allopathic medical school is the state. Second, 89% of UWMC's patient days are comprised of patients who come from outside the North King County planning area (TR47), and it is forced to turn away patients on a regular basis due to capacity constraints[3]. It is not logical to apply a methodology that only measures the need within the planning area when 89% of the care is provided to patients from outside that planning area.

A finding that UWMC meets the need criteria because it primarily serves a population beyond its planning area should not be confused with a finding of institutional need. Throughout the record, Petitioners refer to the decision in *In re: Certificate of Need on Providence Sacred Heart Medical Center Proposal to add 152 Acute Care Beds to Spokane County* (2011) (Sacred Heart). In that case, surplus beds capacity in the service area precluded a grant of the requested CN despite the hospital's individual internal need.

Sacred Heart was clearly decided based on the numeric bed methodology, not Criterion 2. In the current case, the population served is the state of Washington[4]. There is no showing of a surplus of beds providing the types of complex care UWMC provides to citizens of the state of Washington. To the contrary, UWMC receives a large number of

[3] This is noted frequently in the record and generally uncontested, although the exact number of patients turned away is debated by the parties.
[4] And beyond. Ten percent of UWMC's patient days come from outside of Washington. AR 35.

transfer patients from other hospitals (including Petitioners' facilities) that do not have adequate staffing or resources to provide complex care. AR 1092-93.

2. Inclusion of the 34 million construction costs.

Petitioners also contend that UWMC failed to include the 34 million dollar construction cost for the three shelled out floors. This cost was paid in full prior to the CN application. As such, it was an existing asset of UWMC regardless of whether the CN was granted or not. The Presiding Officer correctly determined inclusion of the shell costs in the budget would not have made a difference in the operating costs of the project. Finding of Fact 1.21.

3. Use of 2012 CHARS data.

Throughout the record, Petitioners repeatedly and strenuously objected to the Program's use of 2011 CHARS data and introduction of incomplete or annualized 2012 data. Petitioners sought to introduce the actual 2012 CHARS data that was released on July 9, 2013. TR 844-45. On the final day of hearing, the Presiding Officer ruled that he would not consider 2012 CHARS data but would consider annualized 2012 data. TR 1025-26.

It is within the sound discretion of the health law judge to admit, or not admit, evidence that came into the existence after the close of the public comment period. *Univ. of Wash. Med. Ctr. v. Dept. of Health*, 164 Wash.2d 95,104, 187 P.3d 243 (2008). In this case, the public comment period ended on May 15, 2013. AR 337-38. The parties were given until July 11, 2013, to rebut the public comments. AR 1288-89. The 2012 CHARS data was released after the close of public comment but two days before the close of the rebuttal period and almost four months prior to completion of the Program's evaluation.

On August 11, 2014, Petitioners filed an Offer of Proof Regarding Petitioners' Evidence Concerning 2012 CHARS Data that lists 16 points its expert would make if allowed to use the information. The Review Officer carefully analyzed the Offer of Proof and found it did not impact the ultimate decision in this case. Several points relate to application of the numeric need methodology which is inapplicable here because Criterion 2 was used to determine need. Other points purport to show that UWMC's anticipated growth, using 2012 annualized data, did not materialize at projected rates and that its cases are not unique based on diagnostic-related group (DRG) codes and case mix index.

While reasonable minds can and will differ, the Presiding Officer's decision to exclude the 2012 CHARS data was supported by law and the facts of the case. In addition, while it was undeniably more correct than the projections, the data was not so different that its use would have required (or even strongly suggested) a different outcome under a Criterion 2 analysis.

Request for Stay

If the grant of the CN is upheld, Petitioners request a stay pending resolution of the administrative review and all subsequent judicial and appellant actions because it would be "irresponsible and inappropriate" for UWMC, as a state agency, to expend the funds to implement the CN when there is a "substantial likelihood" it will be revoked. Pet. at 46-47.

Whether a stay pending appeal should be granted depends on (1) whether the issue presented by the appeal is debatable, and (2) whether a stay is necessary to preserve for the movant the fruits of a successful appeal. *Purser v. Rahm*, 104 Wn.2d 159, 177, 702 P.2d 1196 (1985). (emphasis added)

Petitioners have failed to argue that a stay is necessary to preserve for itself the fruits of a successful appeal. A successful appeal for Petitioners would result in maintaining the status quo of beds within the North King County Planning area. Unlike situations where the benefit of a successful appeal would be lost prior to the conclusion of a case, Petitioners will lose nothing in the absence of a stay. To the contrary, it is UWMC that bears the risk of implementing the CN prior to exhaustion of any appellate review.

Request for Oral Argument

Petitioners requested oral argument. RCW 34.05.464(6) states "The reviewing officer shall afford each party an opportunity to present written argument and may afford each party an opportunity to present oral argument." The opportunity for oral argument on a petition for review is clearly discretionary.

The Review Officer has read the entire record for this case which included nearly 1300 pages of application record, more than 200 pages of supplemental record, more than 1200 pages of transcript, and three four-inch binders containing the clerk's files. The parties have each provided detailed and compelling written argument. Oral argument would not assist the Review Officer with her decision making and would likely cause further delay and expense to the parties.

I. FINDINGS OF FACT

1.1 The Findings of Fact in the Initial Order dated September 12, 2014, are adopted herein.

//

//

II. CONCLUSIONS OF LAW

2.1 The Department of Health is authorized and directed to implement the CN Program. RCW 70.38.105.

2.2 The Secretary is authorized to designate a Review Officer to review initial orders and to enter final orders. RCW 43.70.740.

2.3 Petitioners' Petition for Administrative Review and the responses of UWMC and the Program were timely filed. WAC 246-10-701.

2.4 The Conclusions of Law in the Initial Order dated September 12, 2014 are adopted herein.

III. FINAL ORDER

Based on the foregoing, IT IS HEREBY ORDERED:

3.1 The Initial Order dated September 12, 2014, is AFFIRMED.

3.2 The motion for a stay is DENIED.

3.3 The motion for oral argument is DENIED.

Dated this 26th day of January, 2015

JOHN WIESMAN, DrPH, MPH
SECRETARY OF HEALTH

Kristi Weeks

By KRISTI WEEKS
REVIEW OFFICER

//

//

NOTICE TO PARTIES

Any Party may file a petition for reconsideration. RCW 34.05.461(3); RCW 34.05.470. The petition must be filed within ten (10) days of service of this Order with:

Adjudicative Clerk Office
Adjudicative Service Unit
PO Box 47879
Olympia, WA 98504-7879

A copy must be sent to the other parties. If sending a copy to the Assistant Attorney General in this case, the mailing address is:

Agriculture and Health Division
Office of the Attorney General
P.O. Box 40109
Olympia, WA 98504-0109

The petition must state the specific grounds upon which reconsideration is requested and the relief requested. WAC 246-10-704. The petition for reconsideration is considered denied twenty (20) days after the petition is filed if the Adjudicative Clerk Office has not responded to the petition or served written notice of the date by which action will be taken on the petition.

A petition for judicial review must be filed and served within thirty (30) days after service of this Order. RCW 34.05.542. The procedures are identified in chapter 34.05 RCW, Part V, Judicial Review and Civil Enforcement. A petition for reconsideration is not required before seeking judicial review. If a petition for reconsideration is filed, the thirty (30) day period for requesting judicial review does not start until the petition is resolved. RCW 34.05.470(3).

The Order remains in effect even if a petition for reconsideration or petition for judicial review is filed. "Filing" means actual receipt of the document by the Adjudicative Clerk Office. RCW 34.05.010(6). This Order was "served" upon you on the day it was deposited in the United States mail. RCW 34.05.010(19).

Final orders are public documents, and may be placed on the Department of Health's website and otherwise released as required by the Public Records Act, chapter 42.56 RCW.

CERTIFICATE OF SERVICE

I hereby certify that on this date I caused to be served a copy of the foregoing on the following by the method indicated:

Richard A. McCartan Attorney General of Washington 7141 Cleanwater Drive SW P.O. Box 40109 Olympia, WA 98504	☐ Via Messenger ☐ Via ECF Notification ☐ Via Facsimile ☒ Via U.S. Mail ☒ Via Electronic Mail
Jeffrey Freimund Freimund Jackson & Tardif, PLLC 711 Capitol Way S., Suite 602 Olympia, WA 98501	☐ Via Messenger ☐ Via ECF Notification ☐ Via Facsimile ☒ Via U.S. Mail ☒ Via Electronic Mail

Dated this 28th day of September, 2015.

Jackie Slavik

Jackie Slavik