

RECEIVED
SUPREME COURT
STATE OF WASHINGTON

2001 NOV -5 P 4:03

BY RONALD R. CARPENTER

CLERK

No. 80264-5

(Thurston County Superior Court No. 04-2-01506-2)

IN THE SUPREME COURT
OF THE STATE OF WASHINGTON

UNIVERSITY OF WASHINGTON MEDICAL CENTER,

Respondent,

vs.

WASHINGTON STATE DEPARTMENT OF HEALTH

and

SWEDISH MEDICAL CENTER,

Appellants

SWEDISH'S OPENING BRIEF

DORSEY & WHITNEY LLP
Peter S. Ehrlichman, WSBA #6591
Brian W. Grimm, WSBA #29619

U.S. Bank Centre
1420 Fifth Avenue, Suite 3400
Seattle, Washington 98101
Telephone: (206) 903-8800
Facsimile: (206) 903-8820

Attorneys for Appellant,
Swedish Health Services
d/b/a Swedish Medical Center

TABLE OF CONTENTS

I. INTRODUCTION 1

II. ASSIGNMENT OF ERROR..... 3

III. ISSUES PERTAINING TO ASSIGNMENT OF ERROR 3

IV. STATEMENT OF THE CASE 4

 A. THE UNIVERSITY OF WASHINGTON OPERATES THE ONLY LIVER TRANSPLANT PROGRAM IN WASHINGTON. 4

 B. SWEDISH APPLIES FOR A CERTIFICATE OF NEED TO ESTABLISH A SECOND LIVER TRANSPLANT PROGRAM. 5

 C. THE DEPARTMENT OF HEALTH, THROUGH ITS CERTIFICATE OF NEED PROGRAM, ISSUES A CERTIFICATE OF NEED TO SWEDISH..... 6

 D. THE DEPARTMENT OF HEALTH, THROUGH THE HEALTH LAW JUDGE, AFFIRMS ITS DECISION. 7

 E. THE SUPERIOR COURT REVOKES SWEDISH’S CERTIFICATE OF NEED..... 9

 F. SWEDISH SEEKS REVIEW BY THE SUPREME COURT. 10

V. ARGUMENT..... 10

 A. THE DEPARTMENT OF HEALTH’S DECISION TO GRANT SWEDISH A CERTIFICATE OF NEED TO ESTABLISH A LIVER TRANSPLANT PROGRAM WAS SUPPORTED BY SUBSTANTIAL EVIDENCE. 10

 1. This Court Reviews The HLJ’s Decision Under A Substantial Evidence Standard Of Review. 10

 2. The HLJ’s Determination That Swedish’s Application Satisfied The Need Criteria Was Supported By Substantial Evidence..... 12

 3. Having Two Liver Transplant Programs In An Area Improves Both Programs Through “Collegial Competition.” 21

4. Swedish And The Department Adequately Addressed The Potential Impact Of Swedish's Program On The UW's Program.....	22
B. THE HLJ'S DETERMINATION THAT SWEDISH'S PROGRAM WOULD NOT ADVERSELY IMPACT THE UW'S PROGRAM WAS SUPPORTED BY SUBSTANTIAL EVIDENCE.	25
C. THE HEALTH LAW JUDGE'S EVIDENTIARY RULING WAS NOT AN ABUSE OF DISCRETION.	30
1. This Court Reviews The HLJ's Evidentiary Ruling For An Abuse Of Discretion.	30
2. The HLJ Properly Limited Evidence To The Relevant Timeframe.	30
3. The Department Must Be Permitted To Close The Record On A Certificate of Need Application.	32
4. The HLJ Property Determined That Post-2003 Evidence Was Irrelevant And Immaterial To The Issue Before Her.	33
5. Even If The HLJ's Decision Was Error, It Was Harmless Error.....	34
6. At Minimum, This Case Should Be Remanded To The HLJ.	35
VI. CONCLUSION	36

TABLE OF AUTHORITIES

CASES

<u>Callecod v. Washington State Patrol,</u> 84 Wn. App. 663, 929 P.2d 510 (1997)	11, 12
<u>City of Univ. Place v. McGuire,</u> 144 Wn.2d 640, 30 P.3d 453 (2001)	11
<u>King County v. Central Puget Sound Growth Management Hearings Board,</u> 142 Wn.2d 543, 14 P.3d 133 (2000)	11
<u>Moreman v. Butcher,</u> 126 Wn.2d 36, 891 P.2d 725 (1995)	30
<u>Old Dominion Electric Cooperative v. Virginia Electric & Power Co.,</u> 237 Va. 385, 377 S.E.2d 422 (1989)	32, 33
<u>Port of Seattle v. Pollution Control Hearings Board,</u> 151 Wn.2d 568, 90 P.3d 659 (2004)	30
<u>Premera v. Kreidler,</u> 133 Wn. App. 23, 131 P.3d 930 (2006)	12
<u>T.S. v. Boy Scouts of America,</u> 157 Wn.2d 416, 138 P.3d 1053 (2006)	30
<u>U.S. West Communications, Inc. v. Washington Utilities & Transportation Commission,</u> 134 Wn.2d 48, 949 P.2d 1321 (1997)	32
<u>Washington Irrigation & Development Co. v. United States,</u> 110 Wn.2d 288, 51 P.2d 1178 (1988)	35

STATUTES

RCW 34.05.449	8, 35
RCW 34.05.461	8, 36
RCW 70.38.105	5
RCW 70.38.115	27

REGULATIONS

WAC 246-10-102	8
WAC 246-310-010	6
WAC 246-310-020	5
WAC 246-310-090	7
WAC 246-310-200	8, 36
WAC 246-310-210	7, 13, 22, 27
WAC 246-310-220	7, 26
WAC 246-310-230	7, 24, 25, 26
WAC 246-310-240	7, 26
WAC 246-310-490	8

I. INTRODUCTION

The State of Washington has only one liver transplant program, at the University of Washington Medical Center (the "UW"). Indeed, the UW runs the only liver transplant program in the entire "WWAMI" region (Washington, Wyoming, Alaska, Montana, and Idaho), which contains 8.8 million residents. No other population this large anywhere in the country is served by only one liver transplant program. If a Washington resident in need of a liver transplant is unable to obtain one at the UW because, for example, she is not considered a suitable transplant candidate under the UW's criteria, she is unable to obtain this life-saving procedure anywhere else in the state.

Swedish Health Services ("Swedish") and the Washington State Department of Health (the "Department") attempted to remedy this situation. Swedish applied for a Certificate of Need ("CN") to establish a second liver transplant program in Washington, at Swedish's First Hill campus in downtown Seattle. The Department granted Swedish's application and issued a CN to Swedish on June 30, 2004. The Department determined that Swedish's proposed program is needed, will not adversely impact the UW's existing program, and may save the lives of those Washington residents unable to obtain transplants at the UW.

The Department's decision was opposed by the UW, which sought to maintain its status as the exclusive provider of this service in Washington. Following extensive evidentiary hearings, however, and careful consideration of the UW's arguments in opposition to Swedish's

program, the Department's decision approving Swedish's application was affirmed by the Department's Health Law Judge, the Honorable Zimmie Caner (the "HLJ"), in decisions dated August 23, 2005, and August 16, 2006.

In reliance on the Department's decision, and consistent with its obligation under WAC 246-310-580(1) to commence its liver transplant program no later than October 25, 2007, Swedish hired highly specialized medical staff, including a renowned transplant hepatologist from the University of Southern California, spent hundreds of thousands of dollars on equipment for the program, devoted thousands of hours of staff time to planning and training, and undertook the other activities necessary to establish a liver transplant program on a timely basis.

On May 11, 2007, only five months before Swedish's program was scheduled to commence, in the judicial review of the Department's decision commenced by the UW, the Honorable Gary R. Tabor, Thurston County Superior Court, ordered that Swedish's CN should be revoked. The Superior Court did so by setting a new evidentiary standard to be applied in administrative reviews of the Department's CN decisions, and determining that the evidentiary standard applied by the HLJ in this case was an abuse of discretion under this new standard. Essentially, the Superior Court ruled that the Department may not "close" the record on a CN application on a predetermined deadline, which the Department historically has done to allow for a period of deliberation and decision-making, but instead must allow affected parties to continue to "update" the

record during adjudicative review of a CN decision, and to allow them to seek revocation of a CN based on changed circumstances after it is issued.

Notably, the Superior Court did not consider what the evidence excluded by the HLJ would have been in this case. Nor did the Superior Court consider whether this evidence would have had any impact on whether Swedish's application should be approved. Nor did the Superior Court remand for the HLJ to admit and consider the excluded evidence. Instead, the Superior Court simply ordered that Swedish's CN would be revoked, and the UW would remain the exclusive provider of this service in Washington.

Washington residents have therefore been deprived of a second liver transplant program, which the Department repeatedly has said is needed and will save lives. Swedish respectfully requests that this Court reverse the Superior Court's order and reinstate the Department's decision granting Swedish a CN.

II. ASSIGNMENT OF ERROR

The Superior Court erred by reversing the Department of Health's decision to award a Certificate of Need to Swedish to establish a liver transplant program.

III. ISSUES PERTAINING TO ASSIGNMENT OF ERROR

1. Whether the HLJ's determination that Swedish's application satisfied all CN criteria was supported by substantial evidence.
2. Whether Swedish and the Department adequately addressed the potential impact of Swedish's program on the UW's existing program.

3. Whether the HLJ abused her discretion by limiting the evidence presented to the relevant timeframe.

4. If the HLJ's decision limiting evidence was error, whether this error was harmless.

5. If the HLJ's decision limiting evidence was error, and this error was not harmless, whether this matter should be remanded to the HLJ to consider additional evidence.

IV. STATEMENT OF THE CASE

A. The University Of Washington Operates The Only Liver Transplant Program In Washington.

The UW operates the only adult liver transplant program in Washington. AR 1029.¹ Indeed, the UW operates the only program in the entire "WWAMI" region, which includes Washington, Wyoming, Alaska, Montana, and Idaho. AR 1343. The WWAMI region has more than 8.8 million residents. Id. No other population this large anywhere in the country is served by a single liver transplant program. Id.

Washington's reliance on a single liver transplant provider is particularly surprising when compared to other areas with similarly sized

¹ Swedish will cite to the record in this case as follows. Swedish will use "CP" to refer to the 1,157-page record in the judicial review proceeding in Thurston County Superior Court, designated by Swedish in its July 6, 2007 designation of clerk's papers and by the Department in its October 9, 2007 supplemental designation of clerk's papers; "AR" to refer to the 4,127-page administrative record in the original adjudicative proceeding; "AR (Remand)" to refer to the 2,124-page administrative record in the remand adjudicative proceeding; and "RP (13 April 2007)," "RP (11 May 2007)," and "RP (18 May 2007)" to refer to the verbatim reports of proceedings of the three oral arguments in the Superior Court. For ease of reference, Swedish has included key portions of the record in its Appendix, and provided parallel citations to the Appendix throughout this brief.

populations. For example, the San Francisco Bay Area has roughly the same population as Washington, but has three major liver transplant centers, at the University of California at San Francisco, California Pacific Medical Center, and Stanford University Medical Center. AR 1657 (Appendix, Ex. F).

B. Swedish Applies For A Certificate Of Need To Establish A Second Liver Transplant Program.

In order to provide Washington residents with a second liver transplant program, Swedish applied for a CN to establish one at its First Hill campus in downtown Seattle. AR 1027 et. seq. A CN is required before a provider may establish a tertiary service such as a liver transplant program. RCW 70.38.105(4)(f); WAC 246-310-020(1)(d)(i)(D). Swedish anticipated approximately six months of pre-operational start up activities, including staff recruitment, education, training, program development, and preparation of policies and procedures. AR 1041. Assuming a CN would be issued in 2003, Swedish projected it would perform six liver transplants in 2004, eighteen in 2005, thirty-two in 2006, forty-two in 2007, and forty-six in 2008. AR 1048.

Swedish's liver transplant program would operate as a complementary element of Swedish's existing Organ Transplant Program, which has been in operation for many years. AR 1042. Swedish already provides kidney and pancreas transplants, and a liver transplant program would complete Swedish's continuum of care for abdominal transplantation. Id. Swedish's program would add other new services to

Swedish's existing tertiary and outpatient health services, such as hepatology, nursing coordination, anesthesia, and staff training and subspecialty expertise needed for liver transplants. Id.

Swedish's program would increase both access to liver transplants and the number of transplants performed in Washington. AR 1656, 1663 (Appendix, Ex. F). In addition, by "competing" with the UW, Swedish's program would elevate innovation and the practice of liver transplantation in Washington. AR 1663 (Appendix, Ex. F).

C. The Department Of Health, Through Its Certificate Of Need Program, Issues A Certificate Of Need To Swedish.

Swedish submitted a CN application to establish a new liver transplant program on June 9, 2003. AR 1027 et. seq. On July 30, 2003, the UW requested "affected party" status, and also asked that a public hearing be held on Swedish's application. AR 1824. The public comment period for Swedish's application, or the time during which the Department's Certificate of Need Program (the "Program") accepts comments on a CN application, began on September 17, 2003. AR 1327. During the public comment period, the UW submitted more than two hundred pages of material in opposition to Swedish's application. AR 1406-1564, 1573-1627. The UW also presented oral and written testimony, and questioned witnesses testifying in favor of Swedish's proposed liver transplant program. AR 3036-3120.

Following the public hearing, both Swedish and the UW were given ten working days to submit rebuttal statements. AR 1333. Both

Swedish and the UW submitted rebuttal statements on November 24, 2003. AR 1573 et. seq.; AR 1628 et. seq. (Appendix, Ex. F). Upon receipt of the parties' rebuttal materials, and because none of the circumstances permitting an extension of the period for public comment were present, the Program closed the period for public comment on November 24, 2003. See WAC 246-310-090(1)(a)(iii).

After reviewing the information submitted by all parties, the Program determined that Swedish's application met all CN criteria. Specifically, the Program determined that Swedish's application met the Need criteria of WAC 246-310-210, the Financial Feasibility criteria of WAC 246-310-220, the Structure and Process of Care criteria of WAC 246-310-230, and the Cost Containment criteria of WAC 246-310-240. The Program's written analysis addressed the accessibility of the UW's liver transplant program to Washington residents, and also determined that Swedish's program would not adversely impact the UW's existing program. AR 1801-1805, 1810 (Appendix, Ex. D). On June 30, 2004, the Department issued a CN to Swedish. AR 1814 (Appendix, Ex. D).

D. The Department of Health, Through The Health Law Judge, Affirms Its Decision.

The UW sought administrative review of the Department's decision, in an adjudicative proceeding before the HLJ. During a CN adjudicative proceeding, the HLJ takes and evaluates evidence, listens to argument, and issues findings of fact and conclusions of law. RCW 34.05.449(2); RCW 34.05.461(4). She is authorized by the Secretary of

Health to make final decisions and issue final orders on CN applications. WAC 246-10-102. The role of the HLJ is to determine whether the Department's decision issuing the CN was correct. WAC 246-310-200; WAC 246-310-490. A five-day adjudicative hearing was held before HLJ Caner between January 25, 2005 and February 4, 2005. AR 995 (Appendix, Ex. C). During the hearing, the HLJ heard testimony from fourteen witnesses, including eight called by the UW. Id. Both sides presented several expert witnesses. Id.

Following the adjudicative hearing, the HLJ determined that Swedish's application satisfied all CN criteria. AR 994 et. seq. (Appendix, Ex. C). The HLJ also determined that Swedish's proposed program would not adversely affect the UW's program. AR 1007-1009 (Appendix, Ex. C). On August 23, 2005, the HLJ issued a final order affirming Swedish's CN. AR 994 et. seq. (Appendix, Ex. C).

The UW sought judicial review of the HLJ's decision, in Thurston County Superior Court. The UW contended that it had not been given an opportunity to respond to the November 24, 2003 rebuttal statement submitted by Swedish following the public hearing. On January 13, 2006, the Superior Court granted the UW's request to remand to the HLJ to take additional evidence. AR (Remand) 1-2.

The remand hearing was held before the HLJ on June 6, 2006. AR (Remand) 1917 et. seq. The HLJ limited evidence at the remand hearing "to that which existed as of December 31, 2003, which is approximately one month after [the] [P]rogram closed the record." AR (Remand) 288

(Appendix, Ex. E). Both Swedish and the Program actually had asked the HLJ to adhere more strictly to the date the record closed. AR (Remand) 88, 146. However, the HLJ gave the UW the benefit of a December 31 cutoff date.

Although the hearing was scheduled to last three days, the UW rested after less than a day of testimony. In fact, the UW did not present any substantive testimony during the remand hearing. Swedish observed at the time that the UW could have offered a wide range of additional evidence if it had wished to do so, but that the UW simply declined to put on a case. AR (Remand) 1618-23. The HLJ herself expressed surprise that the UW chose not to put on any substantive evidence. AR (Remand) 2093, 2100. Following the remand hearing, the HLJ issued a final order, again affirming the Department's issuance of Swedish's CN. AR (Remand) 1906 et. seq. (Appendix, Ex. B).²

E. The Superior Court Revokes Swedish's Certificate Of Need.

The UW again sought judicial review in Thurston County Superior Court. On May 11, 2007, the Superior Court reversed the Department's decision awarding Swedish a CN, on two grounds. First, the Superior Court determined that the HLJ erred by limiting evidence in the

² The UW also moved, during the remand hearing, for the HLJ to disqualify herself. The UW claimed in the Superior Court judicial review, without any basis, that the HLJ had "a bias" against the UW. CP 445. The UW also claimed that the HLJ did not conduct "a fair, impartial, lawful hearing[.]" Id. The Attorney General accurately described the UW's position as "frivolous." AR (Remand) 1975. The Superior Court rejected the UW's argument that the HLJ was biased, noting that "simply because someone rules in a way that a party doesn't agree with doesn't mean that that person is disqualified or prejudiced, and the request for disqualification was not . . . well taken[.]" CP 969 (Appendix, Ex. A).

adjudicative proceeding to that which existed as of December 31, 2003. Second, the Superior Court determined, in the alternative, that Swedish did not adequately address the potential impact of its program on the UW's training programs. CP 961-70 (Appendix, Ex. A). The Superior Court stayed the effect of its ruling pending appeal, upon the posting of a bond by Swedish. As a result, Swedish's CN remains in effect, but Swedish is stayed from actually commencing its program. CP 971-72 (Appendix, Ex. A).³

F. Swedish Seeks Review By The Supreme Court.

On June 8, 2007, Swedish timely appealed the Superior Court's decision. CP 958-59. Swedish has asked this Court to grant direct review under RAP 4.2(a)(4) (public import) and RAP 4.2(a)(1) (authorized by statute). See Swedish Medical Center's Statement of Grounds for Direct Review (filed June 22, 2007).

V. ARGUMENT

A. The Department Of Health's Decision To Grant Swedish A Certificate Of Need To Establish A Liver Transplant Program Was Supported By Substantial Evidence.

1. This Court Reviews The HLJ's Decision Under A Substantial Evidence Standard Of Review.

"On appeal, this Court reviews the [agency's] decision, not the decision of the superior court." King County v. Central Puget Sound

³ The UW argued in the Superior Court that the two-year validity period, during which a CN holder must commence the service or else lose its CN, continued to run on Swedish's CN while Swedish was stayed, by court order, from commencing its program. CP 1019 et. seq. The Superior Court denied UW's motion. CP 1158.

Growth Mgmt. Hearings Bd., 142 Wn.2d 543, 553, 14 P.3d 133 (2000). This Court “appl[ies] the standards of RCW 34.05 directly to the record before the agency, sitting in the same position as the superior court.” Id. “The burden of demonstrating that the . . . [agency’s] order is not supported by substantial evidence, remains on the party asserting the error” – in this case, on the UW. Id.

Under the substantial evidence standard of review, a decision “must be supported by a sufficient quantity of evidence to persuade a fair minded person of the truth or correctness of the [agency] order.” Callecod v. Wash. State Patrol, 84 Wn. App. 663, 673, 929 P.2d 510 (1997). However, the substantial evidence test does not require that the reviewing court, like a fair-minded person, be persuaded of the truth or correctness of an order. Instead, the question “is whether any fair-minded person could have ruled as the [agency] . . . did after considering all of the evidence. . . . it does not matter that a reviewing court would likely have ruled differently had it been the trier of fact.” Id. at 676 fn. 9 (emphasis original). Furthermore, evidence must be viewed “in the light most favorable to . . . ‘the party who prevailed in the highest forum that exercised fact-finding authority” – in this case, in the light most favorable to Swedish. City of Univ. Place v. McGuire, 144 Wn.2d 640, 652, 30 P.3d 453 (2001).

When an agency is presented “with conflicting expert opinion on an issue, it is the agency’s job, and not the job of the reviewing appellate body, to resolve those differences.” Premera v. Kreidler, 133 Wn. App.

23, 52, 131 P.3d 930 (2006). The agency's assessment of witness credibility prevails. Id. Indeed, the substantial evidence standard of review "does not permit [a reviewing court] to substitute [its] judgment for that of the [agency] on the credibility of witnesses or the weight to be given to conflicting evidence." Callegod, 84 Wn. App. at 676, fn. 9.

2. The HLJ's Determination That Swedish's Application Satisfied The Need Criteria Was Supported By Substantial Evidence.

In order to grant a CN, the Department must find that the population to be served has a need for the project and that other services and facilities of the type proposed are not sufficiently available or accessible to meet that need. WAC 246-310-210(1). To establish need, Swedish provided a comparison between national and local liver transplant statistics, disease and mortality statistics, liver transplant waiting list length statistics, liver export rate statistics, and waiting list characteristics statistics. Taken together, this information established that Washington residents are underserved by having only one adult liver transplant facility.

a. The UW Performs Too Few Transplants.

Despite the large area the UW serves, the UW performs far fewer transplants than would be expected based on national transplant rates. The United Network of Organ Sharing ("UNOS") releases liver transplant figures for the nation based on population. AR 1047. Based on the national transplant rates, one would expect for one hundred eleven Washington residents to have received liver transplants in 2001. AR

1048. However, in 2001, only seventy-three Washington residents received liver transplants at either the UW (sixty-five adult patients) or Children's Hospital ("Children's") (eight pediatric patients). AR 1090. Accordingly, in 2001, there were thirty-eight Washington residents whom one would have expected to receive transplants, but are not accounted for at the UW or Children's. Id.

One possible explanation for the whereabouts of these missing thirty-eight liver transplant candidates is that they received transplants at hospitals located in other states. However, data gathered by the Organ Procurement and Transplantation Network ("OPTN") shows that, in 2001, only ten Washington residents received transplants at out-of-state liver transplant programs. AR 1970-71. Therefore, in 2001, there were twenty-eight Washington residents one would have expected to receive liver transplants, but who did not receive such transplants. This accounts for one-fourth of the expected number of liver transplants for Washington residents.

**b. The Incidence Of Chronic Liver Disease
In Washington Confirms That The UW
Performs Too Few Transplants.**

The difference between the number of expected transplants, based on national liver transplant rates, and the number of actual transplants at the UW, could be explained if the rate of chronic liver disease were lower in Washington than in the rest of the United States. However, data from the Centers for Disease Control ("CDC") shows that Washington death rates for liver disease actually exceed the national average. AR 1634

(Appendix, Ex. F). Thus, although the UW provides significantly fewer transplants than would be expected, Washington residents are not healthier than residents in other states with respect to mortality from liver disease. Id.

c. The UW's Waiting List Is Too Short.

The length of the UW's waiting list also demonstrates that Washington residents are underserved. Shorter waiting lists indicate that few patients have been deemed "eligible candidates" by their transplant institution. AR 1647 (Appendix, Ex. F). UNOS data shows that, in 2003, the liver transplant waiting list rate for the United States as a whole was fifty-nine persons per million residents. Id. As Washington's 2003 population was approximately six million residents, it would be expected that three hundred fifty-four persons would be on the UW's waiting list in 2003. Id. Because mortality associated with liver disease in Washington is comparable to other states, and is actually above the national average, it is reasonable to estimate the expected size of the UW's transplant waiting list using the national rate. Id. However, in stark contrast to the expected waiting list projection of three hundred fifty-four, the UW's waiting list in 2003 was comprised of only one hundred twenty-seven persons, only one-third of the expected level. Id.

The significant disparity between the expected waiting list size and the UW's actual waiting list is too large to be based on random chance. That the UW's waiting list in 2003 represented more than two hundred twenty-five fewer residents than would be expected based on national

rates is particularly striking when considering that Washington, unlike many other states, has only one adult liver transplant provider, and that this provider serves not only Washington residents, but also residents of Wyoming, Alaska, Montana and Idaho.

d. The UW's Waiting List Is Skewed Towards Healthier Patients.

The reason the UW's waiting list is so short, despite national waiting list rates and the large population the UW serves, is likely due to the characteristics of those represented on the UW's waiting list. Simply put, the UW does not transplant as sick of patients as its peers, the other higher-volume teaching hospitals in the western U.S. AR 1641 (Appendix, Ex. F). The relative health of the patients the UW transplants can be measured through the nationwide system used by UNOS to rank patients waiting for liver transplantation, the Model for End-Stage Liver Disease ("MELD"). The MELD system numerically ranks each patient waiting for a liver from 6 (less ill) to 40 (gravely ill). AR 1034. A patient's MELD score determines how urgently a liver transplant is needed. Id. UNOS mandates that livers be transplanted to the sickest persons, or those with the highest scores, on the waiting lists first because such patients are most in need of liver transplants in order to survive. AR 1642 (Appendix, Ex. F).

Patient MELD score data is available for every U.S. liver transplant program. The MELD score data for patients on the UW's waiting list suggests that the UW limits access to its waiting list to

healthier patients. Specifically, the UW has one of the lowest percentages of the sickest, or MELD 31-40, patients, and the second highest percentage of the healthiest, or MELD 6-20 scores, of any of its peers. AR 1643 (Appendix, Ex. F). Of the UW's peer institutions, only the Hawaii transplant center has a higher percentage of MELD 6-20 scores. AR 1643 (Appendix, Ex. F). However, Hawaii also has the lowest per capita incidence of deaths from chronic liver disease in the nation. Id. In addition, when compared with liver transplant programs at "peer centers of excellence," such as Stanford, the University of California at Los Angeles, the University of California at San Francisco, California Pacific Medical Center, and the University of Colorado, the UW had the lowest percentage of MELD 31-40 scores. AR 1644 (Appendix, Ex. F). Without any local competition, the UW is not forced to aggressively seek more complex cases, or patients with higher MELD scores. AR 1656 (Appendix, Ex. F). As a result, sicker patients do not have adequate access this life-saving service in Washington. AR 1641 (Appendix, Ex. F).

e. The UW "Exports" Too Many Livers.

In addition to its conservative approach to the patients on whom it performs transplants, the UW is also highly selective of livers it accepts for transplantation. Data from LifeCenter Northwest, the organ procurement organization for the UW, shows that the UW rejected an average of twenty-eight livers per year between 1999 and 2002. AR 1650 (Appendix, Ex. F). Because livers rejected by one transplant program are

then “exported” to transplant institutions in other regions, the liver transplant success rate of the livers the UW rejected can be measured. AR 3169-70. Significantly, between 1999 and 2002, one hundred twenty-six total livers were exported from the UW, only seven of which were mandatory exports under UNOS criteria. AR 1651 (Appendix, Ex. F), AR 3183. Of these livers, one hundred twenty-four, or 98.4 per cent, were successfully transplanted elsewhere. Id.

The high success rate of livers exported by the UW demonstrates that the UW is overly selective in accepting livers for transplant. That the UW’s export rate is too high is further illustrated by the fact that, between 1999 and 2002, sixty-four patients on the UW’s waiting list died while waiting for transplants. Id. Moreover, comparing the UW’s 2002 export rate to export rates in service areas with similar characteristics to those of the UW also shows that the UW’s export rate is too high. In comparison to the UW’s 2002 export rate of 27.8 per cent, organ procurement organizations serving similarly sized programs, in similar markets to that of the UW, had 2002 export rates of between 10 and 15.6%. AR 1652 (Appendix, Ex. F).

The evidence submitted to the Department by Swedish shows that, compared to its peer institutions, the UW transplants less sick patients, does not wait list sicker patients in significant numbers, does not list patients at an expected rate, and exports too many livers. AR 1649 (Appendix, Ex. F). More than five hundred Washington residents die each year from liver disease, but less than twenty of these deaths occur in

patients awaiting liver transplantation on the UW's waiting list. AR 1640 (Appendix, Ex. F).

As the only liver transplant provider in Washington, the UW has the sole authority over which patients qualify for a liver transplant and which donated livers are suitable for transplantation. Those who do not meet the UW's highly selective criteria either leave the state for transplantation if they have the resources to do so, or are left without hope for survival.

f. The Health Law Judge Weighed Evidence And Relevant Testimony, And Determined That Swedish's Witnesses Were Credible.

Swedish's witnesses provided further support at the hearing for these facts. For instance, Dr. Rolland Dickson, medical director of solid organ transplantation and research at the Mayo Clinic, Jacksonville, one of the two largest volume liver transplant centers in the country, testified that the UW's waiting list contained a "disproportionate" number of low MELD score patients compared to high MELD score patients. AR 3783. With respect to the length of the UW's waiting list, Dr. Dickson testified that "the WWAMI region is grossly underrepresented in persons on the wait list per million residents . . . if your waiting list per million residents is very low . . . it's suggesting that there are many more patients that should be on the list awaiting a liver transplant." AR 3788-89. Given the UW's low wait list number, Dr. Dickson suggested "there are patients that

are not . . . getting access to the system or are being . . . denied being placed on the list.” AR 3807 (Appendix, Ex. G).

Dr. Charles Miller, director of the liver transplant program at the Cleveland Clinic, also confirmed that the UW transplants “a higher proportion of patients . . . at the lower MELD scores and less Status 1 patients than . . . the majority of the other transplants centers, major transplant centers in the west.” AR 3853 (Appendix, Ex. H). With respect to waiting list length, Dr. Miller confirmed that “a very small number of patients per million population have access to the [UW’s] liver transplant patient waiting list at any one point in time.” AR 3854-3855 (Appendix, Ex. H). Dr. Miller further testified that the UW has a “very low transplant rate” and that it is “unusual to see MELD scores that low.” AR 3856-3857 (Appendix, Ex. H).

Dr. William Marks, director of Swedish’s organ transplant program, also provided extensive testimony during the administrative hearing explaining how a comparison between national and local statistics illustrates need for a second liver transplant program. For instance, Dr. Marks confirmed, with respect to incidence of liver disease, that “Washington residents and those in the area we serve have an incidence of chronic liver disease that’s at or higher than the rest of the United States.” AR 3164 (Appendix, Ex. I). Given the rate of liver disease in Washington and the large population the UW serves, Dr. Marks explained that the length and characteristics of the UW’s waiting list demonstrate that “a number of patients were not being recognized and not having an

opportunity to receive transplants.” AR 3160-3161 (Appendix, Ex. I). As medical director of LifeCenter Northwest, Dr. Marks also testified that the UW’s export rate is too high given the 98.4 per cent success rate of such livers upon transplantation at other institutions. AR 3901-03 (Appendix, Ex. I).

After considering the evidence contained within the administrative record, and weighing the testimony of Swedish’s witnesses with that of the UW’s witnesses, the HLJ determined that a preponderance of the evidence supported need for Swedish’s facility. In finding Swedish’s application satisfied the need criteria, the HLJ noted “a comparison of statistics regarding population, liver disease/death and transplant rates of the University to other programs indicates that the University is not meeting the needs of Washington or WWAMI region.” AR 997 (Appendix, Ex. C). With respect to the factors demonstrating need discussed above, the HLJ determined:

[T]he statistical analysis indicates that the University has been too conservative and less innovative in its approach. As a result, healthier patients with lower MELD scores and an insufficient number of patients have been placed on the University’s wait list, and too many donor livers have been ‘turned down’ by the University. The statistics indicate that the University’s conservative approach has underserved patients suffering from end stage liver disease who warrant a place on the wait list and/or patients on the wait list who would be a reasonable recipient of a ‘rejected’ donor liver.

AR 1001 (Appendix, Ex. C).

Although the UW presented conflicting evidence regarding the significance of the evidence of need, the HLJ weighed such evidence and

determined that the evidence presented by Swedish was more convincing. Because substantial evidence supports the HLJ's findings that Washington residents are underserved by having only one liver transplant program, the HLJ's determination that Swedish satisfied WAC 246-310-210 was without error, and should be affirmed.

3. Having Two Liver Transplant Programs In An Area Improves Both Programs Through "Collegial Competition."

As noted by the HLJ, medical research shows that liver transplant programs in areas with competition treat patients with significantly higher MELD scores, thereby increasing sicker patients' access to liver transplants. AR 1002-1003 (Appendix, Ex. C). For example, the San Francisco Bay Area has roughly the same population as Washington, but has three major liver transplant centers. The success of the Bay Area transplant centers demonstrates the benefits of competition. Each of the Bay Area centers outperforms the UW in terms of transplanting sicker patients and patient survival rates. AR 1657 (Appendix, Ex. F).

Moreover, Dr. Dickson testified during the administrative hearing that a "second program actually will improve the quality of the other program, that competition and actually having another program in the state forces the program to be more innovative . . . to take better care of their patients." AR 3792 (Appendix, Ex. G). By adding Swedish's program, Dr. Dickson predicted "that transplants in the entire state and region will increase, quality will increase, and it will be better service, both to the

provider sending the patient and to the patient and their family.” AR 3793 (Appendix, Ex. G).

Dr. Miller testified that “by having a second center you can more fully utilize your organs in a better and more effective way. Competition, by the way, is good for this; it builds innovation and reduces complacency.” AR 3858-59 (Appendix, Ex. H). Dr. Miller further explained, “in my experience[,] centers with regional or local monopolies actually can never serve the community as well as centers or regions with non-monopolies.” AR 3857 (Appendix, Ex. H). Through “collegial competition,” Dr. Miller testified that the UW would likely “get some better ideas once Swedish opens” and will expand the organ pool to the point where Washington may start importing more livers than it exports. AR 3859 (Appendix, Ex. H); AR 3863.

In addition to considering the medical research regarding the benefits of competition, and the success of regions with multiple liver transplant programs, such as the Bay Area, the HLJ weighed the testimony of Drs. Dickson and Miller with that offered by the UW and determined that the benefits of competition should be considered in determining need for a second liver transplant program.

4. The HLJ’s Determinations That Swedish’s Application Satisfied The Remaining Certificate Of Need Criteria Are Supported By Substantial Evidence.

To assess structure and process of care, the Department’s regulations require an applicant to show that its proposed project would

foster an acceptable or improved quality of healthcare, and that its proposed program would have “[a] sufficient supply of qualified staff for the project, including both health personnel and management personnel [] available or [to] be recruited.” WAC 246-310-230(1).

Swedish’s proposed program would include a skilled liver transplant surgeon and a skilled hepatologist. AR 1068. In addition, Swedish’s existing staff includes three additional organ transplant surgeons, Drs. William Marks, Lisa Florence, and Andrew Precht. Dr. Marks is the director of the organ transplant program and the director of the Laboratory for Transplantation Biology at Swedish, and is a UNOS qualified abdominal surgeon. AR 3126, 3215. Dr. Florence is assistant director of Swedish’s transplant program. ~~AR 1809 (Appendix, Ex. D).~~ Dr. Florence is a UNOS qualified abdominal surgeon who completed a liver transplant fellowship at the University of California, San Francisco. AR 3215-16. Dr. Precht did a full liver fellowship and liver specialty at the University of California, San Francisco, and is a UNOS qualified liver transplant surgeon. AR 3216. Together, Drs. Marks, Florence and Precht would provide backup and aid to the full time liver transplant surgeon and hepatologist to be recruited by Swedish. AR 3215-16.

Thus, Swedish’s program would be served by, in addition to a liver transplant surgeon and hepatologist, three UNOS qualified abdominal surgeons, one of whom is also a UNOS qualified liver transplant surgeon, as well as by Swedish’s existing ancillary and support staff, which includes a urologist, a nephrologist, and six rotating

nephrologists, as well as residents in training, transplant nursing staff, a transplant pharmacist, transplant pathologist, a transplant infectious disease group, a social worker, a data manager, and a research fellow. AR 1010 (Appendix, Ex. C), 1068, 3215-3216.

After considering Swedish's proposed staffing levels, both the Program and the HLJ determined that Swedish satisfied the Structure and Process of Care criteria of WAC 246-310-230. AR 1808-1810 (Appendix, Ex. D); AR 1009-1010, 1017 (Appendix, Ex. C). This finding is supported by substantial evidence because, as the HLJ explained in her Final Order, Swedish's proposed program would satisfy the UNOS standards. AR 1010 (Appendix, Ex. C) and 1809 (Appendix, Ex. D).

UNOS establishes the standards that must be met by a transplant program in order to be qualified to participate in the OPTN. AR 3193. The OPTN is "charged with assuring the quality, as well as the fairness and equitable distribution, of organs throughout this country." Id. UNOS liver transplant standards require one qualified liver transplant surgeon on site. AR 1978. Swedish's proposed program would exceed this requirement, offering two qualified liver transplant surgeons, a hepatologist, and Drs. Marks and Florence, both of whom are board certified by the American Board of Surgery, on site. AR 1010 (Appendix, Ex. C), 1809 (Appendix, Ex. D), 3216.

Although the UW challenged Swedish's staffing levels, the HLJ weighed the testimony on this issue, and determined that Swedish's compliance with the established national standard for liver transplant

programs was more significant. Because the HLJ relied on the UNOS criteria, and because Swedish's proposed program would not only meet, but exceed, this standard, the HLJ's decision with respect to Swedish's compliance with WAC 246-310-230 was supported by substantial evidence and should be affirmed.

Moreover, aside from noting that all "financials submitted by Swedish in its application were built on [Swedish's proposed] staffing levels," the UW did not provide any basis for its claim that Swedish failed to meet the Financial Feasibility criteria of WAC 246-310-220. Because the HLJ correctly determined that Swedish's proposed staffing levels were adequate, the UW's claim as to financial feasibility is without support. Like the structure and process of care determination, the HLJ's determination that Swedish's application met the Financial Feasibility criteria is supported by substantial evidence, and should be affirmed. AR 1010-11, 1016 (Appendix. Ex. C). Swedish's satisfaction of the Cost Containment criteria of WAC 246-310-240 was uncontested by the UW.

B. Swedish And The Department Adequately Addressed The Potential Impact Of Swedish's Program On The UW's Program.

The Superior Court's order contained an "alternative" basis for revoking Swedish's CN, specifically that "Swedish did not in its CON application address any potential impact on existing or proposed institutional training programs as required by RCW 70.38.115 and/or WAC 246-310-210[.]" CP 963 (Appendix, Ex. A). This determination is without any basis, either legally, as these statutes and regulations require

this issue to be addressed by the Department in its evaluation, not Swedish in its application, or factually, as both the Department and Swedish did address this issue.

The statute states: “The department shall consider the application in terms of its impact on existing and proposed institutional training programs for doctors of osteopathic medicine and surgery and medicine at the student, internship, and residency training levels[.]” RCW 70.38.115(2)(d) (emphasis added). The regulation similarly provides that the Department’s “determination of need for any project” shall include whether the project will “have an adverse effect on health professional schools and training programs.” WAC 246-310-210(4).

The issue of the potential impact of Swedish’s proposed liver transplant program on the UW’s existing program was an inextricable element of the entire application review process. The underlying premise of everything that the UW did and said during the review process was that a new program at Swedish would be detrimental to the UW. See, e.g., AR 1439, 1573-75, 1607, 3048-51.

Swedish addressed this issue at length in its written submissions to the Department. See, e.g., AR 1653-55, 1668-69, 1687 (Appendix, Ex. F). Swedish also addressed this issue through expert testimony at the adjudicative hearing. For example, Dr. Marquis Hart, director of transplant services at the University of California, San Diego, testified that the implementation of Swedish’s program would not jeopardize the UW’s training and educational programs. Dr. Hart testified that a volume of

“between 45 and 50 liver transplants” is sufficient to maintain a training program in liver transplant surgery. AR 3819 (Appendix, Ex. J). Dr. Hart also testified that a volume of forty-five to fifty liver transplants is sufficient to maintain a training program for hepatologists. Id. Finally, with respect to other educational programs, such as physician residency programs and medical student training, Dr. Hart explained, “[T]he medical students’ training and residency training are not closely linked to the volume of transplants and is more closely linked to educating the students and residents about the principles of transplantation. So, again, the volume is not as important, but a program that does anywhere close to 45 to 50 certainly would meet the academic needs for medical students and residents.” AR 3819-20 (Appendix, Ex. J).

The Department carefully considered this issue, and concluded that Swedish’s program would not have an adverse impact on the UW’s training and research programs. AR 1810 (Appendix, Ex. D); AR 1007-9 (Appendix, Ex. C). With respect to the UW’s training program, the HLJ determined that if Swedish’s program were established, the UW would still perform enough transplants to satisfy UNOS and ASTS standards to maintain a liver transplant training program, and to maintain its fellowship program. AR 1007-9 (Appendix, Ex. C). The HLJ also noted that the UW stated that it had an excellent program even when it was only performing sixty-seven transplants per year. AR 1008 (Appendix, Ex. C). In addition, the HLJ determined that the establishment of a second liver transplant program will actually increase the total number of transplants.

It “is not a ‘zero sum game.’” AR 1009 (Appendix, Ex. C). Moreover, with respect to research, the UW never identified a single research project that would be adversely affected by establishing Swedish’s program.

Finally, the UW’s implicit argument that it needs to perform all liver transplants in Washington to maintain its training and research programs should be viewed in the context of liver transplant volumes at other programs. As discussed above, no other population the size of the WWAMI region’s population is served by a single program; the UW’s monopoly here truly is an anomaly. Moreover, the UW performed seventy-nine liver transplants in 2002. This volume is much higher than the liver transplant volumes at many well-respected liver transplant programs, including major academic programs, throughout the U.S. For example, this is higher than the number of transplants in 2002 at the University of Southern California (fifty-eight), the University of Colorado (fifty-six), New York University (fifty), Georgetown (forty-eight), the University of North Carolina (forty-seven), Johns Hopkins (forty), the University of Iowa (forty), Duke University (thirty-five), and the University of Illinois (thirty-two). AR 1422-36.

In order to accept the UW’s argument that its training and research programs will be jeopardized by the implementation of Swedish’s liver transplant program, the HLJ would have had to conclude that these other institutions, and many others identified in the record, do not conduct meaningful research or maintain viable training programs. Moreover, as Drs. Miller and Dickson testified, and the HLJ determined, it is erroneous

to assume that Swedish's transplants will simply be taken from the UW. Instead, having multiple programs in a service area results in a greater total number of transplants because competition promotes innovation and expands the use of available livers. AR 3793; AR 3862.

With respect to the UW's fellowship program, UNOS requires a research fellow to perform a minimum of forty-five liver transplants over a two-year period as primary surgeon or first assistant. AR 3362. Dr. Hart explained that there are typically two surgeons on every liver transplant, a primary surgeon and first assistant. AR 3832 (Appendix, Ex. J). If a research fellow acts as a first assistant, this would count towards the forty-five transplants. Id. Thus, because the UW performed seventy-nine transplants in 2002 and one hundred four transplants in 2003, this means that there were one hundred eighty-three opportunities during that two-year period for a liver transplant fellow to satisfy the UNOS liver transplant requirement of forty-five transplants. Given this, the HLJ correctly determined that the UW's minimum volumes would be above the UNOS requirements, even if the UW were to have two fellows. AR 1007 (Appendix, Ex. C).

The Superior Court's determination that Swedish did not adequately address impact on the UW's research and training programs was legally and factually in error. Swedish did address these issues, and the Department carefully considered the potential impact of Swedish's program on the UW's research and training programs, and determined that

Swedish's application should be approved. This determination was supported by substantial evidence and should be affirmed.

C. The Health Law Judge's Evidentiary Ruling Was Not An Abuse of Discretion.

1. This Court Reviews The HLJ's Evidentiary Ruling For An Abuse Of Discretion.

The HLJ's evidentiary rulings are reviewed under an abuse of discretion standard. Port of Seattle v. Pollution Control Hearings Bd., 151 Wn.2d 568, 642, 90 P.3d 659 (2004). Therefore, the HLJ's evidentiary rulings should be reversed "only if there is a clear showing" that her decision "was manifestly unreasonable, based on untenable grounds, or based on untenable reasons." Moreman v. Butcher, 126 Wn.2d 36, 40, 891 P.2d 725 (1995).⁴

2. The HLJ Properly Limited Evidence To The Relevant Timeframe.

The Department closed the record on Swedish's application on November 24, 2003, ten working days after the public hearing. On November 24, both Swedish and the UW filed their rebuttal statements. The HLJ accordingly ruled that "[a]ny evidence submitted by the University or Swedish shall be limited to evidence that existed as of December 31, 2003, which is approximately one month after program

⁴ The Superior Court applied the wrong standard of review in this case. Contemplating further appellate review, the Superior Court "recognize[d] that reasonable minds can differ[.]" but stated, "I'm ruling today not based on any anticipation of how anybody else might look at this, but rather, the way I see things." CP 966 (Appendix, Ex. A) (emphasis added). Under the abuse of discretion standard, the Superior Court should not have considered whether *it* would have decided the issue as the HLJ did, but rather whether "no reasonable person would take" the same view as the Health Law Judge. T.S. v. Boy Scouts of Amer., 157 Wn.2d 416, 424, 138 P.3d 1053 (2006) (emphasis added).

closed the record.” AR (Remand) 288 (Appendix, Ex. E). This was logical and consistent with the scope and purpose of the adjudicative proceeding.

Both Swedish and the Program actually had asked the HLJ to adhere more strictly to the date the record closed. AR (Remand) 88, 146. However, the HLJ gave the UW the benefit of a December 31 date. The HLJ explained her ruling as follows:

The December 31, 2003 date was selected by the HLJ because it provided the University with an opportunity to respond to the new theory raised in Swedish’s November 2003 rebuttal statement, and at the same time set a reasonable date that does not deviate unnecessar[il]y far from the closure of the public input stage of the administrative record. If no date was set as the University requested, new information could be submitted that did not exist at the time the Program made its decision. Such a ruling could result in a revolving door of litigation with additional information submitted for the first time during the adjudicative and judicial stages. As a result, applicants and/or interested parties may tactically benefit from postponing the submission of additional facts until the adjudicative or judicial stages. This may be of special advantage when the interested party is a potential competitor who may want additional time to change the manner in which it provides health care. Closure is needed so a revolving door of delayed responses does not unreasonabl[y] draw out the process. Late presentation of facts and data would result in an increase[d] number of appeals/remands and delays in the resolution of CN appeals. The purpose of CN adjudicative appeals is not to supplant the certificate of need application review process but to assure that the procedural and substantive rights of the parties were observed and that the factual record supports Program’s analysis and decision. The December 31, 2003 cut off date for evidence during the remand hearing is reasonable and consistent with the facts at hand and the CN regulatory framework.

AR (Remand) 1910-11 (Appendix, Ex. B).

3. The Department Must Be Permitted To Close The Record On A Certificate Of Need Application.

It is axiomatic that a decision on an application for a certificate of need, or any other type of license, must be made based on facts as they exist at a particular point in time. This Court has recognized that an agency must be permitted to close its record, so that it can then deliberate and make a decision. For example, in U.S. West Communications, Inc. v. Washington Utilities & Transportation Commission, 134 Wn.2d 48, 949 P.2d 1321 (1997), this Court considered the evidentiary record before the Washington Utilities and Transportation Commission on a petition for an accounting order filed by a telecommunications company. This Court upheld the exclusion of declarations regarding events that “took place . . . after the Commission records . . . were closed” because “[t]he declarations d[id] not include any evidence which relates to the validity of the Commission’s action at the time it was taken.” *Id.* at 73 (emphasis added).

The high courts of other states have reached similar conclusions. For example, in Old Dominion Electric Cooperative v. Virginia Electric & Power Co., 237 Va. 385, 377 S.E.2d 422 (1989), a Virginia state commission made a decision in a utilities rate case based on the facts as they existed when the commission closed the record. As in the present case, a party argued that events occurring after the close of the record would mandate a different result, specifically that later data “proves conclusively that the capacity purchase projections presented by the utility at the hearing were not an accurate prediction of its 1988 capacity

purchases.” Id. at 392 (emphasis original). The Hearing Examiner excluded the updated data, writing, “Rate cases have to end, and we will not open this record to accommodate events and arguments arising after all parties have had a fair opportunity to address the issues.” Id. at 392. The Virginia Supreme Court affirmed, holding that “the record has to close at some time” and that the argument “that current data is more accurate than the projections relied on at the hearing . . . is beside the point.” Id. at 397 (emphasis added). The agency must necessarily “view the operations of a utility at a moment in time.” Id. at 397 (emphasis added).

The Department of Health must be permitted to close the record on an application so that it may deliberate and make a time-specific decision. The alternative is chaos. If the Department cannot set a deadline for parties to submit information on an application, the inevitable result is that the parties will keep adding to the record, in a never-ending cycle of responses to other parties’ updates, up through the date of decision. The Department would be deprived of ever having a complete record, and would simply have to issue a decision at some point in the midst of the flow of information.

4. The HLJ Property Determined That Post-2003 Evidence Was Irrelevant And Immaterial To The Issue Before Her.

Under the Administrative Procedure Act (the “APA”), the Health Law Judge had the discretion to control the scope of an adjudicative proceeding. See RCW 34.05.449(1) (“The presiding officer shall regulate

the course of the proceedings, in conformity with applicable rules and the prehearing order, if any.”). “The presiding officer may exclude evidence that is irrelevant, immaterial, or unduly repetitious.” RCW 34.05.452(1).

Consistent with her discretion to control the scope of the proceeding, the HLJ excluded post-2003 evidence. AR (Remand) 288 (Appendix, Ex. E). Such evidence would be irrelevant to the issue before her, specifically whether Swedish’s proposed liver transplant program satisfied the CN criteria. See RCW 34.05.461(3) (HLJ must issue a final order “on all the material issues of fact, law, or discretion presented on the record . . .”) (emphasis added); WAC 246-310-200 (basis for decisions on CN applications). Whether the UW made changes to its own program in 2004, 2005, or 2006 is not material to Swedish’s 2003 application for a CN.

5. Even If The HLJ’s Decision Was Error, It Was Harmless Error.

Even if the Court concludes that the HLJ should not have limited the evidence to that which existed as of December 31, 2003, this error was harmless. The latest cutoff date the HLJ could have applied for relevant evidence would be June 30, 2004, the date the Department issued the CN to Swedish. Certainly the UW could not be permitted to retroactively attack Swedish’s license based on events which occurred after the CN was issued – i.e., to argue that although a second liver transplant program was needed when Swedish was issued its CN, it is no longer needed, and therefore Swedish’s license to operate the program should be revoked.

This would be profoundly unfair and, as the HLJ explained, this would encourage sandbagging by affected parties. AR (Remand) 1910-11 (Appendix, Ex. B).

Even if the HLJ had permitted the UW to offer evidence from this additional six-month period, the UW identified no such evidence below which could have materially affected the Department's decision.⁵ In addition, much of the UW's post-2003 evidence was also excluded because it was not timely disclosed in accordance with the HLJ's prehearing order for disclosure of witnesses and exhibits. AR (Remand) 1624-25 (summarizing grounds for exclusion of the UW's proposed exhibits).

6. At Minimum, This Case Should Be Remanded To The HLJ.

If the HLJ erroneously excluded evidence, the proper remedy would be to remand to the HLJ, with instructions to admit specific, wrongfully excluded evidence and issue a new decision. See, e.g., Washington Irrigation & Development Co. v. United States, 110 Wn.2d 288, 298, 751 P.2d 1178 (1988) ("Because evidence of O'Connor's tax liabilities for the third quarter of 1980 was improperly excluded, we remand for a recalculation . . .") The Superior Court refused to do so in

⁵ The Superior Court appeared to recognize this, stating: "I'm not sure of why particular parties had particular tactics. I wouldn't have done it that way. I would have suggested that the University of Washington attempt to make more of a record of how that information was relevant[.]" Appendix Ex A - CP 967 (emphasis added). Nevertheless, the Superior Court revoked Swedish's CN without making any finding that any relevant evidence was excluded by the HLJ, or that it would have affected the ultimate determination.

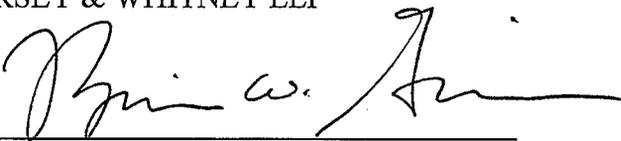
this case. The Superior Court was unwilling to “say here’s the way to do it right” to the HLJ. CP 965 (Appendix, Ex. A). In fact, although the Superior Court stated that there can be cutoffs, it declined to explain what would have been a permissible cutoff for the HLJ to apply in this case, other than to state that the HLJ’s December 31 cutoff was “artificial.” CP 967 (Appendix, Ex. A). Given the importance of this matter, the Superior Court should have remanded to the HLJ to admit whatever evidence the Superior Court believed was improperly excluded and issue a new decision.

VI. CONCLUSION

The HLJ did not abuse her discretion by setting the evidentiary cutoff in this case, and the Department of Health’s decision to award Swedish a certificate of need to establish a liver transplant program is supported by substantial evidence. Indeed, the evidence is overwhelming that a second program is needed in Washington. So is the evidence that Swedish’s program will not harm the UW. Having two “competing” programs in Washington will make both programs better, and result in constant innovation and improvement. More Washington residents will receive transplants, and more donated livers will be used here. Swedish respectfully requests that this Court reverse the Superior Court and reinstate the Department’s decision to issue Swedish a certificate of need.

Respectfully submitted this 5th day of November 2007.

DORSEY & WHITNEY LLP

By: 

Peter S. Ehrlichman, WSBA #6591
Brian W. Grimm, WSBA #29619

U.S. Bank Centre
1420 Fifth Avenue, Suite 3400
Seattle, WA 98101
Telephone: (206) 903-8800
Facsimile: (206) 903-8820

Attorneys for Appellant,
Swedish Health Services
d/b/a Swedish Medical Center