No. 93569-6
SUPREME COURT
OF THE STATE OF WASHINGTON

No. 73454-7-I
COURT OF APPEALS, DIVISION I
OF THE STATE OF WASHINGTON

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.

PETITION FOR REVIEW

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Regulations

Other Authorities

I. IDENTITY OF PETITIONERS AND INTRODUCTION

Petitioners Providence Health & Services – Washington and Swedish Health Services (collectively, "Petitioners") respectfully request review of the Court of Appeals decision in this case, which raises important issues of substantial public interest with respect to health care planning in Washington that should be resolved by this Court.

This case concerns whether a state institution, 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 Washington hospitals, as required by state law. In a published opinion, the Court of Appeals affirmed the Department's erroneous decision to "make an exception" for UWMC and to grant it a CON to construct 79 acute care hospital beds, even though the legal standards consistently applied by the Department in every other similar case indisputably required UWMC's application to be denied.

For the first time in the 35 years of the CON program, the Department abandoned its prior uniform interpretation of the CON statutory review criteria and adopted an "alternative" analysis focused on the "needs" and desires of the specific institution (UWMC), instead of on community needs, as required by law. The Department's decision, and the Court of Appeals decision affirming it, marks an unprecedented and unwarranted departure from decades of settled practice and dramatically

alters the health care planning framework for acute care beds in Washington. Particularly disturbing is the fact that this unprecedented "exception" was made by a state agency to award another state institution a de facto exemption, by administrative decree, from the rules that apply to all other participants in the state health care system.

This decision raises important administrative law issues and has profound consequences reaching far beyond this case. It accords unfair preferences to another state institution, contrary to law, and establishes that the rules that always apply to all other providers can be disregarded at the Department's whim. In doing so, the decision undermines the predictability, consistency, and transparency achieved over decades in the Department's CON process. Thus, Petitioners respectfully request review.

II. THE COURT OF APPEALS DECISION

Petitioners seek review of the Court of Appeals's published opinion affirming the Department's decision to grant UWMC a CON. A copy of the Court of Appeals opinion (the "Decision") is attached as Appendix A. The Department sought partial reconsideration, which was denied on August 2, 2016. A copy of the order denying reconsideration is attached as Appendix B. This Petition for Review timely follows.

III. ISSUES PRESENTED FOR REVIEW

Under Washington law, CON applications for new acute care beds are analyzed using four review criteria, which *all* must be satisfied to obtain approval. *See* WAC 246-310-210 (need), -220 (financial feasibility), -230 (structure and process of care), -240 (cost containment).

The applicant must prove that the proposed project is needed by the community, will foster containment of costs, is financially feasible, and will benefit the structure and process of care delivery in the community. *Id.* This framework permits the Department to plan in a comprehensive way based upon *community* interests, rather than those of particular facilities, thus avoiding duplication of services and controlling costs. *Id.* An applicant's desires or "needs" are not part of the review criteria. *Id.*

Since the enactment of the CON statute in 1979, the Department has analyzed applications for new acute care beds by applying a multi-step numeric need methodology (the "Methodology"), which forecasts the number of beds actually needed in the applicable community planning area. Indeed, the Department has relied upon the Methodology in *every* prior evaluation of the need for new acute care beds, and has denied any CON application where the Methodology does not show a need for new beds. RP820, 831-35, 838; AR3029. This has ensured an objective, "predictable, transparent, and consistent"[1] process by the Department and for applicants that complies with the requirements of Washington law.

In this case, the Methodology showed no community need for the beds requested by UWMC and, thus, that UWMC's application should be denied. In order to grant a CON to UWMC nonetheless, the Department refused to apply the Methodology. Instead, for the first time, it applied an "alternative" analysis, referred to as "Criterion Two." Criterion Two

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[1] *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, footnote 8 (AR2375).

consists of previously forgotten language from the long-defunct State Health Plan.[2] Whereas the Methodology is an objective method for calculating community need for beds,[3] Criterion Two improperly focuses on institutional interests, citing subjective factors comparing the requesting institution to other providers. The Department's use of Criterion Two was contrary to law and to decades of CON practice. The Department compounded its error through a series of deeply flawed and unprecedented decisions further aimed at achieving its desired result of awarding a CON to UWMC. By affirming, the Court of Appeals legitimized these errors and established them as precedent for future cases.

The issues presented for review are:

1. Did the Court of Appeals err in concluding that the CON need criterion could be satisfied through the unprecedented application of Criterion Two, to permit approval of a CON application that otherwise should have been denied under governing law and longstanding uniform Department policy, practice, and interpretation of the law?

2. Did the Court of Appeals err in affirming the Department's flawed and unprecedented analysis of UWMC's CON application, in which, among other errors, the Department (1) contradicted decades of

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[2] The Plan was repealed twenty-six years ago. Laws 1989, 1st Ex. Sess. Ch. 9, Sec. 610 (former RCW 70.38.919). Criterion Two was contained in the Plan, but was never applied while the Plan was in effect or thereafter. Criterion Two is not a real standard; it is merely verbiage in a historical document that has been without legal effect for decades.

[3] In general, the Methodology uses patient hospital utilization data, population projections, adjustments for patient planning area in-migration and out-migration, and the existing bed inventory, to calculate the numerical need for, or surplus of, beds in a planning area as of the target year (seven years in the future).

Department action in finding the non-need criteria were satisfied in UWMC's application for unneeded beds; (2) disregarded the findings of Department employees, who found the application had to be denied, in favor of implementing the unsupported instruction of a Department director to grant the CON; (3) failed to properly apply the language of Criterion Two, its purported "alternative" need standard; and (4) refused to use the most accurate, up-to-date data to evaluate the application?

Health care is a matter of great public importance, and the CON process is an integral part of the health care system. By affirming the Department's erroneous decision, the Court of Appeals Decision directly affects all future CON applications for acute care beds. The creation of an "exception," by one state agency for the benefit of another, also erodes public trust in the neutrality of state decision-making bodies. In short, this Petition raises issues of "substantial public interest that should be determined by" this Court, and review should be granted. RAP 13.4(b)(4).

IV. STATEMENT OF THE CASE

A. UWMC's Application And The Program's Review

In 2012, UWMC constructed a new building ("Montlake Tower") capable of providing medical services. AR3519-20; RP72. UWMC understood from the outset that a CON was required before it could add acute care hospital beds to the new building. *Id.* It also knew there was no community need for additional beds, but nonetheless decided to shell in the entire building for internal financial reasons. AR3783-84. Once it did so, UWMC decided to accelerate the timetable for acute care bed use of

the space it had built, and in November of 2012 it applied for a CON to add 79 beds to the Montlake Tower (the "Application"). AR3519-20. UWMC hoped it could convince the Department to approve the beds despite the community's well-known bed surplus and lack of need for the foreseeable future. The Application stated that the total capital cost of the project to add 79 beds was $70,771,363, but that figure omitted the $34,000,000 in construction costs incurred for shelling-in the space in which the beds would be located. AR3550.

Over the next year, the Department's CON Program ("Program") thoroughly evaluated the Application. AR4712-58. The Program Analyst (Bob Russell) and the Department's financial expert (Ric Ordos), who were charged with conducting the evaluation, correctly concluded that the Application *failed* the CON statutory review criteria (i.e., need, financial feasibility, cost containment, and structure and process of care), in significant part because there was no community need for new beds under the Methodology always used by the Department. AR4758, 4765-69; RP819-20, 831-35, 838, 1249-51. Accordingly, the Analyst prepared a draft evaluation concluding that the Application should be denied. RP880.

At the last minute, however, the then Executive Director of the office responsible for managing the Program (Bart Eggen) unilaterally ordered his subordinate, the Analyst, to award a CON to UWMC. RP880-81. It is undisputed that, when doing so, Mr. Eggen had not reviewed the Application or any of the materials submitted in opposition to the Application. RP881-86. The Analyst complied with his superior's

directive, and revised the evaluation to change the conclusion from "no" to "yes." RP1257. The Program did not cite Criterion Two in its revised evaluation. AR4712-58. Tellingly, the Analyst 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 Department thus approved the Application, despite UWMC's failure to meet the legal standards universally applied to all previous acute care bed applications.

Notably, this was the first time that: (1) the Program approved a CON for acute care beds in the absence of need under the Methodology; (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 found that the Application failed those criteria; and (4) the Analyst responsible for the evaluation was overruled at the last minute by a superior and was directed to approve an application that failed the review criteria. RP831-35, 838, 846, 926-27.

B. The Adjudicative Proceeding And The Department's Decision

Petitioners requested an adjudicative proceeding to contest the Department's decision. At the hearing, the Program made no effort to defend its evaluation, instead permitting UWMC to try to justify the CON. Because the Application failed under the standards always applied by the Department, UWMC asked the Department's hearing officer ("HLJ") to grant the CON based on Criterion Two, which the Program had not

applied in its evaluation.

On September 12, 2014, the HLJ entered an initial order approving UWMC's Application, essentially adopting UWMC's positions in their entirety. AR3119-56. With respect to the need criterion, the HLJ refused to apply the Methodology, which showed no need. *Id.* Instead, he held that UWMC would be treated as "unique" and, for the first time ever, the Application would be approved under so-called Criterion Two. *Id.* Prior to this ruling by the HLJ, the Department had never applied or even disclosed that it would apply Criterion Two. The HLJ concluded that UWMC had shown an institutional need for more beds, principally based on its (inflated) claims of overcrowding. *Id.* With respect to financial feasibility, the HLJ acknowledged that UWMC had omitted $34,000,000 in capital costs from its Application, but concluded that the criterion was satisfied despite the Department having failed to analyze the project's true capital cost. *Id.* With respect to the criteria of cost containment and structure and process of care, the HLJ concluded that those criteria were met, also without any substantive analysis. *Id.*

Petitioners sought administrative review. The Review Officer affirmed the HLJ's decision with little further analysis. AR3493-507.

C. The Court of Appeals Decision

Petitioners filed a petition for judicial review, which was certified for direct review to the Court of Appeals, with review then accepted by the Court. While Petitioners dispute virtually all aspects of the Department's decision, the appeal focused on five principal deficiencies. First, there is

no legal or factual basis for the Department's decision to abandon the need Methodology and to approve UWMC's project based on Criterion Two – language outside of the governing statute and regulations that has never been used before and is inconsistent with the review criteria as uniformly applied for decades. Second, even if Criterion Two could be considered, and it cannot, the evidence 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 evaluate the $34,000,000 omitted from UWMC's Application. Fourth, the record cannot support a conclusion that UWMC has proven that its project is the superior alternative to address any purported need and will not result in duplication or fragmentation of care, as required by law. Finally, the Department erred in refusing to admit up-to-date and accurate statistical data while permitting UWMC to introduce inaccurate projections of old data, resulting in a decision prejudicially based on false information.

On July 5, 2016, the Court of Appeals issued its published Decision affirming the Department's final administrative decision. The Court rejected Petitioners' arguments and deferred to the Department. It concluded that the Department had not committed legal error and that there was sufficient evidence in the record to support the Department's decision. The Court of Appeals, like the Department, essentially accepted UWMC's arguments in their entirety. The Court of Appeals Decision, like the Department's decision it confirmed, was error.

V. ARGUMENT WHY REVIEW SHOULD BE ACCEPTED

This Court may grant review if the underlying decision "involves an issue of substantial public interest that should be determined by the Supreme Court." RAP 13.4(b)(4). That standard is met here. Health care planning is a matter of inherent public interest and the decision here alters decades of settled practice based on a previously uniform interpretation of law. In affirming the Department's errors, the Decision has sweeping consequences for Washington's health care system, affecting all future CON applications for acute care hospital beds. The Decision will create confusion in a system previously grounded in consistency, and transform a transparent process into one without clear standards, spurring distrust and unnecessary litigation. It also sanctions the great unfairness to all Washington providers, whose ability to expand is restricted by CON requirements from which their state competitor, UWMC, has effectively been exempted. This is precisely the sort of matter of public consequence that deserves final resolution by this Court. Review should be granted.

A. The Decision Directly Affects Health Care Planning In Washington, Which Is An Issue Of Substantial Public Interest.

The Washington legislature has recognized that health care planning is a matter of public importance. It is public policy in this state to "promote, maintain, and assure the health of all citizens in the state, provide accessible health services, health manpower, health facilities, and other resources while controlling increases in costs, and recognize prevention as a high priority in health programs." RCW 70.38.015(1).

The CON process is a vital part of this public policy, as a crucial "component of a health planning regulatory process that is consistent with the statewide health resources strategy and public policy goals that are clearly articulated and regularly updated." *Id.* As this Court has noted, the CON process seeks "to control costs by ensuring better utilization of existing institutional health services and major medical equipment." *St. Joseph Hosp. and Health Care Ctr. v. Dep't of Health*, 125 Wn.2d 733, 735, 887 P.2d 891 (1995); *see also Hospice of Spokane v. Wash. State Dep't of Health*, 178 Wn. App. 442, 454, 315 P.3d 556 (2013) (observing that the CON process promotes public health "by providing accessible health services and facilities, while controlling costs").

Thus, this Court has long recognized the strong public interest in the CON process. On many prior occasions, it has granted review in CON matters to analyze applicable law and review Department decisions. *See King Cty. Pub. Hosp. Dist. No. 2 v. Wash. State Dep't of Health*, 178 Wn.2d 363, 371, 309 P.3d 416 (2013) (granting petition for review in CON matter); *Overlake Hosp. Ass'n v. Dep't of Health*, 170 Wn.2d 43, 49, 239 P.3d 1095 (2010) (granting petition for review in CON matter); *Univ. of Wash. Med. Ctr. v. Wash. Dep't of Health*, 164 Wn.2d 95, 102, 187 P.3d 243 (2008) (granting direct review in CON matter); *St. Joseph Hosp.*, 125 Wn.2d at 738 (evaluating CON matter on direct appeal); *Providence Hosp. of Everett v. Dep't of Soc. & Health Servs.*, 112 Wn.2d 363, 355, 770 P.2d 1040 (1989) (accepting certification and evaluating CON matter); *cf. Wash. State Hosp. Ass'n v. Dep't of Health*, 183 Wn.2d 590,

594, 363 P.3d 1285 (2015) (granting direct review of dispute involving CON rules and finding Department exceeded its statutory authority).

Just as in these prior instances, this case involves matters of public importance deserving of this Court's review. The affirmance by the Court of Appeals of the Department's arbitrary and capricious actions unfairly changes CON law and practice for providers across the state. The use of Criterion Two in the manner it was used here will effectively forever exempt UWMC from the health care planning framework established by the legislature, and permit arbitrary decision-making by the Department. This is not a case in which an error affects only the parties, or where an agency decision affects only the applicant. To the contrary, the decision here effectively reverses the longstanding approach taken for all acute care bed applications, thus impacting all future applicants. CON applicants can no longer expect a determination by the Department that is transparent, predictable, and consistent with past application of the governing law. Accordingly, this case presents issues of substantial public interest under RAP 13.4(b)(4), and review should be granted.

B. The Decision Changed Washington CON Law.

Without basis in law or fact, the Court of Appeals Decision, and the Department decision it affirmed, fundamentally altered Washington CON practice and law. The principal issues are identified below.

1. The Use Of Criterion Two To Favor UWMC Was Contrary To Law And Decades Of Department Action.

Once it became clear that UWMC's Application had to be denied,

the Department changed the rules. To achieve its desired goal, it disregarded whether the means of achieving that goal were appropriate or fair. They were not. The Department's use of Criterion Two as the basis for determining need constituted an error of law that was contrary to decades of consistent application of the CON statute and regulations.

By law, the need criterion assesses "[t]he need the population served or to be served" has for the proposed services. RCW 70.38.115(2); *see also* WAC 246-310-210(1) (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"). Until this case, the Department had always applied the Methodology in determining the need for new acute care beds because it provides an objective, predictable, transparent, and consistent tool for evaluating community need. The Methodology focuses on community interests and avoids consideration of provider self-interest. As the Department has consistently explained, the law requires it to evaluate the "need for additional acute care beds in the service area" and not "whether the individual facility needs more beds."[4]

Here, for the first time ever, the Department abandoned the Methodology and applied Criterion Two, in order to favor UWMC. But, unlike the Methodology, Criterion Two is *not* based on community need.

[4] *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) (AR 2441-99), Finding of Fact No. 1.32 (AR2465-66); *see also id.* (stating that the analysis of need under CON law "is not a determination whether the [applicant] meets the requirements but whether the proposed additional beds are needed in the [applicable] service area").

Rather, Criterion Two is an institution-based analysis and the Department's finding of need was based upon UWMC's purported institutional "need" for additional beds. Nothing in CON law, however, permits consideration of institutional needs. According to the Department's own prior interpretation of the governing law, the focus is solely on the needs of the community. Thus, the Department's use of Criterion Two to obtain a "yes" for UWMC was not just inequitable, it contradicted established law and decades of consistent policy and practice.

In its Decision, the Court of Appeals essentially held that the fact that the Department had exclusively used the Methodology for decades did not preclude it from using other standards. The Court's analysis was erroneous in many respects. In particular, it failed to recognize that Criterion Two is inconsistent with Washington law because it focuses on institutional rather than community needs. Not only was the use of Criterion Two *new*, its use was contrary to the requirements of Washington law, as they have been consistently interpreted and applied by the Department for decades. The Department dug out the Criterion Two language from the long-defunct State Health Plan because it knew it needed to cite something to justify approving UWMC's Application in the absence of community need. Doing so was contrary to law.

Moreover, the Department's belated application of Criterion Two in its adjudicative decision also violated WAC 246-310-200(2)(c), which requires the Department to identify the standards it will use *before* it conducts its evaluation. That did not happen here. Indeed, the

Department did not even use Criterion Two in its evaluation; it was used for the first time by the HLJ in his opinion, after the evaluation was challenged. The Court of Appeals essentially held that the Department's violation could be ignored because UWMC argued for the application of Criterion Two, and Petitioners were able to present their position in the adjudicative proceeding. But the regulation is intended to provide *all* members of the public with fair notice about the standards the Department will use, and to ensure that the Department fairly follows the standards it says it will use. None of that happened here. In this case, the initial evaluation concluded that the Application had to be denied, but the CON was granted anyway on order from a Department director. Then, when that decision was challenged and it became clear that the rules required denial of the Application, the Department's adjudication changed the rules. This departure from ordinary practice deserves review.

2. The Department's Analysis Was Inconsistent With Settled Policy And Practice In Many Other Respects.

The Department's use of Criterion Two in order to accord special treatment to UWMC was not the only aspect of its decision that was contrary to its longstanding, standard policy and practice. The decision was unprecedented in many respects that are deserving of further review.

First, the Department rejected past practice and concluded that the Application satisfied the cost containment and financial feasibility criteria even though there was no numeric need. Until this case, the Department had always held that these criteria could not be met in the absence of need

under the Methodology. *Cf. Dist. No. 2*, 178 Wn.2d at 372 (discussing that financial feasibility, cost containment, and structure and process of care criteria fail where there is no numeric bed need). The Department's financial expert could not recall *any* prior instance – out of 200 or more CON applications 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, this was the *first time* the Department found an applicant to have satisfied the financial feasibility criterion where there was a lack of numeric bed need. RP834-35, 838.

Second, the Department acted contrary to statutory requirements and its long-established policy and practice by finding that UWMC's project satisfied the financial feasibility and cost containment criteria even though the true capital cost of the project was never analyzed. UWMC's Application identified the capital cost of its project as $70,771,363, which omitted $34,000,000 of construction costs spent just prior to the Application's filing to shell-in the Montlake Tower. AR3550. The Department's review of the Application was based upon the inaccurate $70 million figure. AR4765-69. Thus, the Department never evaluated whether the Application satisfied the financial feasibility and cost containment criteria based on the true capital cost of the project. This directly contravened the CON statute, which requires that all construction costs be included in the capital expenditure estimate contained in a CON application. RCW 70.38.025(2); WAC 246-310-010(10). The Department has always required the complete capital costs of a project to

be disclosed and evaluated. UWMC was given a special exception.

Finally, the Department acted in violation of its normal policy and practice by relying on inaccurate, out-of-date data in its evaluation of the Application. The Department has consistently taken the position that, in reviewing CON applications, it will utilize the "most recent available" statistical data, as of the date on which its evaluation is issued. It is the Department's "standard practice" to "ensure the most up-to-date or current information is used when evaluating the application." *In re Valley*, Finding of Fact 1.8 (AR2373). Yet, in this case, the Department violated this practice and refused to consider the most recent data available (2012 CHARS), which notably showed that many of UWMC's claims in its Application were wrong. Again, UWMC received special treatment.

In all of these respects, and others, the Department deviated from past practice and its consistent application of the governing law. These cumulative decisions to grant UWMC special treatment deserve review.

C. The Decision Has Adverse Consequences Beyond This Case.

The legal issues raised in this case on matters of substantial public interest offer compelling reasons why review should be granted. The practical impact of the decision provides additional reasons for review.

First, if the Department is permitted to use Criterion Two in the way it did here, the practical result will be to exempt UWMC from the CON rules applicable to all other providers, and to undercut the fairness of the review process itself. The Department's decision that UWMC has "need" for beds was based on institutional factors that can always be met

by UWMC, regardless of the nature of the proposed project – including, for example, that UWMC is affiliated with the state's only allopathic medical school, and that it provides certain complex services. The Department cannot be permitted to exempt a state institution from the requirement to demonstrate need for a project by applying new criteria only its sister agency will satisfy. Allowing such an exception would not only sanction arbitrary and capricious decisions, but would also establish a structure under which one state institution, UWMC, will always receive approval for its projects because the standards are essentially contrived by its fellow state agency.

If the Department is granted limitless authority to devise its own new "standards" whenever it wishes to do so – without advance notice, rulemaking, or other regulatory safeguards – any desired outcome can be reached. The decision here is a perfect example: the Department repeatedly deviated from its longstanding policies and practices in order to ensure that UWMC would receive a CON. No health care provider should be exempted from the established health care planning framework in this manner, nor should the structure for CON review be left to the whims of the Department. The Decision permits just such an outcome.

Second, the determination that UWMC's Application satisfied the financial feasibility and cost containment criteria – even though it omitted $34,000,000 in capital costs (and thus never had those costs evaluated) – is an invitation to manipulation and deception in the CON process. The ruling incentivizes future applicants 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 be approved 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 CON evaluation process will be undermined if applicants are permitted to "game" the system in this way. This is yet another reason the Decision has implications for the validity and trustworthiness of the CON process.

Finally, the Department's actions in this case run contrary to basic principles of fair and impartial decision-making. Its experts engaged in a thorough, yearlong evaluation, which included multiple screenings of the Application, a public hearing, and the receipt and review of extensive written materials. At the end of this process, the Department's responsible Analyst and its financial expert each concluded that the Application failed to satisfy the review criteria and had to be denied. Yet, just before the decision was issued, a senior administrator – who, by his own admission, had not reviewed *any* materials relating to the Application – unilaterally directed that UWMC be awarded a CON. Never before has a Department supervisor ordered approval of an application that failed the traditional CON review criteria. Then, when the Department's normal rules required reversal of the CON, its presiding officer changed the rules and applied a "criterion" that had never been disclosed, considered, or applied before.

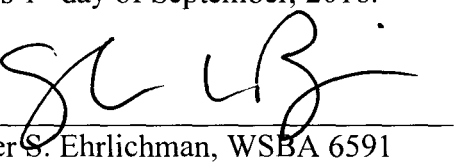
By affirming the decision resulting from this troubling process, the Court of Appeals sends a damaging and disheartening signal to CON

applicants and interested parties: agency review may be meaningless, and submission of materials may be for naught, because, if the Department has predetermined an outcome – certainly where UWMC is involved – it can and will break the rules to achieve that outcome without consequence. That is not, and cannot be, the law. This Court's review is appropriate in order to make clear that agency decisions must be made in ways that are fair and impartial, and have all indicia of the appearance of fairness.

VI. CONCLUSION

To achieve its desired result, the Department changed the rules it had always applied for CON applications, and in doing so it has damaged the CON review process itself. This is not a case in which a state agency has conducted a legitimate, lawful analysis entitled to deference. Instead, the Department simply invented an exception, contrary to law. By affirming the Department's grant of a CON to UWMC, the Court of Appeals has, unfortunately, taken a deeply flawed agency decision and given it precedential weight. The adverse effects of this ruling will be felt far beyond this case. Petitioners respectfully request that this Court grant review to address the important legal issues identified above, and to protect the Washington CON process from the deleterious consequences of the Department's unprecedented departure from the governing law and long-established policy and practice.

Respectfully submitted this 1st day of September, 2016.



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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:

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Dated this 1st day of September, 2016.

Erica Knerr

APPENDIX

A. Court of Appeals' Decision (July 5, 2016)

B. Denial of Reconsideration (August 2, 2016)

APPENDIX A

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

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, Appellants, v. DEPARTMENT OF HEALTH OF THE STATE OF WASHINGTON, Respondent, UNIVERSITY OF WASHINGTON MEDICAL CENTER, Intervenor.	No. 73454-7-I DIVISION ONE PUBLISHED OPINION FILED: July 5, 2016

APPELWICK, J. — UWMC applied for a certificate of need to add 79 acute care beds to its Seattle facility. The traditional numeric methodology did not demonstrate need. However, the Department's certificate of need program approved the application. The HLJ upheld this approval, reasoning that an alternative methodology, Criterion 2, showed a need for additional beds. This

appeal challenges the review officer's subsequent decision that it was proper to utilize Criterion 2 and that it was properly applied. We affirm.

BACKGROUND

The State Health Planning and Resources Development Act, chapter 70.38 RCW, regulates the number of healthcare providers in the market. Univ. of Wash. Med. Ctr. v. Dep't of Health, 164 Wn.2d 95, 99, 187 P.3d 243 (2008). Under this statutory scheme, providers may open certain healthcare facilities and programs only when the Washington State Department of Health (Department) issues a certificate of need (CN). Id. at 99-100. The CN program is intended to promote accessible health services while controlling costs. RCW 70.38.015.

When considering a CN application, the Department analyzes the need for the proposed project, the financial feasibility of the project, structure and process of care, and cost containment. 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).

FACTS

The University of Washington Medical Center (UWMC) is a tertiary and quaternary care[1] hospital located in Seattle. It is also the teaching hospital for the University of Washington (UW) School of Medicine. UWMC is part of the UW Medicine health system. This system also includes Harborview Medical Center, Northwest Hospital & Medical Center, Valley Medical Center, the UW School of

[1] "Tertiary care" is a level of medical care available only in larger medical institutions, involving specialized techniques and equipment. "Quaternary care" is an advanced level of tertiary care.

Medicine, UW Physicians, UW Neighborhood Clinics, and Airlift Northwest. UWMC is currently licensed for 450 beds, 360 of which are used for acute care.

In 2005, UWMC began planning to build a new patient care tower. The UW Board of Regents approved the Montlake Tower in 2007, and construction was complete in 2012. The last three stories of the eight story tower were shelled in for future expansion, but unfinished.

In November 2012, UWMC applied for a CN to add 79 additional acute care beds in the Montlake Tower. Its original estimated capital expenditure was $70,771,363. This amount was estimated to be the cost of completing the three floors that had already been shelled in for future expansion.

Over the next year, the Department thoroughly assessed UWMC's application. It requested supplemental information from UWMC. It held a public hearing on UWMC's application. And, it collected written statements from interested parties.

Robert Russell was the CN program analyst leading the evaluation. Russell applied the numeric methodology that the Department traditionally uses to calculate need for acute care beds. This methodology revealed that there was not enough projected need in the planning area to support UWMC's request for 79 additional beds. Because need is an integral CN requirement, Russell drafted an evaluation that denied UWMC's CN application.

Then, Bart Eggen, executive director of the office that manages the CN program, reviewed Russell's draft evaluation. Eggen did not look at UWMC's CN application. He did not review UWMC's responses to the Department's requests

for supplemental information. He did not review any of the public comments submitted in connection with UWMC's application. He did not review the financial analyst's memo to Russell concerning the costs of UWMC's proposed project. Instead, after reviewing only Russell's draft evaluation, Eggen ordered Russell to rewrite the evaluation, find that the need requirement was met, and grant UWMC the CN.

Russell complied. He revised the draft evaluation to conclude that while the numeric methodology did not show enough need to justify UWMC's project, the methodology inaccurately allocated bed need in the planning area. The evaluation did not cite other approaches to calculate bed need. Yet, due to Eggen's instructions, the Department found that UWMC's project met all of the CN criteria, including need. The Department issued the CN to UWMC.

Several of UWMC's competitors—Providence Health and Services, doing business as Providence Sacred Heart Medical Center and Providence Regional Medical Center Everett, and Swedish Health Services, doing business as Swedish Medical Center/First Hill (collectively "Providence")—opposed UWMC's application during the public comment period. In its written statements opposing the CN, Providence urged the Department to correctly apply the numeric methodology and find that UWMC's project did not satisfy the need requirement. Then, after the Department departed from this methodology in order to award the CN to UWMC, Providence again insisted that the Department should follow its own rules. It requested an adjudicative hearing to contest the CN. After requesting the hearing, Providence deposed Russell and Eggen. These depositions informed

Providence of the Department's initial review of UWMC's application and Eggen's direction to grant the CN.[2]

The adjudicative hearing was held in June 2014 before Health Law Judge Frank Lockhart. Both UWMC, as intervenor, and Providence called witnesses and presented exhibits. The HLJ used "Criterion 2" of the hospital bed need forecasting method contained in the Washington "State Health Plan" to determine that there was a need for the additional beds. See former RCW 70.38.919 (1989), repealed by LAWS OF 2007, ch. 259, § 67. He did so rather than relying on the traditional numeric methodology that is also found in the State Health Plan. The numeric methodology provides a formula to calculate bed need in the planning area, whereas Criterion 2 looks at whether other circumstances—such as accessibility to underserved groups, expansion of programs with better results, and promotion of training programs—indicate a need for additional beds. The HLJ relied on Criterion 2 because he believed that the numeric methodology did not accurately capture the need for additional acute care beds. The HLJ concluded that UWMC's project satisfied all of the CN requirements. On September 12, 2014, the HLJ entered findings of fact, conclusions of law, and an initial order approving UWMC's CN to add 79 acute care beds.

[2] The discovery of Eggen's role in the Department's evaluation likely energized an otherwise routine competitor dispute over bed allocation.

Providence sought administrative review of the HLJ's initial order. On January 26, 2015, the review officer adopted the findings of fact and conclusions of law from the initial order. And, the review officer entered a final order that affirmed the initial order.

Providence filed a petition for judicial review in King County Superior Court. The parties jointly requested an order certifying the petition for judicial review to this court. The trial court certified the matter to this court. The parties jointly filed a motion for discretionary review to this court. This court granted the motion.

DISCUSSION

The Washington Administrative Procedure Act (WAPA), chapter 34.05 RCW, governs this court's review of administrative actions. King County Pub. Hosp. Dist. No. 2 v. Dep't of Health, 178 Wn.2d 363, 371-72, 309 P.3d 416 (2013); RCW 34.05.570. We sit in the same position as the superior court, applying WAPA to the record before the agency. DaVita, Inc. v. Dep't of Health, 137 Wn. App. 174, 180, 151 P.3d 1095 (2007). The agency decision is presumed to be correct, and the challenger bears the burden of proof. RCW 34.05.570(1)(a); Overlake Hosp. Ass'n v. Dep't of Health, 170 Wn.2d 43, 49-50, 239 P.3d 1095 (2010).

Under WAPA, this court may grant relief only in limited circumstances. DaVita, 137 Wn. App. at 181. We may grant relief when the agency followed an unlawful procedure, erroneously interpreted or applied the law, or entered an order that is not supported by substantial evidence. RCW 34.95.570(3)(c), (d), (e). We review an agency's factual findings to determine whether they are supported by substantial evidence sufficient to persuade a fair-minded person of the stated

premise. DaVita, 137 Wn. App. at 181. This court overturns the agency's factual findings only if they are clearly erroneous, meaning that the entire record leaves us with the firm and definite conviction that a mistake was made. Univ. of Wash. Med. Ctr., 164 Wn.2d at 102. Under the error of law standard, this court may substitute its interpretation of the law for that of the agency, but the agency's interpretation is accorded substantial deference, particularly where the agency has special knowledge and expertise. Id. This court may also grant relief from an agency order that is arbitrary and capricious, meaning that it is the result of willful and unreasoning disregard of the facts and circumstances. RCW 34.05.570(3)(i); Overlake, 170 Wn.2d at 50.

Although Providence articulates strong concern over the Department's evaluation of UWMC's application, we do not review Eggen's or Russell's actions directly. Their decisions received an adjudicative hearing before the HLJ. And, when the HLJ affirmed the decision of the Department, a review officer then reviewed the matter and entered a final order upholding the CN. We review the correctness of this final administrative decision. DaVita, 137 Wn. App. at 181 (noting that this court reviews the Department's final order pertaining to a CN application).

I. Utilization of Criterion 2 to Determine Need

Providence argues that the HLJ's reliance on Criterion 2 was an unprecedented departure from the Department's consistent use of the numeric methodology. Providence asserts that the regulatory scheme does not allow the Department to use Criterion 2 to assess bed need. And, it contends that the

Department disclosed its reliance on Criterion 2 too late for Providence to participate meaningfully in the public comment process. As a result, Providence argues that the decision to use Criterion 2 of the State Health Plan to assess need for UWMC's proposal was an error of law, arbitrary and capricious, and unsupported by substantial evidence.[3]

Criterion 2 of the State Health Plan states,

> 2. CRITERION: 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 a 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 a wider range of important services, or whose programs have evidence of better results than do neighboring and comparable institutions; or

[3] Providence assigns error to findings of fact 1.6, 1.7, 1.11, and 1.12, which contain the HLJ's Criterion 2 analysis.

- 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.

Neither RCW 70.38.115 nor WAC 246-310-210 provide an exclusive, finite approach for determining a population's need for hospital beds. RCW 70.38.115(2) provides only that the Department must consider "[t]he need that the population served or to be served by such services has for such services." And, WAC 246-310-210 lists several factors on which a determination of need shall be based. The first factor is 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."[4] WAC 246-310-210(1).

The Department has traditionally relied on a 12 step numeric methodology contained in the State Health Plan to calculate the need for hospital beds. The 12 step methodology provides a formula for forecasting the aggregate need for hospital beds in a particular planning area. Its steps are separated into three elements: develop trend information on hospital utilization, calculate baseline non-psychiatric bed need forecasts, and determine total baseline hospital bed need

[4] This lack of definite standards for determining acute care bed needs stands in contrast to several other situations in which a facility must apply for a CN. For example, WAC 246-310-284 provides a concrete methodology to determine need for kidney dialysis stations, WAC 246-310-290(7) states the steps used to project the need for hospice services, and WAC 246-310-360 contains guidelines for calculating need for nursing home beds.

forecasts.[5] The State Health Plan remained effective until June 30, 1990. See former RCW 70.38.919 (1989) (LAWS OF 1989, 1st Ex. Sess., ch. 9, § 610), repealed by LAWS OF 2007, ch. 259, § 67. But, the Department continues to use this methodology.

Providence argues that the Department's consistent use of the numeric methodology means that the Department may not use other standards to determine bed need. To support this contention, Providence relies on language from the Department's prior administrative decisions.[6] In In re Certificate of Need Decision on Providence Sacred Heart Medical Center & Children's Hospital Proposal to Add 152 Acute Care Beds to Spokane County, No. M2009-1141 at 14-15 (Dep't of Health Aug. 9, 2011) ("Sacred Heart"), the Department explained that it relies on the numeric methodology because there is no statutory or regulatory process to calculate bed need. It recognized that both the CN program and applicants have used this methodology, and "[t]he predictability afforded by the consistent use of the State Health Plan methodology argues for its continued use." Id. at 15. But, it also noted, "This does not prohibit an applicant from submitting an alternative approach to show need exists." Id. The Department used similar language in In re the Certificate of Need Decision on Valley Medical Center's, Auburn Regional Medical Center's, and Multicare Health System's Application for

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[5] The numeric methodology uses population and healthcare use statistics on the statewide, health service area, and planning area level. The planning area involved here is the North King Planning area, which is comprised of select zip codes within King County.

[6] Although we are not bound by these decisions, we examine them to the extent they demonstrate the Department's prior bed need analyses.

Acute Care Beds in Southwest King County, No. M2011-253 (Dep't of Health Feb. 13, 2012) ("Valley"). The Valley decision also recognized the value in the consistent application of the methodology. Id. at 14. But, the Department acknowledged that, "[a]ny bed need methodology used should provide a predictable, transparent, and consistent process for applicants." Id. at 14 n.8. It clarified, "An applicant should know what is required to apply for a CN (transparency of process), how the program will apply the process (predictability of the process), and whether the program follows the process (consistency with the past process)." Id.

Neither of these cases requires that the Department apply only the 12 step methodology. Although the Department recognized the value of consistency and predictability, in both decisions it acknowledged the fact there may be other approaches to determine bed need. In Sacred Heart, the Department explicitly stated that applicants may submit alternative methods to show need. No. M2009-1141 at 15. And, Valley emphasized the importance of consistency and transparency in the CN review process—not that the 12 step methodology is the only means of determining bed need. No. M2011-253 at 14 n.8. Moreover, in neither case did the applicant request the Department to apply Criterion 2.

The recognition that there may be other methods of determining bed need is consistent with the statutory and regulatory scheme. WAC 246-310-200(2)(b), which outlines the criteria for a Department's review of a CN application, allows the Department to consider

> (i) Nationally recognized standards from professional organizations;
> (ii) Standards developed by professional organizations in Washington state;
> (iii) Federal [M]edicare 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; and
> (vi) The written findings and recommendations of individuals, groups, or organizations with recognized expertise related to a proposed undertaking, with whom the department consults during the review of an application.

And, RCW 70.38.115(5) recognizes that "[c]riteria adopted for review in accordance with subsection (2) of this section may vary according to the purpose for which the particular review is being conducted or the type of health service reviewed."

Utilizing standards other than the numeric methodology is not inconsistent with the Department's previous CN evaluations. The Department has previously acknowledged,[7] "The methodology is a flexible tool, capable of delivering meaningful results for a variety of applications, dependent upon variables such as referral patterns, age-specific needs for services, and the preferences of the users of hospital services, among others." Sacred Heart CN Evaluation at 8. In its

[7] The record contained a copy of the Department's evaluation of the CN in Sacred Heart (Sacred Heart CN Evaluation).

evaluation of Sacred Heart's proposal to add 152 acute care beds, the Department concluded that the methodology did not show a need for additional beds until well beyond the projection period. Id. at 16. But, the Department did not end its analysis there—it looked to whether there was evidence supporting Sacred Heart's claims of overcrowding, increased population growth within the community, and long waits before patients could be admitted. Id. Because it found that Sacred Heart had not demonstrated that there were no other facilities available to meet the need, and because the methodology did not indicate need, the Department found that the need criterion was not met. Id. at 17. Similarly, on reconsideration of Kennewick General Hospital's (KGH) application (KGH RCN) to add 34 beds, 30 of which would be acute care beds, the Department assessed external and internal factors affecting the need for additional beds at KGH, in addition to the numeric methodology. KGH RCN at 15. The Department concluded that even though the methodology did not show need for additional beds in the planning area until past the projection year, "patient utilization trends support a need for additional bed capacity at KGH, regardless of the number of beds already available in the planning area." Id.

Given the Department's previous history of relying on the numeric methodology but recognizing its limitations, we conclude that the Department's use of Criterion 2 here was not unprecedented, as Providence claims.

Providence contends that Criterion 2 of the State Health Plan is not a "standard" that WAC 246-310-200 allows the Department to consider. Instead, Providence characterizes Criterion 2 as legally ineffectual language from the State

Health Plan, which has been defunct for 25 years. But, if the fact that the State Health Plan no longer has any legal authority means that Criterion 2 is not a standard, then the 12 step methodology should not be considered a valid standard either. The methodology has not been enacted into law; rather, the Department has previously cited with approval to the State Health Plan when applying it. See Sacred Heart, No. M2009-1141 at 14; Valley, No. M2009-1141 at 14-15.

Criterion 2 recognizes that the numeric based methodology is not always the most effective means of evaluating bed need. It provides an alternative process through which the Department may assess bed need. Although the Department has not previously used Criterion 2, that alone does not preclude the Department from referring to it. Criterion 2 satisfies the language of WAC 246-310-200, as it is an applicable standard developed by a group with expertise in the field. And, by offering an alternative method of evaluating bed need, Criterion 2 is also in line with the purpose of the State Health Planning and Resources Development Act, which is to promote accessibility of health services. RCW 70.38.015.

Providence contends that even if Criterion 2 is a proper standard, the Department was required to disclose the standard before it evaluated UWMC's application. It cites to WAC 246-310-200(2)(c) in support of this proposition. That regulation provides,

> At the request of an applicant, the department shall identify the criteria and standards it will use prior to the submission and screening of a certificate of need application. . . . In the absence of an applicant's request under this subsection, the department shall

> identify the criteria and standards it will use during the screening of a certificate of need application.

WAC 246-310-200(2)(c).

Providence argues that it was not able to contribute meaningfully in the public comment process because the Department did not disclose that it would rely on Criterion 2. But, Providence had notice from the beginning that the Department might consider factors other than the numeric methodology to determine need. In its CN application, UWMC analyzed need using both the numeric methodology and Criterion 2. In the application, UWMC asserted that the numeric methodology understates the need for acute care beds. Accordingly, UWMC encouraged the Department to look at Criterion 2 as an alternative need analysis. UWMC also referred to Criterion 2 in response to the Department's request for supplemental information. Therefore, Providence had notice that the Department might consider Criterion 2 in evaluating UWMC's application.

The public comment period was not the only opportunity to challenge Criterion 2. When the Department issued its decision, Providence had no trouble determining that the numeric methodology would not support the decision. Given that UWMC had sought reliance on Criterion 2, Providence reasonably should have anticipated that was the basis for the Department's decision. Providence had an opportunity for discovery and for a hearing. It does not identify how it was unable to adequately challenge the use of the Criterion 2 methodology.

We conclude that it was not legal error to use Criterion 2 as a standard to assess bed need. And, findings of fact 1.6, 1.7, 1.11, and 1.12 relating to WAC 246-310-220 are not clearly erroneous.

II. Application of Criterion 2

Providence asserts that, even applying Criterion 2, the record does not support a finding of need for UWMC's project. It argues that the record does not contain the comparative data that Criterion 2 requires on factors such as greater training and skill, a wider range of important services, and programs with evidence of better results. And, Providence contends that the findings of fact concerning Criterion 2 are arbitrary and capricious and unsupported by substantial evidence.

The HLJ found that all three of the Criterion 2 standards were met in this case: UWMC's project would improve the accessibility of services for underserved groups; allow expansion of an institution with a wider range of services, programs with better results, and staff with greater training or skill; and facilitate expansion of a crowded institution with good cost, efficiency, or productivity. In support of this, the HLJ made several factual findings: 89 percent of UWMC's patient days come from outside the North King planning area; UWMC provides a higher percentage of care for tertiary and quaternary areas including cardiology, high risk pregnancy, oncology, and organ transplants than other providers in the state; 10 percent of UWMC's patient days come from persons who live outside the state; the population in the Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI) region is projected to grow 11 percent over the next decade; UWMC is at maximum effective capacity; many patients with complex medical needs in Washington and the WWAMI region will not have other treatment options available; UWMC provides the highest percentage of inpatient care to Medicaid recipients out of any King County hospital except its affiliated hospital, Harborview; and

UWMC also provides training to physicians as the WWAMI region's only teaching hospital.[8]

Here, there is evidence in the record supporting the finding that UWMC's project would improve the accessibility of services for underserved groups. The evidence shows that, compared to other hospitals in the North King County planning area, UWMC provides an above average percentage of charity care, meaning care to patients with little to no ability to pay for health care. In 2011, the UW Medicine system provided more than $300 million in uncompensated care. During that time frame, UWMC provided 23 percent of its care to Medicaid patients, and 7.5 percent to self-pay patients. This was at the high end of the range for providers in King County. There is also evidence in the record that many of the patients who are transferred to UWMC from other hospitals for complex care are uninsured or receiving Medicaid—including patients that are transferred from Providence's hospitals.

The record also supports the finding that UWMC's project would allow the expansion or maintenance of an institution with staff possessing greater training or skill, or a wider range of important services, or programs with evidence of better results than neighboring and comparable institutions. The record shows that UWMC has received numerous awards recognizing the quality of its acute care services. Since the *U.S. News & World Report* began ranking hospitals in 1990, UWMC has made its honor roll. And, in the latest rankings UWMC was ranked the number one hospital in Washington. UWMC's organ transplant programs have

[8] Finding of fact 1.8.

been nationally recognized. In 2010, UWMC received two silver awards from the Health Resources and Services Administration for outstanding transplant care in its kidney and liver transplant programs. It also received a bronze award for its kidney/pancreas transplant program. In 2012, UWMC received bronze awards for its heart, kidney, and liver transplant programs. UWMC's organ transplant programs have also been recognized by the Blue Cross and Blue Shield Association. In 2013, UWMC was awarded a Blue Distinction for its positive outcomes in lung, liver, and pancreas/kidney transplant programs.

There is also evidence showing that UWMC serves complex patients from across the WWAMI region, not just within the planning area. Its cardiac surgery service has the highest volume of heart transplant and mechanical assist procedures in the state. In 2012, UWMC performed 20 heart transplants, placed 58 left ventricular assist devices and seven total artificial hearts, and put one patient on extracorporeal life support. Of the most recent 99 patients, 12.1 percent were from out-of-state. At the UWMC Regional Heart Center, which treats complex cardiac patients, about half of the patients reside outside of King County, and 7 or 8 percent reside out-of-state.

UWMC is also the training hospital for the only allopathic medical school in the WWAMI region. There are 1,318 residents and fellows in training at UWMC. The school's accreditation depends on its students handling a minimum volume of cases. In many instances, these cases must occur at a single clinical site. And, the UW School of Medicine is nationally recognized for its research—the greater university is ranked the top public research institution in the country. Evidence

supports the finding that additional beds would help UWMC train new physicians and meet its research goals, which would benefit the wider WWAMI region.

The record further shows that neighboring and comparable institutions do not provide the same level of care as UWMC. The other hospitals within the planning area are either specialized, like Seattle Cancer Care Alliance, which is limited only to oncology, or general community based hospitals, like Swedish's Ballard hospital or Northwest Hospital. These hospitals are not capable of providing the complex care that UWMC provides. And, there is evidence that UWMC treats a higher percentage of patients in select quaternary areas, particularly cardiology, oncology, and organ transplants, than other providers in the state. Although Providence argues that UWMC has inaccurately represented its share of complex cases,[9] it conceded in public comments and at the adjudicative hearing that UWMC's total share of complex cases is higher than other providers, and that UWMC provides more organ transplants and oncology care than other providers in the state.

And, the evidence shows that UWMC is currently operating near its maximum effective capacity. During 2011, the average midnight occupancy rate[10] for UWMC's acute care beds was 78 percent. The Department generally treats a

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[9] Providence has continually argued that UWMC's data analysis misrepresents the percentage of its patients who receive complex care that is unavailable at other hospitals. It has contended that UWMC's comparison of cases and services is a "cherry-picked" group of complex cases, inflating UWMC's relative market share of these particularly complex cases. Providence asserts that when analyzing a complete group of complex cases in the state, UWMC's total share of the complex cases is only slightly higher than other providers.

[10] Midnight is the lowest census point of the day. The average midnight occupancy rate is also called the average daily census (ADC).

75 percent occupancy rate as the ideal point for the efficient provision of services—an occupancy rate above 75 percent begins to compromise access to health care and often justifies additional beds. When looking at only UWMC's ICU beds, the occupancy rate in 2012 was 84 percent for one unit and 92 percent for the other.

These high occupancy rates have resulted in UWMC having to turn away patients. The director of the UW Medicine Transfer Center testified that in 2011, UWMC had to deny transfers to around seven percent of patients because it had no available acute care beds. During the public comment period, numerous health care providers in the WWAMI region submitted letters explaining that patients who have needed to be transferred to the UWMC have been delayed in receiving treatment. And, they expressed concern that without additional acute care beds, UWMC would deny transfers to patients in need of specialized care.

And, the population UWMC serves—the WWAMI region—is expected to grow by over eleven percent in the next decade. Within that same population and time frame, the age range of 65 and over, a group that receives a disproportionate amount of acute inpatient hospital care, is projected to grow 36 percent.

It is not enough for Providence to show that there is some credible evidence to the contrary of the HLJ's findings. Univ. of Wash. Med. Ctr., 164 Wn.2d at 102. Instead, Providence must show that those findings were clearly erroneous—that the entire record leaves this court with the definite and firm conviction that the HLJ made a mistake. Id. We conclude that there is substantial evidence supporting findings of fact 1.8, 1.13, 1.14, and 1.15, which found that UWMC established need

under WAC 246-310-210. Therefore, we hold that the HLJ did not err in determining that UWMC met the need requirement.

III. Building Costs

Providence argues that UWMC's project fails the financial feasibility and cost containment criteria, because UWMC omitted $34 million in building costs from the application. It argues that, because these costs were not included in UWMC's application, the Department has not analyzed the true costs of UWMC's project. As a result, Providence claims that the HLJ's decision that the financial feasibility and cost containment criteria were met is legally erroneous.

Both the financial feasibility and cost containment criteria touch on a project's costs. WAC 246-310-220 lists three criteria on which a determination of financial feasibility shall be based: (1) whether the immediate and long range capital and operating costs can be met, (2) the cost of the project, including construction costs, will probably not result in an unreasonable impact on the cost of health services, and (3) the project can be appropriately financed. WAC 246-310-240 also lists three criteria on which a determination of cost containment shall be based: (1) superior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable,[11] (2) if a project involves construction, the costs, scope, and method of construction are reasonable and the project will not have an unreasonable impact on the costs to the public of providing health services, and (3) the project will involve appropriate improvements in the delivery of health services.

[11] See section V, infra.

In its CN application, UWMC stated that its estimated capital expenditure for the project was $70,771,363. It broke down its expenses into construction costs, fixed and moveable equipment, architect fees, consulting fees, taxes, financing, and CN fees. In reviewing the financial feasibility of the project, the Department relied on its own experience and expertise to determine if UWMC's pro forma income statements reasonably project that the proposal would meet its immediate and long range capital and operating costs by the end of the third year of operation. It noted that this project is part of a larger construction project, as the physical shell for the proposed beds was already constructed as part of the Montlake Tower project. After analyzing the cost of this project in relation to UWMC's assets, the Department concluded that the project would not adversely affect UWMC's financial health. The Department also concluded that the cost of the project would probably not result in an unreasonable impact on health care costs. And, it concluded that the project was appropriately financed. With regards to cost containment, the Department determined that based on its financial feasibility analysis, the criteria were met.

After the adjudicative hearing, the HLJ found that UWMC met the financial feasibility requirements, even though it did not include the $34 million that it spent to build the shell for the current project.[12] Responding to Providence's argument that this expense should have been included in the construction costs, the HLJ noted that UWMC was forthcoming about the relationship between the Montlake

[12] This decision is reflected in findings of fact 1.3, 1.4, 1.17, 1.18, 1.19, 1.20, 1.21, and 1.22.

Tower project and the current project. He found that UWMC disclosed or referenced the cost of the shell on three different occasions. First, in 2008, UWMC filed a request for a determination of non-reviewability with the Department in which it disclosed the cost of the shell. Second, in 2010, UWMC applied for a CN requesting approval for an expanded neonatal service, in which it included the expenses associated with the entire Montlake Tower project, including the shell. UWMC did not finance the shell—it paid for the shell in full using cash from UWMC's reserves. The shelled space then became an asset of UWMC, and its ownership has not diminished UWMC's ability to pay the capital and operating costs of the project. And, in UWMC's application for the CN at issue here, it stated that the physical shell for the proposed beds was already constructed as part of the Montlake Tower project. UWMC later clarified in response to the Department's questions, that it had already provided all of the expenses for the Montlake Tower project in the 2010 CN application.

From this, the HLJ concluded that it was not unreasonable for UWMC to assume that it did not have to include the shell costs in its capital expenditure budget for this project. Further, the HLJ pointed out that the crux of the financial feasibility requirement is the reasonableness of the financing, and including the shell costs in the capital expenditure costs would not have made the project unreasonably expensive.

Providence asserts that UWMC was legally required to include the shell costs, and the HLJ's contrary decision is legally erroneous. It cites to RCW 70.38.025(2) and WAC 246-310-010(10), both of which define capital expenditure.

Both definitions provide that a capital expenditure is an expenditure "which, under generally accepted accounting principles, is not properly chargeable as an expense of operation or maintenance." RCW 70.38.025(2); WAC 246-310-010(10). Providence claims that this definition indisputably establishes that all construction costs must be included in an applicant's capital expenditure estimate, and therefore UWMC's estimated capital expenditure was legally inaccurate. But, the shell was already paid for. No new construction of the shell was contemplated. No financing for shell construction was needed; no debt repayment was identified. Therefore, no negative impacts of construction costs or financing of the shell existed nor needed to be evaluated under WAC 246-310-220 and 240.

We conclude that findings of fact 1.17, 1.18, 1.19, 1.20, 1.21, 1.22, 1.30, 1.31, and 1.32 are not clearly erroneous. Therefore, the conclusion that UWMC's application satisfied the financial feasibility and cost containment criteria was not legally erroneous or arbitrary and capricious.

IV. Superior Alternatives

Providence also argues that UWMC has not met the superior alternative prong of the cost containment requirement. Providence alleges that a superior alternative to this project would be to transfer less complex services from UWMC to its affiliated hospital, Northwest.

As discussed above, WAC 246-310-240 contains three criteria that must be assessed to determine whether a proposed project will foster cost containment. One of these factors is if "[s]uperior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable." WAC 246-310-240(1).

But, the record supports the finding that Providence's proposed superior alternative would not be feasible. UWMC has already transferred less complex service lines to Northwest, including hip and knee replacement surgeries, hernia surgery, midwifery, and its multiple sclerosis center. And, UWMC considered shifting additional acute inpatient programs to Northwest as an alternative to the current proposal. But, it determined that this alternative would require significant investments—it would require the duplication of expensive equipment, as well as the need for additional staff with the specialized training and knowledge base of its UWMC staff. UWMC reasoned that because its staff largely support the entire hospital, rather than a single unit, transferring patient lines to Northwest would not eliminate staff or equipment from UWMC.

Northwest's director, Cynthia Hecker, testified that as a community-based facility, Northwest delivers secondary and low end tertiary care. As such, she explained that Northwest does not have the staffing expertise or equipment necessary to provide the high end care available at UWMC.

In arguing that shifting services to Northwest would be a superior alternative, Providence relies on a comparison of DRGs[13] to suggest that Northwest provides "virtually all of the services offered by UWMC." Providence points to the testimony of its expert, Dr. Frank Fox, who explained that he looked at the DRGs that occurred at both UWMC and Northwest and compared the lengths of stay for those DRGs. He concluded that when the DRGs and the lengths

[13] DRGs are Diagnostic Related Groups, which is a common system of labeling hospital cases.

of stay were the same, the care delivery in terms of resource consumption would be roughly the same. Dr. Fox's data showed that 91.5 percent of the DRG cases he analyzed are also observed at Northwest.

But, Providence did not produce any evidence to show that Northwest has the staff or equipment necessary to duplicate additional inpatient lines. Nor did it show that Northwest has the capacity to accommodate the transfer of additional patient lines. Hecker testified that Northwest currently has a 60 percent occupancy rate during any given 24 hour period, but it usually reaches 100 percent occupied during the middle of the week when patients come in for and recover from elective procedures. Jody Carona, the principal with Health Facilities Planning & Development, testified that if Northwest were to meet its target occupancy rate, its available ADC would be 15.8. She explained that this is the only room for growth available at Northwest. Yet, UWMC would have to relocate patient services lines amounting to an ADC of 50 by 2015-2016 in order to avoid the need for the proposed bed expansion. Thus, Northwest currently does not have the ability to take on additional patient lines from UWMC such that would make it the superior alternative here.

From this evidence, we hold that finding of fact 1.29, which found that UWMC satisfied the superior alternative requirement, was not clearly erroneous.

V. Structure and Process of Care

Providence argues that UWMC has not met the structure and process of care requirement, because it has not shown that its project will not result in an unwarranted fragmentation of services. Providence asserts that, without a finding

of numeric need for additional beds, UWMC's project cannot meet the requirement that its project will not result in fragmentation of services. And, it contends that the HLJ's finding 1.25, that UWMC's project would not create a surplus of the type of beds that the beds will be used for, is unsupported by the record.[14]

WAC 246-310-230 sets out criteria for determining that a project fosters an acceptable or improved quality of health care. These criteria include that "[t]he 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." WAC 246-310-230(4).

But, as discussed above, UWMC presented evidence that its tertiary and quaternary services are not available at other hospitals in the planning area.[15] Northwest Hospital does not have the equipment or staff to provide this level of care. Swedish's Ballard facility is also a community-based hospital that does not provide tertiary services. This evidence suggests that adding 79 acute care beds at UWMC would promote the continuity of health care, rather than result in fragmentation of services. Instead of duplicating services that are already available in the planning area, UWMC's project will fill an existing need.

Therefore, Providence has not shown that the HLJ erred in finding that UWMC's project will not cause an unwarranted fragmentation of services. We conclude that findings of fact 1.25 and 1.26 are not clearly erroneous.

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[14] Providence also challenges finding of fact 1.26, which determined that UWMC's project satisfies WAC 246-310-330's structure and process of care requirement.

[15] See section III, supra.

VI. 2012 CHARS Data

Providence also asserts that the HLJ erroneously decided to exclude 2012 CHARS (Comprehensive Hospital Abstract Reporting System) data, the most current data available. And, Providence contends that it was materially prejudiced by this decision.

The HLJ decided that he would not consider 2012 CHARS data. But, he did not exclude the UWMC's annualized 2012 projections, instead deciding to treat them as having the same inherent flaws as any projection has. The HLJ determined that new data that comes in after the public comment period, too late for the parties to incorporate it into the application, or too late for the Department to integrate it into its evaluation should generally be excluded from the CN decision.

The review officer concluded that the HLJ's decision to exclude this data was supported by law and by the facts of this case. And, the review officer noted that while the 2012 CHARS data would have been more correct than the 2012 projections, it was not so different as to suggest a different outcome.

This court reviews the health law judge's evidentiary rulings for an abuse of discretion. Univ. of Wash. Med. Ctr., 164 Wn.2d at 104. The HLJ has discretion to decide to admit or not admit evidence that came into existence after the public comment period had closed. Id.

Here, the public comment period closed on May 15, 2013. Afterward, both UWMC and Providence submitted rebuttals to the public comments. The last round of rebuttals were due on July 11, 2013. UWMC did not receive the 2012

CHARS data until July 10, 2013. As such, this data was not available until after the close of the public comment period. Neither UWMC nor Providence included the 2012 CHARS data in any of their materials submitted to the Department. And, the Department did not utilize the 2012 CHARS data in evaluating UWMC's application. Based on these facts, the HLJ did not abuse his discretion by excluding 2012 CHARS data from his review.

Providence claims that the HLJ's decisions regarding 2012 CHARS data were prejudicial, because UWMC was permitted to use annualized 2012 data, which Providence would have been able to rebut if the HLJ admitted the 2012 CHARS data. However, the HLJ specifically stated that he was taking UWMC's annualized 2012 data as argumentative, rather than factual. He assured Providence that he would filter out information that is simply argument, and that he would view the projections as "less reliable." There is no evidence that the HLJ gave these projections more weight than was appropriate. Instead, the HLJ relied on the 2011 CHARS data and Providence's own concessions in making his findings on the most hotly contested issue, bed need. Providence has not shown that the annualized 2012 data affected the HLJ's decision.

We affirm.

WE CONCUR:

APPENDIX B

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION ONE

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, Appellants, v. DEPARTMENT OF HEALTH OF THE STATE OF WASHINGTON, Respondent, UNIVERSITY OF WASHINGTON MEDICAL CENTER, Intervenor.	No. 73454-7-I ORDER DENYING MOTION FOR RECONSIDERATION

The respondent, Department of Health, having filed its motion for reconsideration herein, and a majority of the panel having determined that the motion should be denied;

Now, therefore, it is hereby

ORDERED that the motion for reconsideration is denied.

DATED this 2nd day of August, 2016.

Appelwick J
Judge