

**STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE SERVICE UNIT**

In Re:

CERTIFICATE OF NEED APPLICATION OF
UNIVERSITY OF WASHINGTON MEDICAL
CENTER TO ADD 79 ACUTE CARE BEDS,

Applicant,

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

Petitioners.

Master Case Nos. M2013-1393 (Lead)
M2013-1394
M2013-1395

FINDINGS OF FACT,
CONCLUSIONS OF LAW,
AND INITIAL ORDER

APPEARANCES:

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

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

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

PRESIDING OFFICER: Frank Lockhart, Health Law Judge

FINDINGS OF FACT,
CONCLUSIONS OF LAW,
AND INITIAL ORDER

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

OVERVIEW

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

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

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

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

ISSUE

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

SUMMARY OF PROCEEDINGS

At the hearing, UWMC presented the testimony of:

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

The Petitioners presented the testimony of:

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

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

Program Exhibits

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

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

- a. Appendix 10B to the Evaluation.
- b. The final version of the Department's September 2013 survey of acute care beds at UW Medicine/Northwest.
- c. Zip codes used by the Department to define the North King Planning Area.
- d. Internal Department memorandum regarding UWMC's Application.
- e. Floor plans of UW Medicine/Northwest.
- f. Photographs taken during survey of UW Medicine/Northwest.
- g. June 27, 2013 letter from Janis Sigman to "Affected and Interested Persons."
- h. February 14, 2013 letter from Petitioners to the Department.
- i. May 8, 2013 letter from Petitioners to the Department, enclosing an Excel file. (Note that the excel file listing diagnostic groups is printed out and placed at the end of the Supplemental Application Record).
- j. May 15, 2013 public comments submitted by Petitioner Providence.
- k. May 15, 2013 public hearing key speakers' comments submitted by Petitioners.
- l. May 15, 2013 letters of support for Petitioners' opposition to the UWMC Application.

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

UWMC's Exhibits

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

Petitioners' Exhibits

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

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

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

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

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

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

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

Exhibits Admitted at Hearing

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

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

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

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

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

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

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

Closing Arguments

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

Citations to the Application Record

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

PRELIMINARY DISCUSSION

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

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

1. The purpose of the CN process.

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

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

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

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

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

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

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

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

WAC 246-310-240

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

2. The need for legal fictions

However, as described in other CN decisions,² because the list of factors to be considered and weighed is so expansive, the agency³ employs certain “legal fictions” in

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

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

a. The snap-shot in time

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

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

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

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

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

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

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

b. The planning area

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

c. The State Health Plan

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

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

3. The adjudicative hearing

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

⁴ AR 1227.

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

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

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

I. FINDINGS OF FACT

1.1 The University of Washington Medical Center (UWMC) is the teaching hospital for the University of Washington School of Medicine in Seattle.⁶ It is part of a state agency, governed by the University of Washington Regents, whose members are appointed by the Governor. UWMC operates the fifth largest training program in the United States for physicians, dentists, and other health professionals⁷ and provides a comprehensive range of complex health services in the areas of cardiac surgery, high-risk pregnancy, oncology, solid organ transplant, and other tertiary and quaternary services.⁸ UWMC has a number of distinctions, including being ranked as the number one hospital in Washington by U.S. News & World Report,⁹ being named the nation's first Magnet Hospital for Excellence in Nursing Care by the American Nurses

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

⁷ AR 43.

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

⁹ AR 11.

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

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

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

¹⁰ AR 50.

¹¹ TR 43.

¹² TR 44.

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

¹⁴ TR 350.

¹⁵ AR 243, TR 348-350.

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

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

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

WAC 246-310-210 “Determination of Need”

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

¹⁶ AR 10.

¹⁷ AR 28.

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

CRITERION 2: Need for Multiple Criteria

Hospital bed need forecasts are only one aspect of planning hospital services for specific groups of people. Bed need forecasts by themselves should not be the only criterion used to decide whether a specific group of people or a specific institution should develop additional beds, services or facilities. Even where the total bed supply serving a group of people or planning area is adequate, it may be appropriate to allow an individual institution to expand.

Standards:

b. Under certain conditions, institutions may be allowed to expand even though the bed need forecasts indicate that there are underutilized facilities in the area. The conditions might include the following:

- The proposed development would significantly improve the accessibility or acceptability of services for underserved groups; or
- The proposed development would allow expansion or maintenance of an institution which has staff who have greater training or skill, or which has wider range of important services, or whose programs have evidence of better results than do neighboring and comparable institutions; or
- The proposed development would allow expansion of a crowded institution which has good cost, efficiency or productivity measures of its performance while underutilized services are located in neighboring and comparable institutions with higher costs, less efficient operations or lower productivity.
- In such cases the benefits of expansion are judged to outweigh the potential costs of possible additional surplus.

In its application, UWMC argued that the need criteria could be met looking at either the bed need within the planning area or the demand from outside the planning area. (UWMC argued that within the North King planning area there would be a need for 112 additional beds by the year 2021.¹⁸ The issue of need within the planning area is discussed in Paragraph 1.9 below.) However, given the fact that 89% of UWMC's patient days come from patients who reside outside of the planning area, it makes no sense to determine "need" only in terms of the 11% of UWMC's patient days that come from residents within the North King planning area. UWMC's situation in Washington State is unique and is exactly the type of CN application that Criterion 2 of the State Health Plan envisioned.

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

¹⁸ AR 25.

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

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

- a. 89% of UWMC's patient days come from outside the North King planning area.²⁰ Even the Petitioner's expert acknowledged this.²¹
- b. UWMC provides a higher percentage of state-wide care for such tertiary and quaternary areas as cardiology, high risk pregnancy, oncology, and organ transplants than other providers in the state. The actual percent amount was hotly disputed at hearing. UWMC provided a table²² of 17 selected complex DRGs²³ that showed that UWMC provides more than 50% of all state-wide care for those types of patients. (The Petitioners' complaint was that the DRGs were "cherry-picked" to show only the complex diagnoses on which UWMC provided the most service, but the percentage of care that UWMC provided to those diagnoses was not contested. In fact, the Petitioners conceded that UWMC's total share of highly complex cases is higher than other providers.²⁴ The Petitioners' public comments also acknowledged that UWMC provided the most organ transplants in the state, and provided oncology care to more inpatients than any other hospital in the state.²⁵)
- c. 10% of UWMC's patient days come from persons who live outside the state. The population of the WWAMI region (Washington, Wyoming, Alaska, Montana, and Idaho) was more than 10.5 million in 2010, and has a projected growth of 11% over the next decade. The population of 65 and

²⁰ AR 7, TR 47.

²¹ TR 1167

²² AR 26.

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

²⁴ AR 418-9.

²⁵ AR 420-422.

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

- d. UWMC is at maximum effective capacity. Its average midnight occupancy rate (the lowest census point of the day) for its 365 acute care beds is 75%. The Program has previously determined that a 75% occupancy rate is the optimal percentage for efficient utilization of services.²⁷ An occupancy rate above 75% begins to compromise access to service and indicates need for additional beds.²⁸ UWMC's occupancy rate for its ICU beds, for example, is in the 90th percentile.²⁹
- e. For many patients with complex medical needs in Washington State, and in the 5 state WWAMI region, there may not be other treatment options available. UWMC's affiliated hospitals and other community hospitals do not have the technology, equipment, or physician support to provide adequate or safe care for these particular complex medical patients.³⁰ Yet those patients are being denied access to UWMC because of a lack of beds.³¹ The

²⁶ AR 35.

²⁷ AR 429 & Exhibit A-2, page C-37.

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

²⁹ TR 78.

³⁰ TR 80-82.

³¹ TR 188.

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

- f. UWMC provides the highest percentage of inpatient care to Medicaid recipients of any hospital in King County, except for its affiliated hospital, Harborview.³⁵
- g. In addition to providing medical care to patients, UWMC provides training to physicians as the 5 state WWAMI's only teaching hospital. There are 1,318 residents and fellows in training at UWMC.³⁶ The Accreditation Council for Graduate Medical Education requires a minimum volume of cases occur at a hospital to maintain accreditation.³⁷

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

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

³² AR 584, TR 185.

³³ TR 185.

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

³⁵ AR 29.

³⁶ TR 82.

³⁷ AR 1108.

- allowing expansion or maintenance of an institution which has staff who have greater training or skill, or which has wider range of important services, or whose programs have evidence of better results than do neighboring and comparable institutions; or
- allowing expansion of a crowded institution which has good cost, efficiency or productivity measures of its performance while underutilized services are located in neighboring and comparable institutions with higher costs, less efficient operations or lower productivity.

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

³⁸ AR 1225-1226.

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

1.11 Although the Program did not refer to Criterion 2 by name, in essence what it did next was to look at UWMC's application under the Criterion 2 requirements³⁹ and concluded that "allocating the projected patient days to all the hospitals in the North King planning area as the methodology does, will not provide an accurate allocation of the needed beds in the North King planning area."⁴⁰ This is because the other hospitals in the planning area "do not have the facilities, personnel, or other resources to provide the needed services."⁴¹ The Program determined that "the occupancy levels for UWMC especially in their intensive care units indicate a need for beds"⁴² and concluded that UWMC had met the criteria for establishing need.

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

³⁹ AR 1234-1239.

⁴⁰ AR 1238.

⁴¹ AR 1239

⁴² AR 1239

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

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

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

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

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

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

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

WAC 246-310-220 “Financial Feasibility”

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

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

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

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

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

⁴⁶ AR 1245.

⁴⁷ AR 1242.

⁴⁸ AR 1244.

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

The physical shell for the beds proposed in this application was constructed as part of UWMC's Montlake Tower inpatient bed tower project. A draft supplemental Environmental Impact Statement (EIS) (which supplements UW's existing Campus Master Plan EIS) was issued May 20, 2008 and a final supplemental IES was issued on December 23, 2008. Documentation of these filings is included as Exhibit 2.⁴⁹

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

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

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

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

⁴⁹ AR 10.

⁵⁰ AR 243.

⁵¹ AR 268, 270, and 278.

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

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

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

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

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

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

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

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

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

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

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

⁵⁴ TR 345 and 351.

⁵⁵ TR 75, AR 1245.

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

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

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

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

WAC 246-310-240 “Cost Containment”

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

⁵⁷ AR 1248-1249.

⁵⁸ AR 50-52.

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

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

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

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

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

⁵⁹ AR 1247.

⁶⁰ AR 54.

⁶¹ AR 1250-1251.

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

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

II. CONCLUSIONS OF LAW

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

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

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

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

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

(1) The findings of the department's review of certificate of need applications and the action of the secretary's designee on such applications shall, with the exceptions provided for in WAC 246-310-470 and 246-310-480 be based on determinations as to:

- (a) Whether the proposed project is needed;
- (b) Whether the proposed project will foster containment of the costs of health care;
- (c) Whether the proposed project is financially feasible; and
- (d) Whether the proposed project will meet the criteria for structure and process of care identified in WAC 246-310-230.

(2) Criteria contained in this section and in WAC 246-310-210, 246-310-220, 246-310-230, and 246-310-240 shall be used by the department in making the required determinations.

(a) In the use of criteria for making the required determinations, the department shall consider:

- (i) The consistency of the proposed project with service or facility standards contained in this chapter;

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

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

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

(i) Nationally recognized standards from professional organizations;

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

(iii) Federal medicare and medicaid certification requirements;

(iv) State licensing requirements;

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

2.5 WAC 246-310-210 defines the “determination of need” in evaluating

CN Applications, to wit:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.6 WAC 246-310-220 sets forth the “determination of financial feasibility”

criteria to be considered in reviewing CN Applications, to wit:

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

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

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

(3) The project can be appropriately financed.

2.7 WAC 246-310-230 sets forth the “criteria for structure and process of care”

to be used in evaluating CN Applications, to wit:

A determination that a project fosters an acceptable or improved quality of health care shall be based on the following criteria.

(1) A sufficient supply of qualified staff for the project, including both health personnel and management personnel, are available or can be recruited.

(2) The proposed service(s) will have an appropriate relationship, including organizational relationship, to ancillary and support services, and ancillary and support services will be sufficient to support any health services included in the proposed project.

(3) There is reasonable assurance that the project will be in conformance with applicable state licensing requirements and, if the applicant is or plans to be certified under the medicaid or medicare program, with the applicable conditions of participation related to those programs.

(4) The proposed project will promote continuity in the provision of health care, not result in an unwarranted fragmentation of services, and have an appropriate relationship to the service area's existing health care system.

(5) There is reasonable assurance that the services to be provided through the proposed project will be provided in a manner that ensures safe and adequate care to the public to be served and in accord with applicable federal and state laws, rules, and regulations. The assessment of the conformance of a project to this criterion shall include but not be limited to consideration as to whether:

2.8 WAC 246-310-240 sets forth the “determination of cost containment”

criteria to be used in evaluation a CN Application, to wit:

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

NOTICE TO PARTIES

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

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

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

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

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

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

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

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

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

For more information, visit our website at:

<http://www.doh.wa.gov/PublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/Hearings.aspx>

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