No. 73454-7-I

COURT OF APPEALS
OF THE STATE OF WASHINGTON
DIVISION I

PROVIDENCE HEALTH & SERVICES – WASHINGTON, D/B/A PROVIDENCE REGIONAL MEDICAL CENTER EVERETT, and 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.

BRIEF OF INTERVENOR UNIVERSITY OF WASHINGTON MEDICAL CENTER

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I. INTRODUCTION

The University of Washington Medical Center ("UWMC") applied for and received a Certificate of Need ("CN") to add 79 acute care beds to the hospital. *See* RCW 70.38.105(4)(e) (hospital bed expansion projects are subject to CN review). Three petitioners, all of whom are affiliated with Providence Health & Services (collectively "Providence") requested an adjudicative proceeding to challenge the Department of Health's Certificate of Need Program's ("the Program's") decision granting UWMC's CN.

After independently reviewing the pre-hearing administrative record (AR 3509-5105), hearing exhibits (AR 5106-725), and conducting a five-day hearing (RP 1-1264), the Presiding Officer affirmed the issuance of UWMC's CN. AR 3119-55. Providence appealed the Presiding Officer's decision to a Reviewing Officer, who conducted another de novo review of the record (*see* WAC 246-10-702). The Reviewing Officer adopted the Presiding Officer's findings of fact and conclusions of law, rejected Providence's request for a stay of implementation of the CN, and affirmed. AR 3493-505. Providence sought judicial review of the Reviewing Officer's final decision. Upon the parties' stipulation, the superior court certified the case for direct review by the Court of Appeals pursuant to RCW 34.05.518, and this Court granted review. CP 174-76.

The agency action subject to appellate review is the Reviewing Officer's final decision granting a CN to UWMC. *See DaVita, Inc. v. Dept. of Health,* 137 Wn. App. 174, 181, 151 P.3d 1095 (2007); AR 3127 n. 3; AR 3141 n. 44.[1] Applicable law and substantial evidence support the Reviewing Officer's decision allowing UWMC to add 79 acute care beds to its hospital. The Reviewing Officer's decision should be affirmed.

II. ASSIGNMENTS OF ERROR

Providence assigns error to nearly every finding of fact and conclusion of law made below. UWMC assigns no error to the Reviewing Officer's findings of fact and conclusions of law.

III. COUNTER-STATEMENT OF THE ISSUES PERTAINING TO PROVIDENCE'S ASSIGNMENTS OF ERROR

Providence raises five issues on appeal:

A. When evaluating CN applications, RCW 70.38.115(2)(a) requires consideration be given to the "need that the population served or to be served by such services has for such services." Beyond this general guidance, no statute or regulation provides any method for determining need for hospital beds. The 1987 State Health Plan ("SHP"), which was sunset in 1990, contains detailed standards and methods for determining

[1] Providence criticizes the Program's and Presiding Officer's decision-making processes (*e.g.,* Appellants' Opening Br. ["AB"], pp. 1-3, 11-17), but those criticisms are largely irrelevant to this appeal of the Reviewing Officer's decision, except to the extent the Presiding Officer's findings and conclusions were adopted by the Reviewing Officer.

need for hospital beds. The SHP has continued to be used by the Program and hospitals statewide. The SHP provides two ways to determine need for hospital beds: (1) through use of a numeric need methodology that focuses on the needs of the population in the local planning area where the hospital is; or (2) in cases where a planning area has community hospitals and a tertiary care hospital that draws most of its patients from outside of the planning area, through use of the so-called "Criterion 2" methodology that focuses on the needs of the population region-wide who use the tertiary care hospital, rather than the population in the planning area who rarely use the hospital.[2] There is no dispute UWMC is a tertiary care hospital and 89% of its patient days are provided to patients who reside outside of the planning area. Providence claims the SHP's numeric need methodology, which is focused on planning area residents, is the only method that may be used to determine need for UWMC's bed expansion project. Did the Reviewing Officer act contrary to law by applying the SHP's Criterion 2 methodology to determine whether the region-wide population to be served has need for additional beds at UWMC?

B. Is there substantial evidence in the record supporting the Reviewing Officer's findings and conclusions that the region-wide population to be served has need for UWMC's bed expansion project?

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[2] Tertiary care "means a specialized service meeting complicated medical needs ...." WAC 246-310-010(58). *See also* AR 3131 n. 8 (definition used by Presiding Officer).

C. Is there substantial evidence in the record supporting the Reviewing Officer's findings and conclusions that UWMC's bed expansion project is financially feasible and does not unreasonably impact the costs and charges for health services?

D. Is there substantial evidence in the record supporting the Reviewing Officer's findings and conclusions that UWMC's project is a superior alternative to meet the needs of the population to be served, and would not result in unwarranted fragmentation of health services?

E. Did the Reviewing Officer abuse her discretion by agreeing with the Presiding Officer's evidentiary ruling excluding evidence that did not exist until after the close of the public comment period?

IV. STATEMENT OF THE CASE

Contrary to RAP 10.3(a)(5), Providence's "Statement of the Case" is argumentative and incorrectly relies almost entirely on evidence Providence presented, while ignoring substantial evidence presented by UWMC. On judicial review of an administrative decision, the evidence is reviewed in the light most favorable to "the party who prevailed in the highest forum that exercised fact finding authority," which is UWMC in this case. *Univ. of Wash. Med. Ctr. v. Dept. of Health,* 164 Wn. 2d 95, 104-05, 187 P.3d 243 (2008). Because Providence claims substantial

evidence is lacking to support the Reviewing Officer's findings and conclusions, the relevant facts are discussed in the "Argument" section.

V. ARGUMENT

A. Standards of Review

"The standard of review in CN cases is that the agency decision is presumed correct and that the challengers have the burden of overcoming that presumption." *Overlake Hosp. Ass'n v. Dept. of Health,* 170 Wn.2d 43, 49-50, 239 P.3d 1095 (2010). Challengers must show the agency decision was contrary to law, arbitrary and capricious, or unsupported by substantial evidence. *Id.*; RCW 34.05.570(3).

"The error of law standard permits this court to substitute its interpretation of the law for that of the agency, but we accord substantial deference to the agency's interpretation, particularly in regard to the law involving the agency's special knowledge and expertise." *Univ. of Wash.*, 164 Wn.2d at 102.

The arbitrary and capricious standard of review "is very narrow," "highly deferential" to the agency and the party challenging an agency decision carries "a heavy burden." *Alpha Kappa Lambda Fraternity v. Washington St. Univ.,* 152 Wn. App. 401, 418, 422, 216 P.3d 451 (2009). "An agency's decision is arbitrary and capricious if the decision is the result of willful and unreasoning disregard of the facts and

circumstances." *Overlake,* 170 Wn.2d at 50. "Where there is room for two opinions, an action taken after due consideration is not arbitrary and capricious even though a reviewing court may believe it to be erroneous." *Washington Indep. Telephone Ass'n v. Washington Utils. and Transp. Comm'n,* 148 Wn.2d 887, 904, 64 P.3d 606 (2003).

Findings of fact are reviewed under the substantial evidence standard of review. *Fox v. Dept. of Retirement Systems,* 154 Wn. App. 517, 523, 225 P.3d 1018, *rev. denied,* 169 Wn.2d 1012 (2010). "Evidence is substantial if it is of sufficient quantity to persuade a fair-minded person of the truth or correctness of the agency order." *Id.* On appeal, "[i]t is not ... [the Court's] function to reweigh the evidence in an effort to reach different conclusions than did the agency." *Providence Hosp. v. Dept. of Soc. and Health Servs.,* 112 Wn.2d 353, 360, 770 P.2d 1040 (1989).

Evidentiary rulings are reviewed under an abuse of discretion standard. *Univ. of Wash.*, 164 Wn.2d at 104. An abuse of discretion occurs when the challenged "decision is manifestly unreasonable or based on untenable grounds or reasons." *Yousoufian v. Ron Sims,* 168 Wn.2d 444, 458-59, 229 P.3d 735 (2010). A decision is "manifestly unreasonable" when a tribunal "adopts a view 'that no reasonable person would take.'" *Id.* "The law gives considerable discretion to administrative law judges to determine the scope of admissible evidence." *Univ. of*

Wash., 164 Wn.2d at 104. In CN cases, administrative law judges have broad discretion "to admit, or not admit, evidence that came into existence after the close of the public comment period." *Id.*

B. Use of the SHP Criterion 2 Methodology for Determining Need Is Lawful

In deciding whether to grant a CN application, four criteria are considered: (1) need; (2) financial feasibility; (3) structure and process of care; and (4) cost containment. RCW 70.38.115(2); WAC 246-310-210 through -240. However, these criteria "may vary according to the purpose for which the particular review is being conducted or the type of health service reviewed." RCW 70.38.115(5). The overriding purpose of the CN laws is the "promotion and maintenance of access to health care services for all citizens." *Overlake,* 170 Wn.2d at 55.

Providence's primary argument is the Reviewing Officer acted unlawfully by applying the SHP's Criterion 2 methodology when determining need. Providence claims the SHP's numeric need methodology should be applied, but inconsistently argues it is unlawful to apply the SHP's Criterion 2 alternative for determining need because the SHP is "defunct" and "legally ineffectual." *E.g.,* Appellant's Opening Br. ("BA"), pp. 2, 16, 19, 21, 24-26. This argument lacks merit.

RCW 70.38.115(2)(a) and WAC 246-310-210(1) state the CN need

determination is focused on "the population served or to be served" by the project, with no geographic limitations to a specific planning area. WAC 246-310-210(3)(a) similarly requires consideration of the "special needs and circumstances" of medical schools that provide "a substantial portion of their services ... to individuals not residing in the health service areas in which the entities are located ...." Aside from this guidance, neither chapter 70.38 RCW, nor chapter 246-310 WAC establish a method for determining need for hospital beds.[3]

WAC 246-310-200(2)(a)(ii) provides that if there are no detailed standards set forth in chapter 246-310 WAC for determining need for a particular type of health service, "the department may consider standards not in conflict with ... [WAC 246-310-210 through -240] in accordance with subsection (2)(b) of this section." Subsection (2)(b) then lists six potential sources the department may consider when making CN determinations. Among those sources are "[s]tandards developed by professional organizations in Washington state" and "[a]pplicable standards developed by other individuals, groups, or organizations with recognized expertise related to a proposed undertaking ...." WAC 246-

[3] The WAC regulations contain detailed standards and methodologies for determining need for a variety of health services, such as open heart surgery (WAC 246-310-261), ambulatory surgery (WAC 246-310-270), dialysis (WAC 246-310-284), and hospice services (WAC 246-310-290). However, that is not the case for hospital bed expansion projects, or other health services such as kidney transplantation (*see* WAC 246-310-260), or home health agencies (*see* WAC 246-310-020(1)(a)(ii)).

310-200(2)(b)(ii) and (v).

The SHP was formally adopted by the State Health Coordinating Council and approved by the Governor. AR 5253-56. It provides detailed statewide standards developed by a professional organization with recognized expertise related to health care planning. *See* AR 5253-373. The SHP provides standards and formulas for forecasting hospital bed need (AR 5320-61), including the numeric need methodology that focuses on a local planning area (AR 5339-41), which Providence argues should have been applied in this case.[4]

Consistent with the focus in RCW 70.38.115(2)(a) and WAC 246-310-210(1) on "the population served or to be served" by the project, the SHP also has an alternative method for determining need in Criterion 2, which provides in pertinent part:

> Hospital services and beds should be planned according to the needs of specific groups of people. ... It is not appropriate to assume that the people within the areas use or should use the hospitals within the area, nor should they assume that hospitals in the area serve only the people in the area. ... Hospital planning should be based on sound evidence about the actual patterns of use by the public. ... 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

[4] The SHP's numeric methodology artificially distributes the in-migration of patients equally among planning area hospitals, but that is not the reality in a planning area comprised of a regional tertiary hospital amid local community hospitals. *See, e.g.,* AR 3533, 4603; RP 644-53, 905-06, 908-09, 1205-07.

> 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 a planning area is adequate, it may be appropriate to allow an individual institution to expand. ... 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 a 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.

AR 4217-18 (emphasis added); *see also* AR 5325-26 (same).

The SHP states "[s]eparate planning area hospital bed need forecasts should be made in each planning area which contains both hospitals providing basic community-oriented services and hospitals providing region-wide tertiary care services."[5] AR 5331-32. The explanation for this SHP standard is that regional tertiary hospitals "serve

[5] The SHP also acknowledges hospital staff and acute care beds are not fungible: "All decisions should recognize that beds, even those within a particular facility, and medical staffs may not be inter-changeable ...." AR 5334.

a relatively widespread clientele with a large proportion of their patients being drawn from outside of the planning area." AR 5332; *see also* WAC 246-310-210(3)(a) (in accord for a medical school's teaching hospital).

The North King County planning area squarely fits the SHP's description of the type of planning area where a bed need forecast for a regional tertiary facility like UWMC should be made independently from community hospitals in the planning area. There is no dispute UWMC is a regional tertiary hospital and that 89% of UWMC's patient days are provided to people who live outside the North King planning area. *E.g.*, AR 3515, 3533; RP 46-47, 1166-67. UWMC is the only non-trauma, non-pediatric hospital in the state that consistently treats adult patients from all 39 counties in Washington State. AR 4605. All of those people comprise "the population served or to be served" by UWMC's bed addition project, not just the small portion from within the planning area that Providence focuses on contrary to RCW 70.38.115(2)(a) and WAC 246-310-210(1).[6]

WAC 246-310-210(3)(a) also applies, requiring consideration of the "special needs and circumstances" of medical schools that provide "a substantial portion of their services ... to individuals not residing in the

[6] The fact that none of the Providence petitioners is located in the North King planning area is an acknowledgement that focusing solely on the North King planning area is an inappropriately narrow way to analyze UWMC's project. Providence's hospitals oppose UWMC's project because they are non-planning area competitors who want to curtail the volume of statewide tertiary care patients seeking treatment at UWMC.

health service areas in which the entities are located ...." The UW School of Medicine is the Washington, Wyoming, Alaska, Montana, and Idaho ("WWAMI") region's only allopathic medical school. AR 3131-32, 3138, 3142, 3515; RP 42-46. UWMC is the campus-based teaching hospital for the UW School of Medicine. *Id.*[7]

The North King planning area includes two other adult acute care hospitals: Swedish Ballard and Northwest Hospitals. These are community hospitals that do not provide region-wide tertiary care (although Northwest provides some limited tertiary care locally). *See, e.g.,* AR 3536-38, 4133-41, 4603-06; RP 42-47, 185-89, 197-203, 258-62, 556-59, 580-83, 904-17, 1166-73, 1178-79, 1225. These two neighboring hospitals are not available and accessible, with the necessary facilities, equipment, specialized staff and infrastructure, to meet the needs of the majority of patients cared for at

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[7] Contrary to Providence's claim that UWMC's status as the primary clinical site for the WWAMI region's only allopathic medical school is legally irrelevant (AB, p. 27 n. 20), RCW 70.38.115(2)(d) requires that when determining need, "[t]he department shall consider the application in terms of its impact on existing and proposed institutional training programs for doctors of ... surgery and medicine at the student, internship, and residency levels." *See also* WAC 246-310-210(1)(c) (in accord). UWMC operates the fifth largest training program in the nation for physicians, dentists and other health professionals. RP 43. Annually, the UW School of Medicine has about 1,300 full-time residents and fellows, plus hundreds of medical students and interns. AR 3549, 4606. The Accreditation Council for Graduate Medical Education sets minimum volume standards for medical specialties and requires that training occur at a "primary clinical site" meeting standards for faculty, support services and other infrastructure. AR 4606, 4664-91; RP 81-83, 165-66, 176. The primary clinical site for the UW School of Medicine is UWMC. *See id.* Increasing the number of acute care beds at UWMC increases the number of patients UWMC is able to serve, which increases the training opportunities available for medical school students at the student, internship and residency levels. AR 3142, 4609; RP 175-76.

UWMC, particularly patients requiring the specialized tertiary care provided at UWMC. *E.g.,* AR 3744-47, 4007-14 (Providence's bar charts showing Northwest Hospital provides little tertiary care as compared to other hospitals statewide), 4123 (Northwest Hospital's Executive Director's letter stating "we are not staffed, equipped or programmatically designed to provide care to the growing tertiary/quaternary patient populations served by UWMC"), 4238 (Providence admits Swedish Ballard is a community hospital with no tertiary services); RP 63-69, 79-83, 165-66, 204-06, 258-62, 323-25, 412-14, 535-69, 571-83, 617-20, 644-49, 1173, 1184-85, 1205-07, 1223-25, 1246-47. For example, over 60% of Northwest Hospital's 36,470 total patient days in 2011 were from residents of the North King planning area, while only 11% of UWMC's 95,031 total patient days in 2011 were from North King residents. AR 4603.

Providence previously agreed Criterion 2 of the SHP may be considered to determine need, even if numeric need is absent under the SHP's alternative methodology. AR 4434; *see also* AR 3917 (acknowledging "the Department has some latitude in evaluating other indicators of 'need' in unique applications"). Persuasive precedent is in accord. *See, e.g., Irvington Gen. Hosp. v. Dept. of Health*, 374 A.2d 49, 52-53 (N.J. 1977) (holding that it is improper to rely solely on a numeric need methodology when analyzing a hospital's CN application to add

acute care beds); *Fairfield Nursing Home v. Whalen*, 64 A.D. 2d 802, 407 N.Y.S.2d 923, 924 (1978) (holding that rejection of a CN application based on "a preset, rigid numerical policy (not contained in the statute) which foredoomed the application ... precluded a fair review and resulted in an arbitrary determination").

However, Providence now argues the Criterion 2 alternative for finding need should not be applied because this alternative has not been previously applied. AB, pp. 1-4, 6-7, 9-10, 13, 16-19, 21-28, 49-50. This claim is untrue. *E.g.,* AR 4136-37; RP 502-03, 513; *see also* RP 830-31 (the Program previously used a statewide planning area for specialty hospitals, such as a children's pediatric hospital, that serve patients from throughout the state).[8] Regardless, even if the Criterion 2 alternative has not been invoked previously, that does not prohibit application of this alternative method for determining need in an appropriate case.

When arguing that Criterion 2 of the SHP should not be considered here because it allegedly has not been considered in prior CN cases, Providence relies on a Presiding Officer's ruling in *In re Sacred Heart.* AB, pp. 3, 22-23, 27. Yet, Providence omits reference to the Presiding Officer's acknowledgement in the *Sacred Heart* case that, although the

[8] There have been few opportunities to determine need for hospital beds. No Washington hospital applied for a CN to add acute beds during the approximately 20 year time period between 1982 and 2001. RP 511. UWMC has not applied for additional acute care beds in the uniquely structured North King planning area since 1982. RP 336, 515, 581.

Program and hospital CN applicants have continued to use the SHP's numeric need methodology despite the SHP being "terminated" in 1990, "[t]his does not prohibit an applicant from submitting an alternative approach to show need exists" because there are no binding statutes and regulations establishing a standard methodology for determining need for hospital bed expansion projects. AR 2454-55. The SHP's Criterion 2 provides an alternative approach for showing need exists consistent with the *Sacred Heart* decision.

Providence's reliance on how need was determined in the *Sacred Heart* case also ignores UWMC's evidence and arguments showing the Spokane planning area where Sacred Heart is located had a significantly different composition of hospitals and circumstances than the planning area where UWMC is located. *See* AR 3501, 4151, 4595-96; RP 591-93. Use of the SHP's Criterion 2 methodology was unwarranted in the *Sacred Heart* case (and not requested), but is warranted (and requested) here. *Id.*[9]

Providence cannot have it both ways: either no portion of the SHP can be considered, or all portions may be considered. If no portion of the

[9] Providence also incorrectly contends the Program had to notify Providence before using the SHP's criteria for determining need to evaluate UWMC's application, relying on WAC 246-310-200(2)(c). Yet, WAC 246-310-200(2)(c) provides only that the Program, upon request from an applicant, must identify the standards it will use to evaluate an application. As the applicant, UWMC had no confusion about what standards the CN Program would apply, and from the outset requested application of the SHP's Criterion 2 methodology. *E.g.*, AR 3536-38. Thus, the focus in WAC 246-310-200(2)(c) on an applicant's right to know the standards that will be applied is not a genuine issue in this case.

SHP can be considered, then need for UWMC's project should be determined by applying the general provisions in RCW 70.38.115(2)(a) and WAC 246-310-210(1) that focus on "[t]he need that the population served or to be served by such services has for such services." Since there undeniably is no numeric need methodology in the statutes or regulations specific to hospital bed expansions, Providence's reliance on the SHP's numeric need methodology would be irrelevant and baseless. UWMC's evidence showing the population to be served throughout the WWAMI region needs a bed expansion at UWMC would still be admissible to support approval of UWMC's application under RCW 70.38.115(2)(a) and WAC 246-310-210(1), even if the SHP's Criterion 2 is not applied.

C. Substantial Evidence Shows UWMC's Project Is Needed under the SHP's Criterion 2 Methodology

Before the CN application at issue, UWMC was licensed for 450 beds. AR 3518, 3522; RP 76. Fifty (50) of those beds are dedicated to neonatal intensive care, 16 are dedicated to inpatient psychiatric care, and 19 are dedicated to rehabilitation care, leaving 365 beds set up for acute care. *Id.* UWMC has not added acute beds since 1982, and has fewer acute beds and fewer Intensive Care Unit ("ICU") beds than most tertiary hospitals in the state, including Providence's hospitals. AR 4734; RP 336, 1188-89.

Providence claims there is "no evidence" UWMC's project meets

any of the SHPS's Criterion 2 conditions when compared to neighboring hospitals (*i.e.,* Swedish Ballard and Northwest Hospitals). AB, pp. 27-32. Providence is incorrect. Substantial evidence shows the region-wide population to be served by UWMC has need for the 79 bed expansion project under the SHP's Criterion 2.

In 2013, UWMC's average midnight occupancy rate for its 365 acute care beds regularly exceeded 75%. AR 4128, 4146; RP 67-68. Midnight is the lowest census point of the day. RP 555-56. For a hospital of UWMC's size, an average midnight occupancy of 75% typically justifies adding beds. *See* AR 3137, 3929; RP 911-12, 972-73, 1187-88.

The midnight occupancy rate for UWMC's ICU beds, which often are used by tertiary care patients, is even higher. In 2012, the average midnight occupancy rate for UWMC's ICU beds was around 90%. AR 3535-36, 4088; RP 62-68. In early 2013, UWMC's ICU occupancy rate regularly exceeded 95%. AR 4146; RP 63-64.

UWMC's bed expansion project includes a new ICU with 24 beds. AR 3520. For each patient day spent in the ICU at UWMC, patients average 1.6 additional days in a less costly, general acute care bed as their conditions improve prior to discharge. AR 3535; RP 380-81. The new 24 bed ICU thus requires a corresponding increase of at least 38 additional acute care beds (24 multiplied by 1.6) for patients transitioning out of the new ICU.

That amounts to 62 additional acute care beds (24 plus 38) out of the 79 total acute care beds UWMC sought in its CN application.

UWMC's occupancy rates are a result of (1) the increasing demand for complex tertiary services provided at the hospital as less complex care is pushed out to outpatient facilities and community hospitals, (2) UWMC's reputation for quality and service excellence, and (3) UWMC's open-door policies for uninsured and underinsured patients. AR 3519, 3524, 3537-38, 3540, 3558, 3563, 4145-47, 4592, 4599-600, 4607-08, 4693-711; RP 54-61, 83-86, 517-28, 532-35, 597-606, 798-800.

UWMC's adult acute care patient days have grown by at least 3.7% every year since 2009 and will continue to grow in the future.[10] *See, e.g.*, AR 3523, 3792, 4128, 4130, 4149, 4441, 4593-94; RP 374-77, 597-611, 1205, 1223-24. The population served by UWMC from throughout the WWAMI region will grow by over one million people over the next few years, which will increase demand for UWMC's services. AR 3136-37, 3542-43; RP 47-54, 597-606, 798-800. The age 65 and over population, a large consumer of acute inpatient hospital care (AR 3546), is expected to grow 36% by 2020. *Id.* Population growth in the North King planning area where UWMC is located is projected to grow 12%, and the 65 and older population is expected to grow 63% by 2021. *Id.* The 65 and over

[10] Patient days spent in a hospital are what primarily drive bed need. RP 618, 1177.

population will increasingly need acute care beds at UWMC due to age-related health needs, including complex cardiac care. AR 3547; RP 48-50, 53-54. UWMC's annual growth rate in patient days will result in an occupancy rate on UWMC's acute care beds in excess of 75% in 2018, within 3 years of project completion, after adding 79 acute beds.[11] AR 3319-21 (explaining UWMC's demonstrative exhibit D-4), 3523; RP 597-610.

This projected growth is due in part to the growth in patient volumes UWMC is experiencing due to its increasing market share of patients from throughout the WWAMI region requiring tertiary care. *See, e.g.,* AR 3534-35, 4142-45, 4210; RP 543-51, 1171-73, 1178-79, 1223-24. Statewide, adult hospital patient days for select tertiary care in areas such as complex cardiology, cardiac surgery, high-risk pregnancy, oncology and organ transplantation increased by nearly 20% between 2008 and 2011, and this growth is expected to continue. AR 3543, 4597, 4600-02; RP 53-54, 1223-24. UWMC's patient days in these tertiary services have consistently grown 20 times faster than less complex hospital inpatient services provided statewide during the four year time span of 2008 to 2011. AR 3543, 4600. For example, the hematology market in Washington has grown by about 8% on average every year since 2008, while UWMC's hematology volumes

[11] Even if the annual growth rate in acute patient days is lowered to 2.7%, UWMC's project would still be profitable by 2018 for financial feasibility purposes; and if a 1.9% growth rate is used, the "break even" point would be reached in 2021. RP 377-80.

have grown by 30% on average each year. AR 4600-02. Similarly, although the statewide inpatient oncology market declined by about 2% annually, UWMC's oncology volume grew by 2% annually. *Id.*

Providence concedes that for the majority of these complex services, especially organ transplantation, oncology and complex cardiac surgery, UWMC is either the sole provider in the state, or among the largest providers by volume. AR 3533-34, 3543, 3920-22, 4600-02; RP 1223. UWMC's statewide market share for these complex tertiary services has increased from 47.7% in 2008 to 52.5% in 2011. AR 3534, 4142-45, 4210; RP 543-51, 1171-73, 1178-79, 1223-24.[12] In comparison, the Providence petitioners' statewide market shares for those services in 2011 were as follows: Providence Everett, 1%; Providence Sacred Heart, 10.7%; and Swedish, 3.6%. AR 4210.

This growth in market share is partly due to the fact that other hospitals in the WWAMI region increasingly transfer inpatients requiring the most complex care to UWMC. AR 4078-87, 4140-41; RP 185-86, 188, 559-73. From 2011 through the first four months of 2013, about 33 inpatients per week were transferred from other hospitals to UWMC, which equates to

[12] The evidence showing UWMC's market share of these complex services, specifically Table 6 on AR 3534, does not show all of the other hospitalizations these patients experience before or after an organ transplant or other complex procedure; it only shows the hospitalization for the particular procedure referenced. RP 798-99, 806. So, Table 6 actually under-represents the patient days associated with these patients. *Id.*

almost 5 inpatients per day on average. *Id.* The average length of stay of UWMC's acute care inpatients in 2011 was about 6 days. *See* AR 3792 (dividing the total acute days of 95,031 by the total acute discharges of 16,623, equals 5.7 days). Thus, these hospital transfers to UWMC can be conservatively estimated to account for about 9,400 patient days in 2011. *See* AR 4140 (1,645 transfers multiplied by 5.7 days per transfer). This is a conservative estimate because patients requiring complex care typically have significantly longer lengths of stay than the average of 5.7 days.

UWMC's high occupancy rates have resulted in UWMC having to regularly deny access to patients whose providers seek to transfer them to UWMC from other hospitals due to the patients' complex care needs. AR 4084-85, 4146; RP 186-87. In 2011, about 7% of other hospitals' requests to transfer their inpatients to UWMC were denied because UWMC had no available acute beds, which amounts to about 4 such patients every week who are denied access to UWMC. *Id.* In 2012 and the first four months of 2013 this situation got worse; 8% of transfer requests were denied due to lack of available beds. *Id.*

Providence hospitals are among the hospitals seeking to transfer their patients to UWMC. AR 4078-87, 4140-41; RP 185-86, 188, 559-73. Providence hospitals transfer an average of more than 5 inpatients per week to UWMC (not counting those denied access due to lack of an available

bed), the majority of whom are transferred to UWMC because those patients' needs exceed the resources of Providence's hospitals. *Id.*; AR 4591-92, 4611; RP 200-01, 537. A disproportionate percentage of the patients Providence hospitals transfer to UWMC are either receiving Medicaid or uninsured. AR 4592, 4628-34; RP 203, 533-35. Data from the Comprehensive Hospital Abstract Reporting System ("CHARS") shows that for nearly all of the patients that Providence's Washington hospitals transfer to UWMC because they exceed Providence's resources, there are other patients having the same diagnostic related grouping ("DRG") code who stayed at Providence hospitals. AR 4591-92, 4613-26.

Another measure of UWMC's increasing provision of region-wide complex tertiary care is the hospital's case mix index. A case mix index measures the level of acuity of all patients receiving care at a particular facility.[13] RP 794-95. There is no dispute UWMC has one of the highest case mix indices in the state. AR 3535, 4015, 4230; RP 61, 1169, 1171.

In 2008, UWMC's case mix index was 1.66 and steadily rose each year to 1.99 in 2012. AR 3535. Over 20% of UWMC's acute care patient

[13] Case mix indices are based on DRG codes. RP 794-95. Although Providence claims Northwest Hospital and Swedish Ballard provide most of the same services to patients as UWMC provides based on a comparison of DRG codes (*e.g.*, AB, pp. 9, 27-28, 30), this claim is dispelled by the fact that neither Northwest Hospital nor Swedish Ballard have a case mix index anywhere close to UWMC's, and Providence does not even attempt to make that comparison. *See* AR 4015, 4048. *See also* Providence's charts at AR 4007-14 and 4233-35, which demonstrate that neither Northwest Hospital nor Swedish Ballard Hospital provide the same types or volumes of complex care as provided at UWMC.

days in 2011 were comprised of patients with DRG codes with a weight of 5 or greater, which translates to the most complex types of care. RP 617-18, 1095. This amounted to an average daily census ("ADC") of at least 56.3 patients requiring this complex care occupying UWMC's 365 acute care beds. *Id.* This metric is another indicator of the growing population's increasing reliance on UWMC to meet the growing need for highly specialized, complex hospital care in the WWAMI region. Without more acute care beds, UWMC's ability to meet the growing need for complex services will be curtailed and patient access increasingly compromised.

1. UWMC's Project Would Significantly Improve Accessibility for Underserved Groups

RCW 70.38.115(2)(j) requires that consideration be given to the needs of charity care patients and other underserved groups. *See also* WAC 246-310-210(2) (in accord) and WAC 246-310-210(2)(c) (requiring consideration of the "extent to which Medicare, Medicaid, and medically indigent patients are served by the applicant" when determining need). The SHP's Criterion 2 similarly states that expansion of a regional tertiary hospital may be approved regardless of numeric need in a local planning area upon a showing the project "would significantly improve the accessibility or acceptability of services for underserved groups." AR 5326.

UWMC provides the highest percentage of inpatient care to

Medicaid recipients, as well as patients with little or no ability to pay, of any tertiary adult inpatient provider in all of King County, except for Harborview Medical Center, which is also part of the UW Medicine health system. AR 3537; RP 83-86. In 2011, 48% of UWMC's patients (almost half of UWMC's revenue) received Medicaid or Medicare, which reimburses at a lower rate than commercial insurers. AR 3524, 3537; RP 85-86. Another 7.5% of UWMC's 2011 patients were self-pay, who generally are unable to pay much, if anything. *Id.*; RP 520-21.

UWMC provides charity care in excess of the averages of other adult hospitals in King County, except Harborview, and provided more than $35 million in uncompensated care during the 2008 to 2010 timeframe. AR 3540; RP 86. Many of the patients that other hospitals transfer to UWMC for complex medical services are either uninsured or Medicaid recipients, including patients transferred from Providence's hospitals. *E.g.,* AR 4592, 4628-34; RP 203, 533-35.

Care to these underserved populations would be compromised without adequate bed capacity at UWMC. RP 83-86, 523-28, 533-35. Since over half of UWMC's patients are Medicaid or Medicare recipients, or uninsured, these underserved populations would bear the brunt of UWMC's increasingly higher occupancy rate and the effect occupancy rates have on patient access if UWMC's growth is curtailed by the denial of additional

beds. AR 3537. Therefore, the SHP Criterion 2 condition (as well as RCW 70.38.115(2)(j), and WAC 246-310-210(2)) emphasizing accessibility for underserved groups justifies approval of UWMC's CN.

2. Approval of UWMC's Project Would Allow Expansion of a Hospital that Has Staff with Greater Training and Skill, or which Has a Wider Range of Important Services, or Whose Programs Have Evidence of Better Results than Neighboring and Comparable Hospitals

Another set of the SHP's Criterion 2 "certain conditions" justifying a hospital bed expansion regardless of numeric need in a local planning area is a showing that a regional tertiary hospital's bed expansion "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." AR 5326 (emphasis added). Substantial evidence supports the Reviewing Officer's findings and conclusions that UWMC meets one or more of these "certain conditions":

- UWMC was named the nation's first Magnet Hospital for excellence in nursing care by the American Nurses Credentialing Center, which has continued to honor UWMC with this award every four years since 1994. AR 3558. This award is partly based on patient outcomes and the percentage of nurses at UWMC having advanced degrees. RP 59.
- Medical staff at UWMC provide more than 52% of all of the care

statewide for the most complex types of patient cases, including organ transplantation, cardiac care, and oncology. AR 3533-35, 3538, 3920-22, 4007-09, 4142-45, 4597, 4600-04; RP 64-67, 536. Providence agrees that UWMC cares for the highest percentage of the most complex patient cases of any hospital in Washington. AR 4005-06; RP 1223.

- UWMC's medical staff includes 2,426 active, associate and adjunct members specializing in 38 different fields of medicine. AR 3516, 3556.
- UWMC is the sole provider in Washington for lung transplants and two types of liver transplants. AR 3534. UWMC provides more heart and kidney transplants than any other hospital in Washington. AR 4008. UWMC is also a major statewide provider of complex interventional cardiology, vascular and cardiac surgeries, obstetrics, neonatology, neurosciences, and orthopedics. AR 4010-14.
- In terms of oncology, UWMC provides care to substantially more inpatients than any other hospital in Washington. AR 4009. Seventy-five percent (75%) of UWMC's complex oncology patients live outside of King County, and 30% come to UWMC from other states. AR 4090.
- UWMC and the Seattle Cancer Care Alliance ("SCCA"), located within UWMC, partner to deliver the latest cancer treatments, including stem cell and bone marrow transplantation, gene therapy, specialized antibody therapies, high-dose chemotherapy, minimally invasive surgical techniques,

and other specialized oncology therapies. AR 3517. In 2011, the UWMC/SCCA Bone Marrow Transplant Program performed 532 bone marrow transplants and was ranked first in outcomes by the National Bone Marrow Donor Program. AR 3517, 4090. UWMC has three comprehensive oncology inpatient units. AR 3517. Together, UWMC and SCCA care for 75% of Washington's bone marrow transplant patients. AR 4090.

- UWMC is consistently rated as one of the best hospitals in the nation, and was ranked as the number one hospital in Washington State by *U.S. News & World Report* in 2012 and in 2013. AR 3519, 3538, 3563, 4147, 4607-08, 4693-711; RP 55. Of nearly 5,000 hospitals considered nationwide, only about 150 received rankings in one of 16 specialty areas, while UWMC was among only 14 hospitals nationwide that received rankings in 6 or more medical specialties in 2012. AR 3563.

- In 2010, UWMC was the only hospital in the nation to earn two silver-level awards for outstanding transplantation care from the U.S. Department of Health and Human Services' Health Resources and Services Administration ("HRSA"), and in 2012 UWMC's heart, kidney and liver transplant programs each received bronze awards from HRSA. AR 3538, 3563, 4607, 4698-707; RP 54-61.

- HRSA's Scientific Registry of Transplant Recipients published data in April 2012 showing UWMC has both higher volumes and better liver and

heart transplant outcomes than Providence's hospitals. AR 4607, 4693-98. For example, during the 2009 to 2011 timeframe, UWMC performed 61 heart transplants with a one year survival rate of 95.08%, which is well above the national survival rate of 90.21%. AR 4607. In comparison, Providence Sacred Heart performed 24 heart transplants during the same time period, but had a one year survival rate of 87.5%, which is lower than the national rate. *Id.* With respect to livers, during the 2009 to 2011 timeframe, UWMC performed 171 liver transplants with a one year survival rate of 92%, which is above the national survival rate of 89.5%, while Swedish Medical Center performed only 6 liver transplants, and had a one year survival rate of 83%; below the national rate. *Id.*

- The Blue Cross and Blue Shield Association awarded UWMC a Blue Distinction in 2013 for its positive outcomes in adult lung, liver, and simultaneous pancreas/kidney transplant programs. AR 4607-08, 4709. No other adult program in Washington has received this distinction. AR 4608.
- UWMC has been designated as an Aetna Institute of Quality for Cardiac Medical Intervention, which is based on measurements of clinical performance, outcomes, access and efficiency in every aspect of cardiac care. AR 3563; RP 57-58.
- In 2012, UWMC performed 20 heart transplants, placed 58 left ventricular assist devices and 7 total artificial hearts, and put one patient on

extracorporeal life support. AR 4078. Only 31% of these complex cardiac patients came from King County. AR 4080-83.

- UWMC's Regional Heart Center ("RHC") treats patients with advanced heart failure, complex congenital heart disease, complex arrhythmias, and acute myocardial infarction with cardiogenic shock. AR 4086. About half of the RHC's patients reside outside of King County, and 7 to 8% reside out of state. *Id.*

- The Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") recently awarded UWMC certificates of distinction for its advanced palliative care, and its ventricular assist device program. RP 55.

- UWMC is the regional referral hospital for high-risk obstetrics with the highest case mix index in this service line of any hospital in Washington. AR 4608, 4711. For example, in 2013 over 16% of UWMC's maternal patients had been transferred from other hospitals to receive specialized care by UWMC's highly trained medical staff. *Id.*

- UW is the number one public research institution in the nation, and second overall to Harvard University, driven largely by research conducted by the UW School of Medicine, for which UWMC is the teaching hospital. AR 3549. In 2012, over $600 million in research grants or contract funding was awarded to faculty members of the UW School of Medicine. *Id.* This was an increase of over $25 million from the prior year. *Id.*

- Other hospitals in the WWAMI region routinely transfer inpatients requiring complex care to UWMC at the rate of 33 patients per week, or 4.65 patients per day. AR 4140, 4220, 4590-92, 4611-34; RP 188.
- The primary reason why Providence hospitals transfer an average of 5 patients per week to UWMC is because the patients' needs "exceeds resources" of the Providence hospitals, meaning those hospitals lack the specialized staff and equipment to meet those patients' complex health care needs. AR 4140-41, 4590-92, 4611-34; RP 188, 199-201, 536-37.

Neighboring hospitals in the planning area (as well as statewide) providing acute care to adult patients do not have nearly the same breadth of specialized staff, services and performance outcomes as found at UWMC. The SCCA, which is a separately licensed 20 bed hospital located within UWMC, is limited to oncology. AR 3517. Providence concedes that Swedish's Ballard hospital is a general community hospital that does not provide any complex tertiary care. AR 4135-36, 4238; RP 1225. That leaves only Northwest Hospital. As mentioned above, Northwest Hospital's Executive Director testified that her hospital is a "community-based facility ... that delivers secondary and low-end tertiary care. We do not have the staffing expertise or the equipment that is needed in order to provide the very high-end tertiary and quaternary care that is provided at UW Medical Center." RP 259; *see also* RP 324 and AR 4161 (in accord). Thus,

substantial evidence shows no "neighboring" hospital in the planning area has staff with greater training and skill, a wider range of important services, or programs with evidence of better results comparable to UWMC. The same is true as compared to other hospitals in the state according to the American Nurses Credentialing Center (AR 3558), the National Bone Marrow Donor Program (AR 3517, 4090), *U.S. News & World Report* (AR 3519, 3538, 3563, 4147, 4607-08, 4693-711; RP 55), HRSA (AR 3538, 3563, 4607, 4693-96, 4698-707; RP 54-61), the Blue Cross and Blue Shield Association (AR 4607-08, 4709), and JCAHO (RP 55).

In addition to this substantial evidence, Providence admits:

- UWMC cares for the highest percentage of the most complex patient cases of any hospital in Washington and has the highest market share of such cases in the state. AR 4005-06; RP 1223.
- UWMC has the second highest case mix index among all Washington hospitals, second only to Swedish Cherry Hill, which provides no services to obstetrical patients or newborns (which skews Cherry Hill's index higher because birthing services have relatively low case mix indices). AR 4014-15, 4230, 4599; RP 576, 1169-71.
- UWMC's case mix index has increased from 2007 to 2011. RP 1175.
- UWMC's patient days are increasing, while the patient days for other hospitals are remaining flat; and the patients migrating into the planning

area for inpatient services predominantly go to UWMC. RP 1205-07.

- UWMC is either the sole provider or the predominant provider of organ transplants in the entire region. AR 4006-08; RP 1178-79.
- "In terms of oncology, UWMC provides care to more inpatients than any other hospital." AR 3922; RP 1168-69.
- UWMC has the highest market share of hematology patients of any hospital in the state. AR 4233, 4235; RP 1172.
- UWMC has among the highest cardiac surgery and neonatal intensive care discharges of all hospitals statewide. AR 3924-25, 4011-13.

Providence claims the wide range of complex tertiary services successfully provided by UWMC's specialized staff should be ignored because these services allegedly represent a "miniscule" portion of resident patient days in the planning area. AB, pp. 30-32. Yet, using Providence's own calculations and just focusing exclusively on UWMC's complex oncology and hematology patients, those patients accounted for 14,875 inpatient days at UWMC in 2011, or an ADC of 41 such patients, who occupy 11% of UWMC's acute beds according to Providence. AR 4235; RP 1172-73. Although Providence might be correct that there are relatively few planning area residents requiring these complex services, Providence's own calculations show such patients statewide do not constitute a "miniscule" portion of UWMC's patient days.

Substantial evidence thus shows that no "neighboring" hospital in the planning area has staff with greater training and skill, a wider range of important services, or programs with evidence of better results comparable to UWMC. The SHP's Criterion 2 (and RCW 70.38.115(2)(a)) standards are met, justifying the Reviewing Officer's findings and conclusions that the population to be served has need for UWMC's project, regardless of whether numeric need exists in the local planning area.

To the extent Providence is claiming the Reviewing Officer's decision on these points was arbitrary and capricious, that claim fails as well. Although there may be room for two opinions after due consideration about the weight of the evidence, Providence fails to overcome the presumption of correctness or to meet their heavy burden of showing the Reviewing Officer's decision was the product of willful and unreasoning disregard of the facts and circumstances, especially when the evidence is properly considered in the light most favorable to UWMC. *See* AR 3500.

D. The Financial Feasibility of UWMC's Project Is Supported by Substantial Evidence

RCW 70.38.115(2)(c) provides that consideration shall be given to "[t]he financial feasibility and the probable impact of the proposal on the cost of and charges for providing health services in the community to be served." *See also* WAC 246-310-220 (identifying three financial

feasibility criteria). There are no recognized standards establishing what the operating revenues and expenses should be, or what an unreasonable impact on costs and charges would be, or how a project of this type and size should be financed. *See* AR 4739, 4741-42.

Providence first argues that UWMC's project automatically fails the financial feasibility criteria, as well as the structure and process of care, and cost containment criteria, because UWMC's project fails the need criteria. AB, pp. 7, 12, 18-19, 33-35, 41, 43. As discussed above, UWMC's 79 bed expansion project meets the need criteria in RCW 70.38.115(2)(a) and WAC 246-310-210, as well as the SHP's Criterion 2 need standards. Thus, Providence is incorrect that UWMC's project fails the financial feasibility, structure and process of care, and cost containment criteria because there is no need for UWMC's bed expansion project.

Providence's alternative argument regarding financial feasibility is that UWMC "omitted" the $34 million cost to shell the space for the 79 bed project, which, according to Providence, means there was insufficient evidence to determine under WAC 246-310-220(1) and (2) whether UWMC can pay for the immediate and long-range capital and operating costs of the project, and can do so without unreasonably impacting the costs and charges for health services. AB, pp. 33, 35-40. This alternative argument is also meritless.

1. Summary of Financing for UWMC's Project

UWMC's 79 bed expansion project is part of a larger, mostly completed construction project to build the eight-story Montlake Tower on UWMC's campus. AR 3132-33, 3143-46, 3494, 3502, 3519; RP 349-51. The Tower was planned in two phases: Phase 1 was the construction of the first five floors; and Phase 2 was constructing the shell for the remaining three floors. AR 3748; RP 349-51. Phase 2 was approved by the UW Board of Regents separately from, and after, the Board of Regents approved Phase 1. *Id.* The Phase 1 cost was $170 million, and the Phase 2 cost was $34 million. *Id.* The total cost to build the Montlake Tower was $204 million. *Id.* Building the Phase 2 shelled space at the same time the other five floors were constructed saved $13 million in construction costs (due to a favorable construction environment during the recession) and avoided additional disruptions of patient care. AR 3564, 3784-85; RP 350-51. Construction of the eight-story Tower was completed and the first five floors were occupied in October 2012, before UWMC applied for a CN to add 79 acute beds. AR 3519.

Before construction began on the Montlake Tower, UWMC asked the Program to confirm that a CN was unnecessary to build the Tower. RP 352-53. The Program responded in 2008 that the construction of the Montlake Tower project was not subject to CN review, but if UWMC

wanted to add beds in the Tower beyond its licensed bed capacity, a CN would be required. AR 5208-09; RP 353-56. Accordingly, the $204 million cost to construct the new patient tower, which included the $34 million cost to shell the top three floors of the tower, was not a capital expenditure subject to CN review. *See id.*

Phase 1 and Phase 2 of the Montlake Tower project were financed separately. AR 3748. The $170 million for Phase 1 was approved by the Board of Regents in 2008 and a Financing Agreement was signed in July 2009, financing Phase 1 through a combination of debt and equity. AR 3748, 3786, 5385, 5416, 5468-71, 5698-99; RP 388-93. In January 2010, the Board of Regents approved UWMC's plan to pay the entire $34 million cost for the Phase 2 construction of the shell on the top three floors of the Tower by using cash from UWMC's reserves. AR 3748, 3774-75, 3783-89; RP 345, 349-50, 351. Once the shell was fully paid for with this $34 million, the shelled space became an asset owned by UWMC. RP 344-45, 365-66, 853. Ownership of this asset did not diminish UWMC's ability to pay the capital and operating costs of the 79 bed project, or otherwise negatively affect the financial feasibility of the project. *See id.*

The total capital cost to equip and finish interior construction of the portions of the shelled Tower where the 79 acute bed project will be located is $70,771,363, including the interest expense of $26,886,728

related to the debt UWMC will incur for borrowing the money from the UW's Internal Lending Program to finish the construction of those three patient floors. AR 3146, 3520-21, 3550-56, 3620, 3622, 3634-37; RP 339-46. The debt will be paid off incrementally by UWMC over 25 years from patient care revenues. AR 3555, 3624-31, 4222. In 2012, UWMC's net patient care revenues were over $842 million and are projected to grow to over $1 billion in 2018. AR 3829. UWMC is projected to have an excess of revenues over expenses in the amount of $90,265,000 in 2018 without the 79 bed project, and an excess of revenue over expenses in the amount of $113,115,000 in 2018 with the project. AR 3829, 3831.

The 79 acute beds will be added in two phases: Phase 1 involves completing interior work on two shelled floors in UWMC's eight-story Montlake Tower by adding 56 acute beds in 2015, including a new 24 bed ICU; and Phase 2 involves completing interior work on the final shelled floor of the Tower by adding the remaining 23 acute care beds in 2017. AR 3520, 4763. At project completion in 2017, UWMC will be licensed for 529 beds, including 444 acute care beds. AR 3521-22, 4764.[14]

[14] The CN issued for the 79 bed project states the project must be commenced before November 2015. AR 4763. *See also* WAC 246-310-580 (CNs are only valid for two years). As required by WAC 246-310-590, UWMC has submitted quarterly reports to the Program describing UWMC's progress toward timely completion of the project. CP 13-34. Construction of the shelled space housing the 79 beds began in August 2014 and should be completed in late 2015, with the first patients to begin occupying the additional beds in early 2016. *Id.* Since issuance of the CN in November 2013 through March 2015, UWMC has spent over $27 million to implement the 79 bed project. CP 35-40.

2. UWMC Fully Disclosed the $34 Million Cost to Shell the Space for the Bed Expansion Project

In addition the above financing information, UWMC notified the Program of the $34 million capital expenditure to shell three floors of the Tower, which UWMC paid for in cash before applying for the CN at issue. *See, e.g.,* RP 344-45, 351, 365-66, 853. This notification was provided in UWMC's prior CN application to add beds to its neonatal intensive care unit ("NICU") in 2010. *E.g.,* AR 5385, 5416, 5468-71.[15] Further notice of this $34 million capital expenditure was provided in the material included with UWMC's CN application at issue in this case. For example, in response to a question from the Program specifically asking for the capital costs of building the shell, UWMC responded that the cost of the Phase 2 construction of the shell was $34 million, and provided the UW Board of Regents meeting minutes further identifying that cost and the Board's approval to pay for it in cash. AR 3748, 3775 (referencing the increase in Phase 1 costs resulting from shelling the top three floors was the difference between $204,000,000 and $170,000,000, which equals $34,000,000), 3783 (same), 3785; RP 479-81. The Program's evaluation acknowledges that the $70,771,363 CN-reviewable cost of UWMC's 79

[15] Providence previously admitted that "[w]e agree that a portion of the Tower project was approved as part of the Department's approval of UWMC's NICU application in 2010" noting that UWMC explained in the NICU application that the "capital expenditure for the larger [Tower] project is estimated at $204,000,000" - - *i.e.,* $170 million for Phase 1 and $34 million for Phase 2. AR 4022 n. 30.

bed project "is the estimated cost of completion of the three floors of the Montlake Tower that was shelled for future inpatient expansion." AR 4716, 4740.[16] Thus, there is no merit to Providence's claim (BA, p. 36) that UWMC failed to identify the $34 million as a prior capital expenditure as defined in RCW 70.38.025(2) and WAC 246-310-010(10).

3. The $34 Million Cost Was Included in the Capital Costs Reviewed by the Department

The $34 million cost of the shelled space, which undisputedly was fully paid in cash in 2012 before UWMC submitted the CN application at issue, was an asset not a liability so UWMC properly included that asset in the "depreciation and amortization" column of UWMC's pro-forma budgets. AR 3634, 3639, 3827-32; RP 344-45, 348-51, 418-24, 853. The $34 million was properly listed in the "depreciation and amortization" column because physical assets are depreciated over the useful life of the asset, which in this case is 30 years. *Id.* There is not a separate line item in UWMC's pro-forma budgets for each and every asset that UWMC is depreciating over time, nor did the Program ask UWMC to identify each

[16] Two of the petitioners, Providence Everett and Providence Sacred Heart, similarly included only the incremental costs of bed expansions in their last CN applications. AR 4150; RP 385-86. This is an accepted practice, and it is disingenuous for Providence to criticize UWMC for engaging in this accepted practice. *See also* AR 2414 (*In re Valley Medical Center*, Presiding Officer's finding that the costs of constructing an emergency room was exempt from CN review even though the emergency room was part of a CN reviewable project to build a new hospital, and thus those construction costs were not a capital expenditure the new hospital had to account for in its CN application).

asset included in the "depreciation and amortization" column. RP 422-23. However, the column does show that after the shell was paid for in 2012 there was an increase in the depreciation column from $31,857,000 in 2012 to $41,094,000 in 2013, which further increases in ensuing years. *E.g.*, AR 3829; RP 344-46, 365-66, 418-24.[17]

Contrary to Providence's mischaracterizations of the evidence, UWMC did not "understate" the costs of the 79 bed project, or "omit" the $34 million cost to build the shell. Owning this fully paid for asset did not diminish UWMC's ability to pay the capital and operating costs of completing the interior construction of the shelled space, or otherwise have a negative effect on the financial feasibility of the project. Further, the Program's financial ratio analysis shows UWMC's finances compare favorably to other hospitals, and the 79 bed project would be "breaking even" by no later than 2019, two years after project completion in 2017. AR 4766-68. This analysis corresponded with UWMC's internal analysis, which showed the project would be "breaking even" by 2018 if the annual growth rate of UWMC's patient days is 2.7%, and would "break even" by

[17] Providence claims UWMC's witness, Helen Shawcroft, "could not identify any amount in UWMC's financials related to the $34,000,000...." AB, p. 40. That is a mischaracterization of her testimony. Ms. Shawcroft identified the $34 million was included in the depreciation and amortization line of UWMC's pro forma, but she could not identify how much of the total amount in the depreciation and amortization line each year was specifically tied to the $34 million capital expenditure for the shelled space because it was a blended amount, and was not itemized by every single depreciating asset owned by UWMC, nor was it required to be. *E.g.*, RP 418-24. She stated she would need to review "backup" documentation if required to perform that itemization. *Id.*

2019 if the annual growth rate is 2.4%.[18] RP 378-79. Thus, substantial evidence supports the Reviewing Officer's findings and conclusions that UWMC's project is financially feasible. AR 3142-47, 3502, 3504.

4. The Project's Costs Will Not Unreasonably Impact the Costs and Charges for Health Services

To determine whether the costs of the 79 bed project would unreasonably impact the costs of care to patients, the Program determined that UWMC's operating revenue per patient day in 2018 will be $7,067, and operating expense per patient day will be $6,453, resulting in a net operating margin per patient day of $737 in 2018. AR 4767-68. The Program compared these rates to the averages for other Washington hospitals and found them similar. *Id.* The Program also determined the $895,840 capital cost per bed ($70,771,363 total cost divided by 79 beds) is within the range of past hospital projects reviewed by the Department. AR 4769.[19] Thus, substantial evidence shows UWMC's project will not unreasonably impact costs and charges for health services.

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[18] In a footnote, Providence claims the Reviewing Officer should have deemed UWMC's projected 3.7% annual growth rate in acute patient days not credible. AB, p. 34 n. 24. As mentioned in the text above, substantial evidence supports the 3.7% annual growth rate. *E.g.,* AR 3523, 3792, 4128, 4130, 4149, 4441, 4593-94; RP 374-80, 597-611, 1205, 1223-24. But, even if the annual growth rate in acute patient days turns out to be 1.9%, UWMC would still "break even" on the project within six years. RP 377-80.

[19] For example, the Program and a Presiding Officer previously found hospital projects with capital costs of $3.3 million per bed, and $2.7 million per bed to be reasonable. AR 2369, 2394, 2398. UWMC's capital costs per bed are millions of dollars less.

E. Substantial Evidence Shows UWMC's Project Will Not Result in Unwarranted Fragmentation of Services

There are no recognized standards for determining "an unwarranted fragmentation of services" under WAC 246-310-230(4). AR 4746. Nonetheless, the evidence shows UWMC's statewide and region-wide role as the hospital to which other hospitals transfer patients requiring the most complex care is integral to the efficient functioning of Washington's and the WWAMI region's health care delivery system. *E.g.*, AR 3847-84, 4152; RP 395-96. Many providers in the WWAMI region commented that health care services will be fragmented and diminished outcomes will result if UWMC is not allowed to add beds. *Id.* Care for patients needing UWMC's services will be increasingly delayed or diverted to other states if UWMC's high occupancy rates, particularly in its ICUs, are not alleviated by adding acute beds. *Id.*

Providence claims UWMC's bed expansion project would lead to unwarranted duplication of services because Northwest Hospital and Swedish Ballard offer "virtually all" of the same services as UWMC. AB, p. 44. This claim is contrary to (1) Providence's admission that Swedish Ballard is not comparable to UWMC and provides no tertiary services (AR 4135-36, 4238, 4603; RP 1166, 1225), and (2) the testimony of Northwest Hospital's Executive Director that her hospital does "not have the staffing

expertise or the equipment that is needed in order to provide the very high-end tertiary and quaternary care that is provided at UW Medical Center" (RP 259, 324). If Northwest Hospital offered "virtually all" of the patient services provided at UWMC, its case mix index would be equivalent, and Northwest Hospital would be included in "virtually all" of Providence's charts showing the tertiary services and volumes offered by hospitals statewide. *See* AR 3920-28. That is simply not the case.

F. Substantial Evidence Shows UWMC's Project Meets the Cost Containment Criteria in WAC 246-310-240(1)

WAC 246-310-240(1) requires consideration of whether a superior alternative to a proposed project is available or practical in terms of cost, efficiency or effectiveness. Providence claims "there is no evidence" to support the Reviewing Officer's conclusion that UWMC's project is a superior alternative to meet the regional need for additional beds. According to Providence, the superior alternative is to have UWMC transfer unspecified "less complex services" to Northwest Hospital, which is affiliated with UWMC. AB, pp. 41-43.

UWMC considered shifting one or more additional acute inpatient programs to Northwest Hospital. AR 3796-97. In 2010, UWMC began diverting less complex service lines to Northwest Hospital, comprising about 3,000 patient days per year, including hip and knee replacement

surgeries, some thoracic surgery, hernia surgery, midwifery and a multiple sclerosis center. AR 3520, 3794, 4605-06; RP 77-83, 260-62, 401-02, 413-14. Despite this relocation of service lines, UWMC's occupancy rates and case mix index continued to increase as more complex patients continued coming to UWMC. *Id.* Shifting even more inpatient programs to other hospitals continues to be explored, but the physical and intellectual infrastructure, the ancillary support and staffing, and the accreditation needs for the UW School of Medicine dictate the service mix at UWMC. *E.g.,* AR 3797, 4152-53, 4605-06; RP 79-82, 174-75, 401-05, 413-14. Significant costs are involved in duplicating additional inpatient services at another location. *Id.* For example, relocating any service that involves surgery or sophisticated diagnostic equipment would require duplication of expensive capital equipment and specialized, multi-disciplinary staff because UWMC's ancillary and support staff and equipment support the entire hospital, not just a single unit or service. *Id.* Providence offers no evidence concerning which, if any, additional service lines Providence believed could be appropriately transferred to Northwest Hospital, or what would be entailed in terms of costs, staffing, equipment and ancillary services to do so. *See* RP 1184-85 (Providence's expert's admission that he has no knowledge or opinions about such matters).

Moreover, Northwest Hospital has 100% occupancy on its acute

beds during the middle of every week as patients come in for, and recover from, elective surgeries. RP 261, 318. As a result, that hospital has very little capability to accommodate the transfer of more service lines from UWMC. RP 323. In order for UWMC to forego adding acute beds, yet be accessible to patients in the short term, UWMC would have to identify and relocate additional patient service lines accounting for at least an ADC of 50 patients in 2016. AR 3797; RP 402-04. In 2011, Northwest Hospital was under its targeted average midnight occupancy rate by the equivalent of 24.3 acute care beds, which translates to an available ADC of only 15.8 patients, or 5,761 patient days. RP 618-20. *See also* RP 326-27, 332 (the hospital would need to construct a new building to increase its existing capacity). Northwest Hospital thus lacks the physical capacity to meet the minimum ADC of 50 patients that would be necessary to alleviate UWMC's growing patient volumes. *Id.* The superior solution to the population's growing need for improved access to UWMC's services is to add acute care beds at UWMC where the specialized staff, equipment and ancillary services already exist, rather than transferring additional, unspecified service lines to Northwest Hospital.

G. Excluding Evidence that Did Not Exist at the End of the Public Comment Period Was Not an Abuse of Discretion

Providence argues the Presiding Officer abused his discretion by

excluding 2012 CHARS data that was published after the end of the public comment period. AB, pp. 44-49. In *Univ. of Wash.*, an intervening competitor challenged a Presiding Officer's evidentiary ruling barring admission of evidence that did not exist until after the CN public comment period ended. *Univ. of Wash.*, 164 Wn.2d at 100-02. The court held "[i]t was within the sound discretion of the health law judge to admit, or not admit, evidence that came into existence after the close of the public comment period." *Id.* at 104.

The public comment period in this matter closed on May 15, 2013. AR 3842, 4719. Providence and UWMC were permitted to submit rebuttals to public comments. *See* AR 1089-90, 1288-89. The last round of rebuttals were due on July 11, 2013. *Id.* The 2012 CHARS data was not received by UWMC until July 10, 2013, the day before the extended rebuttal period ended. AR 4595 n. 4. Neither UWMC, nor Providence incorporated the complete 2012 CHARS data in any of their materials before the extended rebuttal period ended. *See* AR 3141 n. 43. Similarly, the Program did not use the 2012 CHARS data in its evaluation of UWMC's CN application. *Id.* Given these undisputed facts, the Presiding Officer properly exercised his considerable discretion to exclude the 2012 CHARS data. *Id.*; RP 1024-28, 1036-1041.

With respect to Providence's claims of prejudice, the Presiding

Officer stated he gave little, if any, weight to UWMC's use of annualized 2012 data. *Id.* As the Reviewing Officer found after considering Providence's offer of proof on the 2012 CHARS data, much of the data Providence offered pertained only to the SHP's numeric need methodology, which was irrelevant to application of the SHP's Criterion 2 methodology. AR 3503. To the limited extent Providence offered the data for purposes of the SHP's Criterion 2 analysis, the Reviewing Officer concluded the data did not suggest a different outcome. *Id.* Thus, Providence is unable to show an abuse of discretion or prejudicial harm.

H. Providence's Procedural Complaints Are Meritless

Although Providence does not assign error to the order of presentation of witnesses or the time limits for the administrative hearing, Providence nonetheless claims pre-hearing rulings on these matters "stacked [the deck] against Petitioners from the outset." AB 15 n. 7. UWMC is compelled to briefly respond to these meritless claims.

1. The Order of Presentation Was Proper

Providence incorrectly suggests the Presiding Officer erred by denying Providence's request to present its case first. AB 15 n. 7. The Washington Rules of Evidence ("ERs") mostly apply in administrative proceedings. RCW 34.05.452(2); *Univ. of Wash.*, 164 Wn.2d at 103. ER 611(a) grants Presiding Officers discretion to control the order of

presenting witnesses and evidence to make the "presentation effective for the ascertainment of the truth" and to "avoid the needless consumption of time." *Sanders v. State,* 169 Wn.2d 827, 851, 240 P.3d 120 (2010). With these goals in mind, the party with the burden of proof customarily presents their case first. As the CN applicant, UWMC had the burden of proof at the hearing (WAC 246-10-606), so the Presiding Officer properly allowed UWMC to present its case first. *See* AR 1003. On the other hand, competing providers like Providence have a right to judicial review, but no right to an adjudicative hearing. *King County Pub. Hosp. Dist. No. 2 v. Dept. of Health,* 178 Wn.2d 363, 380-82, 309 P.3d 416 (2013). Permitting UWMC to present its case first was not an abuse of discretion.

2. The Presiding Officer's Adherence to Agreed Time Limits Was Proper

Providence incorrectly suggests the Presiding Officer erred by limiting the time of the hearing to five days. AB 15 n. 7. However, the Presiding Officer has wide discretion to impose time limits. *See, e.g., Daly v. Far Eastern Shipping Co.,* 238 F.Supp.2d 1231, 1234-36 (W.D. Wash. 2003). Providence agreed to a 5-day hearing at the prehearing conference (*see* AR 1003), to which the parties were appropriately held. *See Daly,* 238 F.Supp.2d at 1236. Providence fails to describe what material testimony witnesses would have given in the absence of the time

limit (*see* AB, p. 15 n. 7), meaning there is no showing of prejudicial harm. *See id.* Moreover, Providence's counsel failed to heed several warnings during the hearing about the time limits, and instead chose to needlessly consume time with repetitive and argumentative questioning. *E.g.,* RP 217-18, 281-85, 298-304, 477-78, 487-88, 664-65, 712-13, 775-77, 824-25, 872-76, 1260-63. The time-stamped hearing transcript shows that Providence's counsel consumed more hearing time examining witnesses and arguing motions and objections than counsel for the other two parties combined. *See* AR 3010-23 (summarizing the hearing time consumed by each party's counsel based on the time-stamped hearing transcript), at pp. 3014 and 3023. Providence's claim that unfair time restrictions limited its case presentation should be rejected.

I. Providence's Conclusory Reference to a Stay Should Be Disregarded

Without bringing a motion or presenting any argument, Providence makes an alternative request for a stay of UWMC's CN in the concluding sentence of their opening appellate brief. AB, p. 50. The Reviewing Officer denied Providence's request for a stay (AR 3503-04), and Providence does not argue that ruling was erroneous. Providence did not move for a stay in superior court, nor has it done so on appeal. *See* RAP 7.2(h) and 8.1(b)(3). Providence fails to cite or apply the two-prong test

for determining whether to grant a stay of an agency order as set forth in RAP 8.1(b)(3). *See Purser v. Rahm,* 104 Wn.2d 159, 177, 702 P.2d 1196 (1985). Thus, Providence's reference to a stay should be disregarded.

VI. CONCLUSION

UWMC's project will improve the delivery of health care by enhancing patient access to UWMC's nationally recognized services, increasing the availability of acute care beds for Medicaid, Medicare and uninsured patients requiring complex care, and increasing the training opportunities for health care professionals. UWMC's role as a regional referral hospital for adult patients requiring the most complex care is integral to the efficient functioning of Washington's and the WWAMI region's health care delivery system. The 79 bed project is needed, appropriately financed, cost-effective and, among viable alternatives, the superior solution to the region's needs. Without more acute beds, UWMC's ability to meet the growing population's increasing need for complex health services will be curtailed. The Reviewing Officer's decision approving UWMC's bed expansion project should be affirmed.

RESPECTFULLY SUBMITTED this 20th day of November, 2015.

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CERTIFICATE OF SERVICE

I certify that the foregoing was served by the method indicated below to the following individuals this 20th day of November, 2015.

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DATED this 20th day of November, 2015, at Olympia, Washington.

KRISTI JENNE