STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE SERVICE UNIT

In the Matter of: Certificate of Need Decision by DEPARTMENT OF HEALTH re: VALLEY MEDICAL CENTER'S, AUBURN REGIONAL MEDICAL CENTER'S, AND MULTICARE HEALTH SYSTEM'S APPLICATION FOR ACUTE CARE BEDS IN SOUTHWEST KING COUNTY, KING COUNTY PUBLIC HOSPITAL DISTRICT NO. 1 d/b/a VALLEY MEDICAL CENTER, a Washington Public Hospital District, Petitioners.	Master Case Nos. M2011-253 M2011-254 M2011-731 FINDINGS OF FACT, CONCLUSIONS OF LAW, AND FINAL ORDER

APPEARANCES:

Petitioner, King County Public Hospital District No. 1
d/b/a Valley Medical Center (Valley), by
Ogden Murphy Wallace, P.L.L.C., per
E. Ross Farr, Attorney at Law

MultiCare Health System (MultiCare), by
Bennett Bigelow & Leedom, P.S., per
Brian W. Grimm, Attorney at Law

Applicant, Auburn Regional Medical Center (Auburn), by
Freimund Jackson Tardif & Benedict Garratt, 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: John F. Kuntz, Review Judge

A hearing was held in this matter on October 3-7, 2011, regarding certificate of need (CN) applications filed to establish acute care beds in Southeast King County.

ISSUES

A. Does Auburn's CN application for the addition of 54 acute care beds in Auburn, Washington (Southeast King County) meet the criteria set forth in chapters 70.38 RCW and 246-310 WAC?

B. Does Valley's CN application for the addition of 60 acute care beds in Renton, Washington (Southeast King County) meet the criteria set forth in chapters 70.38 RCW and 246-310 WAC?

C. Does Multicare's CN application to establish a new 58-bed hospital in Covington, Washington (Southeast King County) meet the criteria set forth in chapters 70.38 RCW and 246-310 WAC?

SUMMARY OF PROCEEDINGS

At the hearing, the Program presented the testimony of Mark Thomas and Bart Eggen, CN Program. Auburn Regional Medical Center presented the testimony of Larry Coomes and Pat Bailey from Auburn; Jody Carona, Auburn's consultant; Bart Eggen, Mark Thomas, and Ric Ordos from the Department of Health; Bill Akers, Vice President, Health Care Delivery Systems; Robert McGuirk; and Kevin Kennedy, Principle, ECG Management Consultants. Valley Medical Center presented the testimony of Bart Eggen, Executive Manager, Department of Health; Mark Thomas, Analyst, CN Program; Kevin K. Kennedy, Principal, ECG Management Consultants; Robert McGuirk; Janice R. Sigman, CN Program; Todd Thomas, Director of Facilities Engineering, Valley Medical Center; Paul S. Hayes, Chief Operating Officer, Valley Medical Center; Bill Akers, Vice President, Health Care Delivery Systems; and Mike Glenn, Chief Executive Officer, Jefferson Healthcare. Multicare presented

testimony of Theresa Boyle; William H. "Smokey" Stover, M.D.; Lois I. Bernstein; Anna Loomis, C.P.A.; and Frank Fox, Ph.D.

The following Program exhibit was admitted:

Exhibit P-1: The 2884-page Administrative Record compiled by the Program during review of the applications.[1]

The following Auburn exhibits[2] were admitted:

Exhibit A-2: Prior CN Evaluations issued by the Program, including the prior Evaluations (2007 CN for St. Francis Hospital; 2006 CN for Providence Everett; 2002 CN for Legacy Health System and Southwest Washington Medical Center; and 2002 CN for Evergreen Hospital Medical Center);

Exhibit A-3: The JLARC Performance Audit of the CN Program, dated June 26, 2006 (ruling reserved);

The following Auburn exhibits were not admitted:

Exhibit A-1: Excerpts from the transcripts of the depositions taken during the course of discovery (not admitted); and

Exhibit A-4: Signed copy of Thurston County Judge Paula Casey's September 3, 2010 Letter Opinion in *ARMC v. DOH, et al*, Thurston County Cause No. 09-202515-8 (not admitted).

The following Valley exhibits were admitted:

Exhibit V-2: Curriculum Vitae of Robert McGuirk;

Exhibit V-3: Curriculum Vitae of Kevin Kennedy;

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[1] Reference to specific pages within the Application Record (for example AR 1 is page 1) are used rather than reference to Exhibit P-1 (Ex P-1, page 1). This is consistent with the method used by the parties in the closing briefs.

[2] Although Auburn identified exhibits during the prehearing process (*see* Prehearing Order Nos. 4 and 5), Auburn did not submit any exhibits at hearing.

Exhibit V-4: Prior CN Evaluations and Health Law Judge Decisions (ruling reserved – to be identified); and

Exhibit V-6: Deposition exhibits which are not in the Administrative Record:

i. March 13, 2002 Evaluation of Legacy Health Systems and Southwest Washington Medical Center Projects;

ii. December 18, 2006 Evaluation of Providence Everett Medical Center Project;

iii. Chart prepared by CN Program personnel entitled, "Comparison of Hospital Bed Additions and New Hospitals; and

iv. State of Washington Joint Legislative Audit and Review Committee (JLARC) Performance Audit of the Certificate of Need Program, dated June 26, 2006.

The following Valley exhibits were not admitted:

Exhibit V-1: Entire Administrative Record in this matter (duplicative of Exhibit P-1); and

Exhibit V-5: Excerpts from the transcripts of the depositions taken during the course of discovery (not admitted).

The following Multicare exhibits were admitted:

Exhibit M-2: Washington State Health Plan, Volume 2: Performance Standards for Health Facilities and Services;

Exhibit M-3: Martin L.A., et. al., Increasing Efficiency and Enhancing Value in Health Care: Ways to Achieve Savings in Operating Costs per Year, IHI Innovation Series white paper, Cambridge, Massachusetts: Institute for Healthcare Improvement (2009);

Exhibit M-4: Medicare Spending Report, The Dartmouth Atlas of Health Care;

Exhibit M-5: Valley Medical Center Hospital Information;

Exhibit M-6: Minutes of the Meeting of the Board of Commissioners, Public Hospital District No. 1 of King County, Washington, held on March 15, 2010;

Exhibit M-7: Minutes of the Meeting of the Board of Commissioners, Public Hospital District No. 1 of King County, Washington, held on April 5, 2010;

Exhibit M-8: Minutes of the Meeting of the Board of Commissioners, Public Hospital District No. 1 of King County, Washington, held on April 19, 2010;

Exhibit M-9: Minutes of the Meeting of the Board of Commissioners, Public Hospital District No. 1 of King County, Washington, held on May 3, 2010;

Exhibit M-10: Minutes of the Meeting of the Board of Commissioners, Public Hospital District No. 1 of King County, Washington, held on May 24, 2010;

Exhibit M-11: Minutes of the Meeting of the Board of Commissioners, Public Hospital District No. 1 of King County, Washington, held on June 7, 2010;

Exhibit M-12: Minutes of the Meeting of the Board of Commissioners, Public Hospital District No. 1 of King County, Washington, held on July 6, 2010;

Exhibit M-13: Department of Health's Findings for the CN Application Submitted on Behalf of Legacy Health Systems, Portland, Oregon, Proposing to Construct a New 220 Bed Hospital located in the Salmon Creek Area of Clark County, dated March 15, 2002;

Exhibit M-14: Evaluation of the CN Application Submitted by Overlake Hospital Medical Center Proposing to Add 80 Acute Care Beds to the Existing Hospital, dated August 16, 2002;

Exhibit M-15: Evaluation of the CN application Submitted by Franciscan Health System Proposing to Establish a 112-Bed Hospital in the City of Gig Harbor, within Pierce County, dated May 14, 2004;

Exhibit M-16: In Re: CN Application of Swedish Medical Center, Washington Department of Health, No. 04-07-C-205CN, Findings of Fact, Conclusions of Law, and Final Order, dated August 23, 2005;

Exhibit M-17: Remand Evaluation of the CN Application Submitted by Swedish Health Services Proposing to Establish a 175-Bed Hospital in the City of Issaquah, within King County, dated May 31, 2007;

Exhibit M-18: Evaluation of the CN Application Submitted on Behalf of Franciscan Health Care Proposing Two Separate Projects at St. Francis Hospital in Federal Way: 1) Addition of 36-Acute Care Beds in Two Phases; and 2) Establish an Intermediate Care Nursery With Level II Obstetric Services, dated June 12, 2007;

Exhibit M-19: Evaluation of the CN Application Submitted by Franciscan Health System's St. Anthony Hospital Proposing to Amend CN #1339 because of an increase in approved costs, dated October 24, 2008;

Exhibit M-20: Evaluation of the CN Application Submitted on Behalf of Kennewick Public Hospital District d/b/a Kennewick General Hospital Proposing to Relocate 74 of its Existing Acute Care Licensed Bed Capacity to a new campus at the Southridge Area of Kennewick, dated February 4, 2009;

Exhibit M-21: Evaluation of the CN Application Submitted on Behalf of Harrison Medical Center Proposing to Add 92 Licensed Acute Care Beds to the Silverdale Campus and Reduce 42 of its Existing Acute Care Licensed Bed Capacity from the Bremerton Campus, dated May 27, 2009;

Exhibit M-22: Evaluation of the CN Application Submitted by Auburn Regional Medical Center Proposing to Add 13 Geropsychiatric Bed and Increasing their Quota. Licensed Bed Capacity from 149 to 162, dated July 9, 2009;

Exhibit M-23: Settlement Evaluation of the CN Application Submitted on Behalf of Sacred Heart Medical Center and Children's Hospital Proposing Two Separate Projects: 1) Addition of 75 Acute Care Beds; and 2) Reconciliation in the Use of 21 Level II Intermediate Care Bassinets, dated May 12, 2010;

Exhibit M-24: "Hospital election a big surprise: 94% voted no," Seattle Times, May 27, 2006; and

Exhibit M-25: "At least three cities want out of Valley Medical district," Seattle Times, dated June 8. 2006.

The following Multicare exhibit was not admitted:

Exhibit M-1: Administrative Record (duplicative of Exhibit P-1).

The parties were permitted to file briefs in lieu of closing argument. See RCW 34.05.461(7). The first round of briefs were due by October 28, 2011, with the second round (rebuttal) briefs due by November 4, 2011. The administrative hearing record was closed effective November 4, 2011.

PROCEDURAL HISTORY

On December 23, 2009, Multicare submitted a CN application to establish a 58-bed hospital in Covington, Washington. At the time of its application, Multicare did not have a hospital in Southeast King County.

On December 31, 2009, Auburn submitted a CN application to add 70 acute care beds to its hospital facility in Auburn, Washington. At the time of the application, Auburn was licensed as a 162-bed facility, with 124 beds categorized as acute care beds.

On January 25, 2010, Valley submitted a CN application to add 60 acute care beds to its hospital facility in Renton, Washington. At the time of the application, Valley was licensed as a 303-bed facility, with 283 beds categorized as acute care beds.

On February 1, 2010, the Program notified the applicants that it intended to conduct a concurrent review of the three applications pursuant to RCW 70.38.115(7).[3] Under this analysis approach, the Program could approve one or more of the projects if the applicant(s) met the required CN criteria. In the alternative, the Program could deny all three applications in the event that none of the applications met the CN criteria.

On December 21, 2010, the Program completed its evaluation of the Auburn, Multicare, and Valley applications. The Program determined that Multicare's application to establish a 58-bed hospital met the CN criteria. The Program issued Multicare CN No. 1437 on January 7, 2011. Auburn and Valley appealed this decision. The Program also denied both Auburn's application to add 70 beds and Valley's application to add 60 beds. Auburn and Valley each appealed the Program's denial decision on January 18, 2011.

In addition to filing an appeal of the Program's decision denying its application, Valley filed a request for reconsideration with the Program on January 18, 2011, pursuant to WAC 246-310-560. The Program issued its written decision to deny Valley's request for reconsideration on February 25, 2010.

The parties sought permission to intervene in the appeal actions. As the competing cases involve similar issues (CN applications by the parties for the same service area), records, and witnesses, the matters were consolidated. *See* Prehearing Order No. 1.

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[3] The applicants and the Program use the term "comparative review" to mean "concurrent review." The terms can be used interchangeably.

I. FINDINGS OF FACT

General Findings

1.1 A CN is a non-exclusive license to establish a new health care facility. *See St. Joseph Hospital & Health Care Center v. Department of Health*, 125 Wn. 2d 733, 736 (1995). A CN is required when an existing hospital seeks to increase the number of licensed beds. RCW 70.38.105(4)(e). The CN applicant must establish that it can meet all of the applicable criteria. WAC 246-10-606. This requires a showing that the proposed project: is needed; will foster containment of costs of health care; is financially feasible; and will meet the structure and process of care. *See* WAC 246-310-200(1).

1.2 Unlike other CN applications, the primary goal in an acute care bed[4] application is to first determine if additional acute care beds (and not necessarily additional facilities) are needed in the service area. Stated another way, the first determination is whether the beds are need, and not whether a project should be approved, within the applicable service area. Once it is clear that need exists, only then is a determination made whether a new facility or expansion of an existing facility is appropriate.

1.3 A CN application is time sensitive, as it represents a snapshot in time and the statistical data available during that snapshot in time. The snapshot in time includes several specific cutoff dates, including: the submission of the application and response

[4] The term "acute care bed" is not defined. It can best be described as a licensed hospital bed for the short-term treatment of an individual needing medical care.

to the Program's screening questions; the submission of public input regarding the application; and the closure of the application record prior to the Program's evaluating the application and issuing its decision. *See generally* RCW 70.38.115(6), (8), and (9).

1.4 As with the application process, the Program must complete its review within a specified amount of time (90 days for individual application review; 150 days following a concurrent application review). *See* RCW 70.38.115(7) and (8). Given the time limitations involved, the Program reviews the application information for "reasonableness" (is the application information consistent or similar to past applications for similar facilities). See generally WAC 246-310-230(3) and (5) (there is reasonable assurance for the project or services). An example of the reasonableness test is a comparison of Multicare's cost per bed to the cost per bed for other new hospitals.

1.5 When it receives more than one acute care bed application for a service area within a given time period, the Program can elect to examine the applications together in a process known as a "concurrent review." RCW 70.38.115(7); *see also* WAC 246-310-120. A concurrent review is a comparative analysis of competing applications to determine which of the proposed projects best meets the identified needs. RCW 70.38.115(7). A concurrent review is appropriate here. Both Valley and Auburn filed applications prior to the start of the Multicare application review. All three

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applications requested approval for acute care hospital beds in the same planning area (Southeast King County).[5]

1.6 While the Program characterized its analysis as a concurrent review, in actuality the Program did not perform a concurrent review because it did not compare the three applications to each other. In fact, the Program specifically instructed Rick Ordos – the department employee who performs the analysis of the financial health of the applicants – to examine each application separately. TR 5, page 1234, lines 18-19. Rather, the Program performed a regular review; it compared each application to the CN criteria set forth in WAC 246-310-210 through WAC 246-310-240. The Program determined that only one facility (Multicare) qualified under its need analysis.

1.7 Whether a regular or concurrent review is conducted, an applicant must meet specific cutoff dates as a part of the application process. The first cutoff date represents the date by which the applicant's application is considered complete. *See* WAC 246-310-090(2) and (3). Once the applicant answers the screening questions, the applicant's ability to amend the application is limited. *See* WAC 246-310-100. The

[5] Although an argument can be made that it is not appropriate to conduct a concurrent review of the new and existing facilities together, this argument is not well founded. Had there been a review of a new facility or an existing facility, the first review would have absorbed the number of available acute care beds available for a 7-10 year period. This would affect the ability of the remaining facilities in the service area to expand and it illustrates why one acute care bed application frequently initiates additional applications within the same time period and service area.

second cutoff date is the end of the public input period, after which the interested or affected parties are prohibited from commenting on the applicant's application. *See* WAC 246-310-180. The third cutoff date occurs at the conclusion of the public hearing or the end of the public hearing comment period. If an applicant contacts the Program following this cutoff date, the contact is considered ex parte communication and is prohibited. *See* WAC 246-310-190(1).

1.8 While an applicant cannot supplement an application following the screening question cutoff date, the Program can use new statistical information (for example, patient statistical data) in its analysis. The Program's standard practice is to supplement the statistical information provided by applicants with newer statistical information (if available) that is obtained during the evaluation of an application. The Program's stated reason for supplementing the statistical information is to ensure the most up-to-date or current information is used when evaluating the application.[6]

1.9 The Program followed its standard practice in the regular review of the Auburn, Valley, and Multicare applications. Each of the applicants used ten years of patient statistical data for the period 1999-2008. This was the most current data available when each of the applicants submitted the application. When the Program conducted its evaluation, there was an additional year of complete statistical data. For

[6] As an example, Valley relied on 1999-2008 planning area resident utilization data (hospital discharge data) from the period 1999-2008. *See* AR 549. The Program evaluated Valley's application using 2000-2009 planning area resident utilization data. *See* AR 551.

that reason, the Program used ten years of patient statistical data for the period 2000-2009 in its evaluation.

1.10 Given the Program's standard practice of including additional statistical data, applicants try to: include more recent information if such information is available; or estimate an additional year's worth of data based on partial information. One approach an applicant might use is to take partial data (say 3 months worth) and estimate how that data may translate if consistent for 12 months. The applicant may provide this additional data in response to the Program's supplemental questions to the application. While Auburn and Multicare made similar adjustments during the application process, Valley did not.

1.11 The Program's process of supplementing the statistical data both affects the analysis of the number of acute care beds that are needed in the service area and can affect the number of acute care beds an applicant can receive. Normally, the change in the acute bed number is to increase the number needed. In the concurrent review of the Auburn, Multicare, and Valley applications, the Program's supplementation actually showed a reduction in the acute care bed need number.

Bed Need Methodology

1.12 Like other CN projects (for example, kidney dialysis projects or ambulatory surgical facilities), an acute care bed application relies on historical information in the service area (Southeast King County) and uses the known information to project whether acute care bed need exists in the future based on the anticipated population growth within the relevant time period. Here the need for additional acute care beds is

determined using known information (planning area resident hospital discharge information) from a specific period (2000-2009) and used the anticipated population growth in Southeast King County to calculate what the need for additional beds will be by the target date or planning horizon. If the planning horizon is seven years, that date is 2016. If the planning horizon is ten years, that date is 2019.

1.13 There is currently no statute or regulation that addresses how to calculate the number of additional acute care hospital beds in a given service area. The Program relies on a 12-step methodology contained in the State Health Plan to measure whether additional acute care beds are necessary.[7] The State Health Plan was terminated effective June 30, 1990. *See* RCW 70.38.919. Even though the State Health Plan was terminated, both the Program and applicants rely on the bed need methodology in the State Health Plan to determine whether additional beds are required for the service area.

1.14 Both the Program and applicants have consistently followed the State Health Plan bed need methodology. The predictability afforded by the consistent use of the State Health Plan methodology argues for its continued use in measuring acute care bed need.[8]

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[7] Exhibit M-2 is a copy of the Washington State Health Plan, Volume 2. References made to the State Health Plan will be cited in Exhibit M-2 and using the internal page numbering system of the plan.

[8] Any bed need methodology used should provide a predictable, transparent, and consistent process for applicants. An applicant should know what is required to apply for a CN (transparency of process), how the program will apply the process (predictability of the process), and whether the program follows the process (consistency with the past process).

1.15 The State Health Plan uses a seven-year planning horizon (that is, how far into the future to go in assessing bed need) when evaluating if existing facilities qualify for an expansion of the number of acute care beds (here Auburn and Valley). Exhibit M-2, page C-30 (Criterion 4a). For major policy questions (whether a community should have a hospital or an additional hospital), the State Health Plan uses a long range forecast (that is, a 10, 15, or 20 year planning horizon) regarding the expansion of acute care beds. *See* Exhibit M-2, page C-30 (Criterion 4b). The State Health Plan does not specify what planning horizon should be used in a concurrent review situation where there are both existing facilities and a proposed new facility seeking acute care beds.

1.16 In determining the planning horizon for all three applications, the Program considered and rejected a planning horizon of 15 years. *See* AR 563. Given the current trends for in and out migration, the Program decided against the 15-year planning horizon for the Auburn and Valley applications. *See* AR 563; *see also* Appendix A to the Program's Evaluation. Instead, the Program decided to use a seven-year planning horizon for these applications. AR 551 and AR 563.

1.17 The Program used a different planning horizon for the Multicare application; it used a 15-year planning horizon, consistent with most new hospital projects. AR 551. The Program's choice to use two different planning horizons for the three applications was crucial in its decision that only one applicant could meet the need requirement. That is, using the seven-year planning horizon, the Program's need methodology calculation for the service area resulted in a need calculation of

47 additional acute care beds in the service area for the Auburn and Valley applications. AR 606. Using a seven-year planning horizon, the Program determined that neither the Auburn application (seeking 70 beds) nor the Valley application (seeking 60 beds) could qualify because they each applied for more beds than the Southeast King service area required. Because neither Auburn nor Valley provided for a lesser alternative number of beds, the Program decided to deny both applications.[9]

1.18 As discussed above,[10] the Program first determined whether there existed any bed need in the Southeast King County planning area. Having found that need existed, and having disqualified Auburn and Valley using the seven-year planning horizon, the Program looked to see if the Multicare application would qualify. As it could use a 10 to 15-year horizon to evaluate the Multicare application, the Program then looked to see whether Multicare would qualify within that time period. The Program determined there would be a need for 65 additional acute care beds at the eight-year mark of the planning horizon. As Multicare requested 58 beds, the Program concluded Multicare could meet the need requirement by year eight, clearly within the Program's anticipated 10 to 15-year planning horizon. More specifically, because there was a need for 65 additional beds in year eight, and because Multicare applied for 58 acute

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[9] The Program has granted CN applications for less than the full number of acute care beds requested by an applicant. This approach is normally used in single application situations. The Program uses this approach with application projects that phased in the number of beds over time. In such circumstances, the Program made this decision a condition of the CN that the applicant could choose to accept.

[10] *See* Finding of Fact 1.2.

care beds, the Program concluded only Multicare met the WAC 246-310-210(1) need requirement.

1.19 The Program's decision to use two different target dates or planning horizons in a concurrent review of competing applications was brought into question by the testimony of the expert witnesses. All three application experts (Bob McGuirk, Jody Carona, and Frank Fox) testified that using the same planning horizon was appropriate in determining need for Southeast King County.[11] The use of the same planning horizon is consistent with the Program's own past practice. *See* Exhibits M-13 and Exhibit M-17; *see also* TR Vol 4, page 917, line 13 through page 918, line 13 (Testimony of Frank Fox Ph.D.). The Presiding Officer agrees. Based on the totality of the evidence from the experts on this issue, the Presiding Officer finds it appropriate to use a 10-year planning horizon in the concurrent evaluation of the Auburn, Valley, and Multicare applications. Using the Program's bed need calculations, there will be a need for 102 additional acute care beds by the tenth year (2019). *See* AR 606. The use of a 10-year planning horizon rather than a 15-year horizon balances two requirements: (1) new facilities require a longer horizon (*See* Exhibit M-2, Page C-30, Section 4); and (2) the health planning system does not have the ability to eliminate existing surpluses of capacity (See Exhibit M-2, Page C-26, Item 5).

1.20 None of the applicants questioned the Program's need methodology calculations or presented an alternative version of the need methodology at hearing. As

[11] Expert witnesses Bob McGuirk and Jody Carona believed a 10-year target date was appropriate. Expert witness Frank Fox, Ph.D., believed a 15-year target date was appropriate.

stated above, there is a need for 102 additional acute care beds by 2019 (year 10). No applicant (Multicare, Valley, or Auburn) is automatically disqualified based on the number of beds being requested under WAC 246-310-210(1).

Occupancy Rates

1.21 The State Health Plan provides guidance to applicants in addition to the bed need methodology. One of the relevant factors in the State Health Plan includes occupancy standards (the percentage or amount of time an acute care bed is "occupied" with a patient) and bed capacity (when a bed is "available" or could be made available for patient use). *See* Exhibit M-2, pages C-37 to C-39.

1.22 Why is this information relevant? A hospital bed is not "occupied" 100 percent of the time. The number of occupied beds depends on the number of patients being treated at the facility on any given day as determined by the average daily census (a count of the actual number of patients within a given facility, usually taken at midnight or noon each day). The average daily census number is converted into the number of beds available at the facility. For example, if a facility has 200 acute care beds, but an occupancy rate of 50 percent, the hospital has 100 "available" beds within the facility. The State Health Plan provides guidance on the occupancy rate for a facility depending upon its size (the total number of beds). *See* Exhibit M-2, page C-38 (Criterion 11).

1.23 Future bed need is not measured in isolation to the applicant's facility, but requires a count of beds of all of the hospital facilities within the service area. The State Health Plan specifies that the bed count includes all of the beds that are available or

could be available for patient use. This consideration includes beds that are available through being unoccupied. More specifically, the State Health Plan provides the bed capacity standards to include beds that:

A. Are currently licensed and physically set up without *significant capital expenditures* requiring new state approval; and

B. Do not physically exist but are authorized unless for some reason it seems certain that those beds will never be built.

See Exhibit M-2, page C-39 (Criterion 12(a)(1) and (2) (emphasis added). The term "significant capital expenditure" is not defined but can, at a minimum, include such factors as the amount of time, money, and process (permits and construction review) it takes to make the bed available for patient use.

1.24 The occupancy rate of the service area can be affected by the outmigration of patients (patients who leave the planning area to obtain treatment elsewhere). The rate of outmigration can, and is measured with, mathematical precision. It is clear that the reduction of the outmigration rate is desirable, as it ensures the efficient use of the bed capacity in a given planning area.

1.25 The reduction of the outmigration of patients is an important goal. For that reason, it is necessary to identify the reasons for outmigration to reduce the outmigration rate in the service area. Possible reasons for outmigration include: the unavailability of medical services at a given facility; the proximity of a facility to where the patient lives or works; the patient's insurance coverage requires a patient receive treatment services with a specific provider or at a specific facility; the reputation of a

specific facility; or a combination of the factors. While the occupancy rate is measured with mathematical precision, the reasons for outmigration are not specifically addressed in the application process.

Remaining Requirements

1.26 Chapter 246-310 WAC does not specify financial feasibility, the structure and quality of care, and cost containment criteria as identified in WAC 246-310-200(2)(a)(i). *See* AR 569 through 584. There are also no recognizable standards for evaluating these criteria as identified in WAC 24-310-200(2)(a)(ii). *Id.* The Program has developed measures used in determining if an applicant meets the relevant criteria over time. Therefore, the criteria will be assessed using the Program's experience and expertise. *See* WAC 246-310-200(2); *see also* RCW 34.05.461(5). The specific experience and expertise is discussed in evaluating the application criteria below.

AUBURN APPLICATION

1.27 Auburn, a for-profit hospital, is owned and operated by Universal Health Services, Inc., and is located in Auburn, Washington. At the time of the application, Auburn was licensed for 162 beds, with 124 beds categorized as acute care beds. Auburn provides geropsychiatric services in a 38-bed unit located within the hospital.

1.28 Auburn's application proposed to add 70 acute care beds to its existing hospital. Auburn intended to add the beds in two phases: phase one would add 54 of the new beds in a three-story tower built in the northeast corner of the current hospital by 2012; phase two would build the 16 remaining beds in 2013.

1.29 The capital expenditures associated with the tower construction was $34,159,515. Of that figure, 63 percent was related to the tower construction cost, 19 percent to additional equipment, and the remainder was allocated to taxes and fees.

Need Criteria under WAC 246-310-210(1)

1.30 Auburn used the State Health Plan need methodology and calculated that need existed in the Southeast King Planning Area. Auburn's need calculations in its application differed from the need number calculated by the Program in its evaluation, in part because it used a different planning horizon. Auburn did not dispute the Program's need calculations at hearing. Using the ten-year planning horizon, Auburn's request for 70 acute care beds did not cause an automatic denial of the application, given the Program calculated 102 additional beds would be needed by 2019 (year 10 of the planning horizon). This assumes Auburn meets the other relevant criteria and was successful in the concurrent review process. *See* AR 606 (Appendix 10a); *see also* Finding of Fact 1.20.

1.31 If Auburn's application for 70 beds were accepted, the State Health Plan need methodology must be recalculated to include the 70 beds awarded to Auburn. The recalculation of the State Health Plan methodology shows there will be a need for 34 additional acute care beds by 2019. *See* AR 607. If Auburn was awarded a CN application, there is still sufficient need to grant either Valley or Multicare the remaining 34 acute care beds. In its application, Valley anticipated the first phase of expansion would be 30 beds. *See* AR 1481. Multicare's fourth option was for a 34-bed acute care facility. *See* AR 78.

Charitable Care Criteria under WAC 246-310-210(2)

1.32 WAC 246-310-210(2) requires an applicant provide charity care within the relevant service area. The charity care requirement means that a hospital meet or exceed the regional average level of charity care (service to low-income, racial and ethnic minorities, handicapped, and other underserved groups) to qualify for a CN. *See* RCW 70.38.115(2)(j). The Department of Health's Hospital and Patient Data Systems program (HPDS) captures this data for the King County region of which Auburn is a part. The information is captured as a percentage of the facility's gross revenues and adjusted revenues for a three-year period. According to 2006-2008 HPDS data, the three-year average for King County was 1.36 percent (gross revenues) and 2.42 percent (adjusted revenues).

1.33 In its application and at hearing, Auburn conceded that it has not met this requirement in the past because its relevant three-year charity care average was 0.61 percent of its gross revenues for 2006-2008, and 1.12 percent for its adjusted revenues, which is below the King County Regional averages for hospitals. Auburn predicted that it would improve upon this trend so it would exceed the King County regional averages. To meet this criteria, Auburn was willing to agree to a condition that required it to maintain documentation regarding the amount of its charity care and increase its charity care so that it meets or exceeds the King County Regional averages. Auburn submitted a copy of its current Admissions Policy as proof of its intention to provide the requisite charity care at its hospital.

Financial Feasibility under WAC 246-310-220

1.34 Under WAC 246-310-220(1), Auburn must show whether the immediate and long range capital and operating costs of the project can be met. Auburn provided a summary of its overall balance sheet for the project. *See* AR 659-666. The HPDS program then measures Auburn's financial feasibility using a series of ratios that measure: (1) long term debt to equity; (2) current assets to current liabilities; (3) assets financed by liabilities; (4) total operating expenses to total operating revenue; and (5) debt service coverage.

1.35 Auburn projected its capital expenditure for the 70-bed project to be $34,159,514. *See* AR 659. The cost for the project would be borrowed from its parent company (Universal Health Services), which had $1.88 billion in retained earnings available according to its 2009 balance sheet. *See* AR 661 and AR 2839. When compared to the state financial ratios, Auburn can meet its immediate and long-range capital expenditures, as well as its operating costs. *See* AR 2840.

1.36 WAC 246-310-220(2) measures whether Auburn's project costs (including construction costs) will result in an unreasonable impact on the cost and charges for health services. This is measured by comparing Auburn's project costs with similar like projects previously examined by the Program. The costs of the project are the costs and charges the patients and community actually see come out of their pocketbooks.

1.37 Auburn's proposed project would add 70-acute care beds in two phases. As stated above, the total cost of the project is $34,159,514: 60 percent is related to construction; 19 percent related to equipment; and the remainder to applicable

taxes/planning costs. *See* AR 659. The HPDS summary of Auburn's projected costs and charges for the period 2014-2016 showed a range of Auburn's net profit by adjusted patient day. Auburn's net profit by adjusted patient day ranged from a low of $27 (2014) to a high of $55 (2016). These figures were similar to the Washington statewide averages for net profit. AR 2840.

1.38 WAC 246-310-220(3) measures whether Auburn's project can be appropriately financed. As stated above, Auburn will receive funding from its parent corporation (Universal Health Services), which submitted a letter of commitment for the funds. *See* AR 661 and 983. This is an appropriate method of financing the project.

<u>Structure and Process of Care under WAC 246-310-230</u>

1.39 WAC 246-310-230(1) measures whether Auburn's project shows there will be a sufficient supply of qualified staff (both health and management) available or able to be recruited. Auburn expected no difficulty in recruiting staff because: 1) it offers a generous benefit package; 2) it is a clinical training facility; 3) it has national and regional recruiting efforts as well as electronic job postings; and 4) it has an employee referral program. AR 667.

1.40 WAC 246-310-230(2) measures whether Auburn's project has an appropriate relationship to ancillary and support services, and whether the support services will be sufficient to support the project. Auburn currently provides health care services in Southeast King County and the surrounding areas. Auburn's recent facility expansion projects will support the proposed 70-bed expansion.

1.41 WAC 246-310-230(3) measures whether Auburn can provide reasonable assurances that the project will conform with state licensing requirements and Medicaid or Medicare program certification. Auburn currently provides Medicare and Medicaid services to the residents of Southeast King County. It contracts with the Joint Commission[12] to survey and accredit the quality of services provided. The Joint Commission found Auburn to be in full compliance with all applicable standards following the July 2010 survey. AR 2827-2829.

1.42 In addition to the Joint Commission review, the department's Investigation and Inspection Office (IIO) completes licensing surveys for hospitals. The IIO completed a survey in February 2007, which revealed no adverse licensing action for Auburn.

1.43 WAC 246-310-230(4) measures whether Auburn's project will: promote continuity in health care; not result in an unwarranted fragmentation of services; and have an appropriate relationship to the existing health care system in the service area. The promotion of continuity of care and unwarranted fragmentation of services does not require that a single facility provide a patient with all required services. Each hospital is not required to provide all of a patient's needs; continuity of care anticipates that the hospital will transfer a patient to other facilities if the patient's best interest require it.

1.44 One reason Auburn applied for additional acute care beds was to improve its ability to promote continuity of care. Auburn has experienced increased patient

[12] The Joint Commission is an accreditation organization. It has no other, more formal title. *See* AR 2827.

utilization of its hospital for several years. *See* AR 643, Chart 1. Along with its relationship with other community facilities that provide post acute care services, Auburn anticipates the addition of acute care beds within its hospital will facilitate the continuity of care for its patients.

1.45 WAC 246-310-230(5) measures whether Auburn can provide reasonable assurances that the project will provide services in a manner that ensures safe and adequate care in accordance with federal and state laws, rules, and regulations. The recent Joint Commission and IIO survey results support a finding that Auburn can provide safe and adequate care. The Auburn facility complies with the criteria.

<u>Cost Containment under WAC 246-310-240</u>

1.46 WAC 246-310-240(1) measures whether there are superior alternatives currently available or will become available (in terms of cost, efficiency, or effectiveness) to Auburn's proposal to add acute care beds. This criteria assumes that need exists for a project within the appropriate planning horizon. It also assumes that the applicant met all of the other relevant criteria in WAC 246-310-210 through WAC 246-310-230. As a part of its application, Auburn must examine a variety of alternatives including, but not limited to: (1) no project at all; or (2) examining whether one of several alternatives for acute care bed projects (for example, 100 beds vs. 75 beds vs. 50 beds) is superior for

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cost, efficiency, and/or effectiveness.[13]

1.47 The Program did not make a finding in its evaluation regarding Auburn's ability to meet the WAC 246-310-240(1) criteria. *See* AR 590. However, given the decision that all applicants should be viewed with the same 10-year planning horizon, the criteria must be reviewed.

1.48 Auburn considered two alternatives as a part of its application process: (1) expand the current facility; or (2) construct a new hospital at another location within the Southeast King County planning area.[14] AR 671. When considering the two options, Auburn noted that Valley has licensed beds available that were not set up. *See* AR 671. Auburn chose to expand its current facility for three reasons: (1) the ability to complete the project (a new tower to the facility rather than a new hospital) at a lower cost than a new facility; (2) beds in the current facility could be made operational much sooner than a new hospital construction project; and (3) Auburn's current location is in the area where there is the greatest need of acute care beds. *See* AR 671.

1.49 While not addressed in its original application, there is a third option that Auburn must consider in a concurrent review process. That option is whether the Auburn project is the superior alternative to the Multicare and Valley projects. Auburn

[13] The Program traditionally examines the alternatives proposed by the applicants. Auburn and Valley raised the issue that the Program should examine alternatives independent to the ones proposed by the applicants. *See* Exhibits V-6iv and A-3 (JLARC Performance Audit dated June 26, 2006). Given that the Presiding Officer performed a more complete concurrent review in this matter, it was not necessary to address this concern.

[14] Auburn did not consider an alternative normally seen in acute care bed applications, namely to take no action (do nothing).

has argued against the Multicare facility on a number of grounds, including: that Multicare's Covington facility would not be available or accessible to patients requiring complex care; and that building the Multicare facility would unnecessarily duplicate services offered by hospitals within the service area. *See* Auburn's Post-Hearing Closing Argument, pages 4-5. Auburn also argued that Valley should be given priority for any remaining bed need, given its ability to provide the beds in a less costly project. *See* Auburn's Post-Hearing Closing Argument, page 5. This issue will be more fully discussed below.

1.50 WAC 246-310-240(2) applies when the project involves construction and looks at whether: (1) the costs, scope, method of construction, and energy conservation are reasonable; and (2) the project will create an unreasonable impact on the costs and charges to the public of providing health services to the public by other persons.

1.51 Auburn submitted line drawings for its proposed facility. *See* AR 683-685. Auburn anticipates using sustainable design and products in the construction of its proposed tower. AR 672-673. In addition to meeting or exceeding the latest Washington Energy Code requirements, Auburn will evaluate green principles in its design by relying on <u>The Green Guide for Healthcare</u>. AR 673.

1.52 Construction costs can vary due to the type of construction, quality of materials, custom versus standard design, building sites and other similar factors. For that reason, construction costs are viewed in comparison with other similar facilities or similar projects. The HPDS' review of Auburn's $34,159,515 total costs for the

construction project shows the costs are within the construction totals for past projects. AR 2841.

1.53 WAC 246-310-240(2)'s cost containment criteria require that Auburn's project not have an unreasonable impact on the costs and charges to the public. These are the costs and charges the patients and communities see come out of their pocketbooks.

1.54 WAC 246-310-240(3) requires Auburn to show that its hospital project will involve improvements or innovations in the delivery of health care. Auburn projects its 70-bed application will cost $34,159,515. This includes: leasehold improvements; fixed and moveable equipment; architect and consulting fees; financing costs; and taxes and review fees. As discussed above, Auburn's (2016) net profit by adjusted patient days ranges from a low of $27 (2014) to a high of $55. There is a relationship between the amount that a hospital can charge for services and the total amount of revenue that it will receive after raising the patient charges. In other words, if a hospital increases its patient charges by too much, the total amount of revenue the hospital will receive will decrease because of the patient charge increase. Costs are linked to the number of patient days (that is, increased costs can result in decreased patient days). When viewed from that point of view, Auburn's project costs are unlikely to have a negative impact for services in the service area.

MULTICARE APPLICATION

1.55 Multicare, a not-for-profit integrated health system, applied to establish a new 58-bed hospital in Covington, Washington. The site was chosen to complement Multicare's existing Covington Medical Park, which currently houses laboratory, complex imaging, urgent care, and ambulatory surgical services.

1.56 Multicare planned to begin construction of the new facility in its existing Covington Medical Park in 2012. Multicare intended to add the beds in two phases: phase one would add 34 of the new bed total, to be available by July 2014; and the remaining 24 beds would be made operational by July 2015.

1.57 The capital expenditure associated with the hospital construction was $174,700,000. Of that amount, $158,516,891 is attributed to the phased 58-bed expansion of the Covington Medical Park. A capital expenditure for a separate project (to expand the emergency room and imaging department of the Covington Medical Park) constitutes the remaining $16,190,006.

Need Criteria under WAC 246-310-210(1)

1.58 As previously stated, WAC 246-310-210(1) requires an analysis whether the planning area requires additional acute care beds. Multicare used the State Health Plan methodology and calculated that sufficient need existed in the Southeast King Planning Area to support its application by 2014. Using the methodology calculation contained in the Program's evaluation, sufficient need does exist to support the Multicare application by 2017 (the eighth year of the planning horizon). *See* AR 606. Therefore, Multicare's application is not automatically disqualified on the need basis.

1.59 If Multicare's application for 58 beds were accepted, the State Health Plan need methodology must be recalculated to include their proposed 58 beds.[15] If Multicare's 58 acute care beds are included in the calculation, the recalculated methodology shows 51 additional acute care beds will be needed by 2019 to accommodate the increase in the planning area population. *See* AR 608. Thus, in the event Multicare is awarded a certificate of need, there is still sufficient bed need to grant the 51 remaining acute care beds to either Valley or Auburn.

Charitable Care under WAC 246-310-210(2)

1.60 WAC 246-310-210(2) requires an applicant provide charity care within the relevant service area. The charity care requirement means that a hospital meet or exceed the regional average level of charity care (service to low-income, racial and ethnic minorities, handicapped, and other underserved groups) to qualify for a CN. *See* RCW 70.38.115(2)(j). Compliance is measured by comparing a percentage of the Multicare's gross and adjusted revenues for the period 2006-2008 to that of King County for the same period based on HPDS information.

1.61 Multicare currently does not have a facility in King County. It does operate facilities in Pierce County (Good Samaritan Hospital, Mary Bridge Children's Health Center, and Tacoma General Allenmore). When Multicare's charity care averages for its Pierce County facilities is compared to the averages for the hospital facilities in the

[15] Multicare also considered an alternative bed need calculation for a 34-bed project.

King County region, the comparison is favorable to Multicare. Specifically, from 2006-2008, Multicare averaged 1.3 percent in gross revenues and 2.8 percent in adjusted revenues while the hospitals in the King County region averaged 1.36 percent gross revenues and 2.42 percent in adjusted revenues.[16] If granted a CN, Multicare agreed to a condition that it provide charity care at its Covington hospital equal to the King County averages.

Financial Feasibility under WAC 246-310-220

1.62 WAC 246-310-220(1) measures whether the immediate and long range capital and operating costs of the Multicare project can be met. Multicare provided a summary of its project balance sheet. *See* Multicare Supplemental Information, AR 352–355 (58 bed project) and AR 356–359 (34 bed project). HPDS then measured Multicare's financial feasibility using a series of ratios. The ratios include measuring: (1) long term debt to equity; (2) current assets to current liabilities; (3) assets financed by liabilities; (4) total operating expenses to total operating revenue; and (5) debt service coverage.

1.63 Comparing the state financial ratios to Multicare's financial ratios shows that Multicare's assets are held at a higher corporate level (Multicare Health Services). Still, Multicare reports a strong financial position and has sufficient assets to complete the project. AR 2799. There are sufficient assets and funding available to support the project. The HPDS study shows that Multicare's application does not meet the Current

[16] Multicare did not provide Pierce County information for comparison purposes. To allow for relevant comparisons, applicants should provide direct comparison information (county to county).

Assets to Current Liabilities ratio but does retain sufficient funds to address this issue. AR 2800. While Multicare's debt service coverage ratio is also below the state ratio for this category, the discrepancy is explained by the fact that the application only compares Covington income data (the project data) to the Multicare Health System data (the entire system's income data). AR 2800. Based on the totality of the HPDS' analysis, Multicare meets the financial feasibility criteria in WAC 246-310-220(1). This is because it provided sufficient information to support a finding that its project can meet the immediate and long range capital and operating expenses. *See* AR 2798-2801.

1.64 WAC 246-310-220(2) measures whether Multicare's costs for the project (including construction costs) results in an unreasonable impact on the cost and charges for health services. Multicare's project costs are compared with similar like projects previously examined by the Program. The costs of the project are the costs and charges the patients and community actually see come out of their pocketbooks.

1.65 Multicare projects that its 58-acute care bed hospital will cost $158,516,891 (which includes: land and construction; leasehold improvement; fixed and moveable equipment; financing costs; and taxes and review fees). HPDS reviewed Multicare's proposed data for the 2016-2018 period and determined by the third year (2018) Multicare's facility will reach a net profit per adjusted patient day of $164. Multicare's rates and length of stay are similar to a lower case-mix hospital (meaning one that treats patients with less complex illnesses or needing less complex medical care when compared to secondary or tertiary hospitals). AR 2801.

1.66 WAC 246-310-220(3) measures whether Multicare's project is appropriately financed. Multicare anticipated financing 68 percent of the 58-bed project using tax exempt bonds, with the remaining 32 percent being financed by existing cash reserves. Multicare considered financing the project in two ways: using debt instrument financing; or using cash reserves. *See* AR 190-204 and AR 352-355. Multicare Health System (the corporate level) currently has sufficient cash reserves to finance the entire project. It chose to finance the project using tax exempt bonds to maintain flexibility and retain sufficient cash to meet its business needs within the current financial climate. Financing using such bonds is an appropriate business practice.

<u>Structure and Process of Care under WAC 246-310-230</u>

1.67 WAC 246-310-230(1) measures whether Multicare's project shows it has available or can recruit a sufficient supply of qualified staff (both health and management). In the past, Multicare has achieved staffing goals by partnering with local universities and colleges, supporting employee career development, using various apprenticeship programs, and using a variety of recruiting strategies. *See* AR 68-70.

1.68 WAC 246-310-230(2) measures whether Multicare's project has sufficient ancillary and support services to support the project. Multicare currently provides health care services to Southeast King County through its Covington Medical Park facility. The Multicare health system provides an integrated health system. AR 71. The integrated system includes e-visits, telemedicine referrals between facilities, and is currently implementing electronic health records. AR 72. Multicare's 58-bed hospital will not

require the creation of a new integrated health system, only the expansion of the existing system to the Covington hospital.

1.69 WAC 246-310-230(3) measures whether Multicare's project shows or provides reasonable assurances that the project will conform with state licensing requirements and Medicaid or Medicare program certification.

1.70 Multicare currently provides Medicare and Medicaid services in its existing Pierce County facilities. The Multicare facilities contract with the Joint Commission to survey and accredit the quality of services provided. In its February 2007 survey, the Joint Commission found Multicare's facilities (Tacoma General/Allenmore and Good Samaritan Hospital) were in full compliance with all applicable standards.

1.71 The Department's Investigation and Inspection Office reviewed Multicare's hospitals for the most recent three-year period. The Investigation and Inspection Office took no adverse licensing actions following the surveys.

1.72 WAC 246-310-230(4) measures whether Multicare's project will: promote continuity in health care; not result in an unwarranted fragmentation of services; and have an appropriate relationship to the existing health care system in the service area. The promotion of continuity of care and unwarranted fragmentation of services does not require that a single facility provide a patient with all required services. As each hospital is not required to provide all of a patient's needs, it anticipates Multicare's project will transfer patients to other facilities if it is in the best interest of the patient.

1.73 Multicare's business model anticipates that its 58-bed Covington facility will be a part of its integrated health system. As currently planned, if a patient in the

Covington facility cannot receive necessary intensive or tertiary health services,[17] the patient will be transferred to one of Multicare's tertiary hospitals in Tacoma or Puyallup. AR 71. The Covington hospital will also transfer the patient to another hospital (such as Auburn or Valley) if that facility can provide the required service or care.

1.74 WAC 246-310-230(5) measures whether Multicare's project will provide services in a manner that ensures safe and adequate care in accordance with federal and state laws, rules, and regulations.

1.75 The Joint Commission review shows there are no Medicare or Medicaid surveys showing concerns with Multicare facilities. The Program's review by the Office of Investigation and Inspection also show no licensing concerns with Multicare's facilities.

Cost Containment under WAC 246-310-240

1.76 WAC 246-310-240(1) measures whether superior alternatives (in terms of cost, efficiency, or effectiveness) are not available or practicable to the propose project. The WAC 246-310-240(1) criteria assumes that need exists for additional acute care beds within the Southeast King County planning area. The criteria also assumes that Multicare has met the other WAC 246-310-210 through WAC 246-310-230 criteria. Multicare must examine a variety of options including, but not limited to: (1) no project at all; or (2) examining several options for acute care bed projects (for example,

[17] "Tertiary health services" means a specialized service meeting complicated medical needs of people and requires sufficient patient volume to optimize provider effectiveness, quality of service, and improved outcomes of care. WAC 246-310-010(58).

100 beds vs. 75 beds vs. 50 beds) for cost, efficiency, and/or effectiveness.[18]

1.77 Multicare considered four options: (1) do nothing; (2) establish a 120-acute care bed facility; (3) establish a 58-acute care bed facility; or (4) establish a 34-acute care bed facility (that is, establish only the first phase of the 58-bed option.) AR 75-78. Of the four choices, Multicare determined that the 58-bed facility was the most appropriate option for patient quality of care and access. It decided the 120-bed option did not fit within its strategic plan and the 34-bed option provided insufficient capacity for the expected medical patient demand. AR 78. The 58-bed project could be built for $158,516,891. The total capital or cost per bed (the total capital divided by 58 beds) shows the initial investment is $2,733,050 per bed. Multicare's cost per bed compares favorably to other new acute care hospitals in Western Washington. *See* testimony of Frank Fox, Ph.D. Specifically, the Franciscan/Gig Harbor hospital's bed cost is $2 million per bed; the PeaceHealth/Friday Harbor hospital bed cost is $3.3 million per bed. *See* TR IV, at 872-873. Multicare's cost per bed is within the range for the other new hospitals.

1.78 While not addressed in the original application, there is a fifth option that Multicare must consider under the concurrent review process: whether the Multicare project is the superior alternative when compared with the Auburn and Valley projects. Multicare argued that its integrated system was superior to either the Auburn or Valley

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[18] The Program traditionally examines the alternatives proposed by the applicants. Auburn and Valley raised the issue that the Program should examine alternatives independent to the ones proposed by the applicants. *See* Exhibits V-6iv and A-3 (JLARC Performance Audit dated June 26, 2006). Given that a more complete concurrent review in this matter, the Presiding Officer need not address this concern.

projects in its rebuttal submission.[19] AR 480-487. A more complete discussion of WAC 246-310-240(1) is set forth below. *See* Findings of Fact 1.147-1.148 below.

1.79 WAC 246-310-240(2) applies when, as in Multicare's application, a project involves construction. It analyzes whether: (1) the costs, scope, method of construction, and energy conservation are reasonable; and (2) the project will not have an unreasonable impact on the costs and charges to the public of providing health services to the public by other persons.

1.80 In regards to its cost, scope, and method of construction, Multicare submitted line drawings of the proposed facility. AR 116-127. Multicare has applied available design and construction guidelines by utilizing the *AIA Design Guidelines for Healthcare* and the *2006 Guidelines for Design and Construction of Healthcare Facilities*. AR 81. Multicare partnered with CB Richard Ellis, Inc., to ensure that it used the latest and most innovative design and construction techniques. The cost per bed for Multicare's project is within the range for similar new hospital projects.

1.81 In regards to whether its project will have an unreasonable impact on the costs and charges to the public, the costs of the project are the costs and charges the patients and community actually see come out of their pocket book.

1.82 WAC 246-310-240(3) requires Multicare to show its 58-bed application will involve improvements or innovations in the delivery of health care. Here Multicare

[19] Multicare adopted the Program's analysis that neither Auburn nor Valley met the need criteria, so that no comparative review was required. *See* Multicare's Post-Hearing Brief, page 22. Given that the planning horizon for all three applications is 10 years, this argument is not convincing.

projects the 58-acute care bed hospital will cost $158,516,891 (which includes: land and construction; leasehold improvement; fixed and moveable equipment; financing costs; and taxes and review fees). HPDS reviewed Multicare's proposed data for the 2016-2018 period and determined by the third year (2018) Multicare's facility will reach a net profit per adjusted patient day of $164. Multicare's rates and length of stay are similar to a lower case-mix hospital (a hospital that treats patients with less complex medical needs or requiring less complex medical treatment, when compared to secondary or tertiary hospitals). AR 2801. There is no unreasonable impact on the costs to the public by Multicare's project.

VALLEY APPLICATION

Initial Application

1.83 Public Hospital District #1 of King County, d/b/a Valley, is located in Renton, Washington. At the time of the application, Valley was a 303-bed facility, which includes 124 beds categorized as acute care beds.

1.84 Valley applied for a CN to increase its acute care bed total by 60 beds by using a new seven story tower.[20] Valley planned to add the acute care beds in two phases: phase one would add 30 of the beds by January 2012 through re-habituating (reusing) space currently available in the facility and phase two would build out the remaining 30 beds on the sixth floor of the new tower.

[20] The patient tower was constructed in 2010 and did not require a CN when built.

Need Criteria under WAC 246-310-210(1)

1.85 Valley used the State Plan Methodology to determine whether need existed for its project. Valley's calculations showed that need existed for 12 additional acute care beds by 2013, 35 additional beds by 2014, 56 additional beds by 2015, and 78 additional beds by 2016. AR 1280. Calculations using the State Health Plan methodology shows there is need for an additional 102 beds by 2019 (the tenth year of the planning horizon). *See* AR 606; *see also* Finding of Fact 1.19. Valley's application is not automatically disqualified on the basis of need, as there is sufficient need to support Valley's 60 bed request.

1.86 If Valley's application for 60 beds were accepted, the State Health Plan need methodology must be recalculated to include the 60 beds. The recalculation of the State Health Plan Methodology (if it includes Valley's bed request) shows there will be a need for 13 additional beds by the 10th year of the planning horizon (2019). *See* AR 609. If Valley is awarded a CN, there is still sufficient bed need to grant the remaining 13 acute care beds to either Multicare or Auburn. *See* Finding of Fact 1.85 above.

Charitable Care under WAC 246-310-210(2)

1.87 WAC 246-310-210(2) requires that Valley provide charity care within the relevant service area by meeting or exceeding the regional average level of charity care (service to low-income, racial and ethnic minorities, handicapped and other underserved groups) to qualify for a CN. *See* RCW 70.38.115(2)(j).

1.88 Valley's application shows that it currently provides health care services to Southeast King County residents, including low-income, handicapped and other underserved groups. *See* AR 1342. Valley provided a copy of its current admission policy in support of its application. *See* AR 1343-1350. It also participates in the Medicare and Medicaid programs. To prove its compliance with WAC 246-310-210(2), Valley provided the relevant charity care percentages for the 2006-2008 period. Valley's charity care figures, measured as a percentage of its total revenue (1.70 percent) and adjusted revenue (3.12 percent) compare favorably to those of King County (1.36 percent and 2.42 percent respectively). *See* AR 1281.

Financial Feasibility under WAC 246-310-220

1.89 WAC 246-310-220(1) measures whether Valley's project can meet the immediate and long range capital and operating costs. Valley provided a summary of its balance sheet. HPDS then measured Valley's financial feasibility using a series of ratios to measure Valley's: (1) long term debt to equity; (2) current assets to current liabilities; (3) assets financed by liabilities; (4) total operating expenses to total operating revenue; and (5) debt service coverage.

1.90 Valley projected its capital expenditures for the 60-bed expansion to be $19,672,500. Phase one of the expansion was estimated to be $250,000, which consists of adding 30 beds to an existing wing of the hospital. Phase two consisted of building out 30 beds on the 6th floor of the pre-constructed patient care shell, which constituted the balance of the capital expenditures. AR 1290. Valley will fund the balance of the new expenditures for the project with organizational

reserves (90 percent) and operating income (10 percent). *See* AR 574. An HPDS review of the balance sheet from Valley's application shows Valley has an average financial position. Valley's financial assets will allow it to handle the proposed project. *See* AR 2867.

1.91 The HPDS review compared Valley's financial feasibility to the state ratios set forth in Paragraph 1.89 above. On its face, a comparison of the state's 2008 financial feasibility ratios to Valley's 2009 ratios did not appear favorable. Valley's 2009 rations reflect approximately $140 million in construction in progress. Because it appears that Valley will break even (that is, it will almost likely match the state's 2008 ratio figures) by the third year of its operation (2016), Valley can meet the immediate and long range capital expenditures as well as the operating costs. *See* AR 2868.

1.92 WAC 246-310-220(2) measures whether the costs of Valley's project (including construction costs) will result in an unreasonable impact on the costs and charges for health services. Valley's project costs are compared with similar projects previously examined by the Program. The costs of the project are the costs and charges the patients and community actually see come out of their pocketbooks.

1.93 Valley proposed to add 60 acute care beds in multiple phases beginning in 2012. Including the costs associated with for the 6th floor of the patient tower, the total cost of the project would be $38,845,000. *See* AR 1483. As stated above, the bed expansion was $19,922,500. Of that amount, 85 percent goes toward construction of phase 2 of the project. *See* AR 1290 and AR 579. The HPDS analysis of Valley's forecasted rates shows the net profit per adjusted patient days for the period

2015 – 2017 ranges from $151 (2015) to $178 (2017). The costs using this measure show that it is unlikely to have an unreasonable impact on the costs and charges for health services. *See* AR 580.

1.94 WAC 246-310-220(3) measures whether Valley's project is appropriately financed. Valley's project will be financed using reserves and operating income. Valley's approach is an appropriate business practice. There are both sufficient reserves and operating income to finance the project.

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

1.95 WAC 246-310-230(1) measures whether the project shows a sufficient supply of qualified staff (both health and management) is available or can be recruited. Valley anticipated adding full time equivalent positions to the hospital staff in specific areas, including administration, nursing, and other related support staff positions. *See* AR 1294 and AR 1486. The majority of the recruiting effort will be in hiring registered nursing staff.

1.96 WAC 246-310-230(2) measures if Valley's project has an appropriate relationship to ancillary and support services, and whether the support services will be sufficient to support the project. Valley currently provides health care services to Southeast King County through its existing facility. Valley anticipates the previously constructed patient tower will add sufficient capacity to accommodate and support the ancillary services to meet the increased patient census. AR 1294.

1.97 WAC 246-310-230(3) examines whether the project will conform to state licensing requirements, and any Medicaid or Medicare program certification. This

criterion normally measures Valley's history of compliance with the relevant state and federal requirements in these areas.

1.98 Valley currently provides Medicare and Medicaid services to the Southeast King County planning area. Valley contracts with the Joint Commission to survey and accredit the quality of services provided. Based on the Joint Commission's August 2009 survey, Valley is in compliance with the appropriate standard. *See* AR 2860-2864.

1.99 In addition, the Department's IIO reviewed the Valley facility. In the most recent three-year survey period, the IIO reports Valley has no adverse licensing actions. *See* AR 586.

1.100 WAC 246-310-230(4) measures whether Valley's project will: promote continuity in health care; not result in an unwarranted fragmentation of services; and have an appropriate relationship to the existing health care system in the service area. Continuity of care and unwarranted fragmentation of services does not require that a single facility provide a patient with all required services. As each hospital is not required to provide all of a patient's needs, it anticipates that Valley will transfer patients to other facilities if it is in the patient's best interests.

1.101 Because it has provided care in the Southeast King County planning area for many years, Valley has established relationships with community facilities to provide post acute care services. AR 1294 and AR 1351-1354. There is nothing in Valley's proposed project to indicate a change will occur in those relationships if the project was

granted. There is no evidence to suggest Valley's project will result in any unwarranted fragmentation of health care services.

1.102 WAC 246-310-230(5) measures whether there is a reasonable assurance that Valley's project will provide services in a manner that ensures safe and adequate care in accordance with federal and state laws, rules, and regulations. Given the results of the recent Joint Commission and IIO survey reviews, the evidence on record supports a finding that Valley can provide both safe and adequate patient care.

Cost Containment under WAC 246-310-240

1.103 WAC 246-310-240(1) measures whether superior alternatives (in terms of cost, efficiency, or effectiveness) to Valley's project are not available or practicable. This assumes that need exists for a project within the appropriate planning horizon. This requires Valley to examine a variety of options including, but not limited to: (1) no project at all; or (2) examining whether one of several options for acute care bed projects (for example, 100 beds vs. 75 beds vs. 50 beds) for cost, efficiency, and/or effectiveness.[21]

1.104 Valley considered three alternatives as a part of its application: add 40 beds to its existing NW-A and NW-B wings of the hospital with a limited $250,000 capital expenditure; add 60 beds by building out the 6th floor of the previously

[21] The Program traditionally examines the alternatives proposed by the applicants. Auburn and Valley raised the issue that the Program should examine alternatives independent to the ones proposed by the applicants. *See* Exhibits V-6iv and A-3 (JLARC Performance Audit dated June 26, 2006). Given that a more complete concurrent review was performed in this matter, the Presiding Officer need not address this concern.

constructed patient tower for $19,672,500; or build a new hospital in the Covington area – to improve travel time access to Covington area patients – at a cost of $158,500,000. AR 1296.[22] Valley chose the 60-bed option as the most appropriate option. AR 1300. Valley determined that the 60-bed option: (1) had a modest capital cost per bed; (2) required no start up costs; and (3) would not incur any operating costs. AR 1298. While Valley expected the 60-bed option was the best of the available options for hospital bed utilization, it noted the option did not improve travel time for inpatient hospital services in the Southeast King County service area. *See* AR 1298.

1.105 While not addressed in the original application, there is a fourth option that Valley must consider under the concurrent review process. That option is whether the Valley project is the superior alternative when compared to the Auburn or Multicare projects. Valley subsequently addressed this issue by arguing that its cost per bed ($331.042) is superior to Auburn's ($487,994) or Multicare's ($2,733,050). *See* Valley Medical Center Opening Post-Hearing Brief, page 4. Valley further argued that the Multicare project would not contain an intensive care unit, cannot care for stroke or cardiac patients, and cannot provide tertiary services (for example, Level II or III neonatal intensive care; or percutaneous translumenal coronary angioplasty). Valley argues it is a better fit in Southeast King County services area because it has provided

[22] Valley did not include an alternative often seen in the WAC 246-310-240(1) analysis, namely to do nothing. It did provide information addressing the "no action" option in its answers to the supplemental questions. *See* AR 1486.

and can continue to provide such services. *Id*.

1.106 WAC 246-310-240(2) measures Valley's construction costs for the project. Valley must analyze whether: (1) the costs, scope, method of construction, and energy conservation are reasonable; and (2) the project will not have an unreasonable impact on the costs and charges of providing health services to the public.

1.107 Valley submitted single line drawings of it existing services and the proposed changes. See AR 1315-1321 (existing) and AR 1322-1324 (project). Valley proposes capital cost reductions through its use of the existing NW-A and NWB nursing wings of the facility and cost reductions by using the shelled floor in the 2010 patient tower. The HPDS review concluded the Valley construction costs were within the construction costs range for past projects. AR 593 and 2870.

1.108 WAC 246-310-240(3) requires that Valley shows its 60-bed application will involve improvements or innovations in the delivery of health care. The Southeast King County service area has an unmet bed need. *See* Paragraph 1.19 above. Because of this unmet bed need, adding the 60 additional beds Valley is seeking will not have an unreasonable impact on the costs and charges to the public. Valley's net profit per adjusted patient day for the period 2015-2017 supports this finding. The range of Valley's net profit per patient day starts at $151 to $178. *See* AR 580.

<u>Petition for Reconsideration under WAC 246-310-560</u>

1.109 Valley requested the Program reconsider its decision to award the CN. Valley argued reconsideration was warranted because the Program failed to meaningfully complete a comparative review of the Valley, Auburn, and Multicare

applications. More specifically, Valley argued the Program:

A. Failed to evaluate Multicare's and Valley's applications using the same planning horizon and weighted occupancy standards;

B. Based its decision using 2009 CHARS dates that was not available to Valley at the time it filed its application;

C. Failed to conduct any meaningful review or comparative review of certificate of need criteria regarding financial feasibility, structure and process of care, and cost containment; and

D. Made a series of errors that resulted in an inaccurate need calculation.

Valley's Request for Reconsideration.[23] AR 2381. The Presiding Officer is the final decision-maker in this case and has considered the issues raised by Valley in its reconsideration request. *See DaVita v. Department of Health*, 137 Wn. App. 174, 184 (2007). The traditional reconsideration remedy is the referral back to the Program to address the reconsideration issues. That approach is unnecessary here. The Presiding Officer addresses the Valley issues below.

1.110 Based on the totality of the expert testimony at hearing, the same planning horizon must be used when comparing applicants seeking to expand their acute care beds with one or more applicants that seek to establish acute care beds in a new hospital. *See* Findings of Fact 1.19. As the same planning horizon applies to all applicants, Valley's application is not automatically disqualified by the previously used seven-year planning horizon.

[23] Valley raised another issue: an alliance with the University of Washington Medical Center. Given the Presiding Officer's ruling on the 10-year planning horizon and addressing the other issues, the alliance issue will not be addressed further.

1.111 The Program's use of 2009 CHARS data was consistent with its past practice of supplementing CN applications with more recent data to obtain the most accurate picture of those applications. Both Multicare and Auburn attempted to address this fact by including additional information in their respective supplemental information. *See* AR 456, and 489–500 (Multicare) and AR 1185, and 1188–1202 (Auburn). Valley could have provided supplemental information on this issue but did not do so.

1.112 At the hearing, there was no evidence to dispute the need determination calculated by the Program. Absent a showing of error in the need calculations, no review of that information is required here.

1.113 Valley argued that the Program conducted no "meaningful" concurrent analysis of the three applications. The relevant concurrent analysis of the issues for the Auburn, Multicare, and Valley applications are addressed more fully below.

CONCURRENT ANALYSIS

1.114 A CN is made on a "snapshot" in time. *See University of Washington Medical Center v. Department of Health*, 164 Wn. 2d 95, 103 (2008). The snapshot is generally viewed as evidence that was in existence at the time of the application and is contained in the application record. Both RCW 70.38.115(7) and WAC 246-310-240(1) anticipate that the CN project will foster cost containment by showing there are no superior alternatives in terms of cost, efficiency, or effectiveness.

1.115 The RCW 70.38.115(7) concurrent analysis process requires that Valley, Auburn, and Multicare each show that its application met all of the CN criteria, which includes being the superior alternative under WAC 246-310-240(1). While Valley or

Auburn must show its application is the superior alternative, neither Valley nor Auburn bear the burden of showing that Multicare's application was incorrectly granted. *See DaVita v. Department of Health*, 137 Wn. App. 174, 184-185 (2007). The issues the parties identified at hearing and in the post-hearing briefing will be considered to determine if one or more applications is the superior alternative.

1.116 Given the ruling that the planning horizon is ten years, there is sufficient bed need to approve more than one CN application in Southeast King county planning area. *See* Findings of Fact 1.19–1.20 above. None of the three applicants is automatically disqualified under the need criteria.

<u>Patient Access</u>

1.117 As a part of the application process, both Valley and Multicare addressed expansion into the Covington, Washington area, with the stated purpose of improving patient access to hospital services. Valley decided against expansion into the Covington area, given that it could expand more quickly and with less cost at its Renton facility. *See* AR 1296. Multicare decided to expand into the Covington area because it improved patient access. *See* AR 319 – 325.

1.118 A review of a map reveals that the current Valley and Auburn facilities are near or on State Route 167, a busy state route that parallels Interstate 5 (the main north-south arterial in Western Washington). *See* AR 324. For Covington residents to reach either the Valley or Auburn facilities, they must first travel down the State Route 18, which is a heavily traveled road. Traffic congestion, which on a good day is slow, increases during the commute times (7:30 a.m. to 9:00 a.m.; 12:00 to 1:30; and

3:30 p.m. to 6:00 p.m.) or if there is any traffic delay (inclement weather or traffic accident).[24] *See* AR 324–325. The traffic congestion evidence is undisputed.

1.119 By 2009, there were approximately 42,800 people living within a two-mile radius of the Covington area, and 220,651 people within a five-mile radius of the Covington area. While Auburn is currently near the intersection of State Route 167 and State Route 18, the evidence at hearing shows that Auburn is at or very near its acute care bed capacity (indeed, it is the reason why Auburn seeks additional acute care bed capacity). *See* AR 646 and AR 1679. To reach the Valley facility a patient must travel in a southwest direction down State Route 18 and then north up State Route 167 (each a heavily traveled route). Valley acknowledges that even if it was awarded a CN, it would not improve patient travel times. *See* Finding of Fact 1.102. Based simply on the location and traffic congestion patterns, locating a hospital within the Covington area is necessary to improve patient access. When adding in the increased population, it is imperative.

1.120 Based on the totality of the population and traffic congestion factors, there is sufficient reason to approve Multicare's request to locate a hospital in the Covington area on the issue of patient access.

Costs of Construction

1.121 The Program awarded CN No. 1437 to Multicare, even though Multicare's cost per bed figures ($2.7 million per bed) were appreciably more costly when

[24] The Presiding Officer takes judicial notice of the commute times pursuant to Evidence Rule 201.

compared to Auburn's cost per bed ($487,994 per bed) or Valley's cost per bed ($331,042 per bed). If the cost (and speed) of construction were the controlling factor, Valley's application would be superior. Valley can complete the first phase of its project for a capital cost of $250,000 (a cosmetic update of existing space to house the first 30 beds of its 60 bed project). Valley's project could become operational almost immediately upon the approval of its CN application.

1.122 While there is no dispute, Multicare's $2.7 million cost per bed figure is much large than those of Valley or Auburn, the comparison is misleading. It is not appropriate to compare Multicare cost per bed figure (a new facility) to the cost per bed figures for Auburn or Valley (existing facilities). The correct approach is to compare Multicare's cost per bed figure to the cost per bed for other new facilities. When viewed in this light, Multicare's $2.7 million cost for bed figure is in line with other the recently approved hospitals in Gig Harbor in 2008 and Friday Harbor in 2009. *See* AR 481 and 592. Therefore, the cost of Multicare's construction (cost per bed) is reasonable. Even if Multicare's cost per bed is appreciably more costly than either Auburn or Valley, it does not make Auburn or Valley the superior choice by this measure alone.

1.123 Multicare's cost of construction is also reasonable, when viewed in light of its sufficient cash reserves and net assets available to complete the project. *See* Paragraph 1.66 above. So not only are the costs within the range for other new hospitals, the costs are supportable by Multicare's existing resources. For this reason, there is no evidence that Multicare's cost of construction will have an unreasonable impact on the cost or charges to the patients.

1.124 Valley and Auburn argue that Multicare did not include all of its costs for the Covington hospital project. They argue: Multicare should include the costs of incorporating its Covington Medical Center into the project; and Multicare's cost center approach does not accurately describe the overhead[25] for the project.

1.125 Multicare has constructed (or is constructing) a free-standing emergency room.[26] In addition, Multicare already has an outpatient medical center in the Covington area, which includes a radiology department, laboratory, and pharmacy. Unlike nursing homes and kidney dialysis facilities, Multicare is not required to list donated equipment as a capital expense. *See* WAC 246-310-010(10) (nursing homes) and WAC 246-310-270(2)(c) (kidney dialysis facilities). Multicare did not include, and was not required to include, the emergency room, the used radiology equipment, laboratory and pharmacy facility costs. There is evidence that Multicare was advised by a Program representative that it could take this approach and there is no evidence to contradict this assertion.[27]

1.126 Multicare uses a cost center approach (collecting revenues and expenses by services) in allocating overhead costs. *See* AR 194–208. Under this approach, the overhead expenses are allocated by service centers rather than an entry in the pro forma financial statement. *Compare* AR 200 (Multicare Cost Center projections) to

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[25] "Overhead" means all administrative or executive costs incident to the management, supervision, or conduct of the business. *See* Black's Law Dictionary, Sixth Edition, pages 1103-1104 (1990).

[26] Free-standing emergency rooms do not currently require a CN.

[27] There is no written confirmation of this assertion in the application record. The prudent applicant would have this information reduced to written form and included in the application record.

AR 986 (Auburn's Pro Forma with project projections).

1.127 CN applicants submit financial information in a document known as a "pro forma" statement (a description of accounting, financial and other statements or conclusions based upon assumed or anticipated facts).[28] There is no required process for reporting financial information in certificate of need applications. If an applicant provides sufficient financial information that allows the Department to analyze the application under WAC 246-310-220 (financial feasibility) and WAC 246-310-240 (cost containment), the applicant (here Multicare) has met its burden. Breaking down overhead by cost centers does not disqualify Multicare under the superior alternative criteria in WAC 246-310-240.

Acuity of Care

1.128 Another issue raised at hearing relates to the acuity of care being offered by the three facilities. In the best of all worlds, all hospitals would have all of the services a patient might need. In the real world, this is neither practical nor economical. When a hospital does not provide a service, it normally transfers the patient to a facility that does (an example might be a patient needing a heart transplant).

1.129 Both Valley and Auburn have intensive care units on site. Multicare intends to build a community hospital and its business model does not include an intensive care unit in its facility. Current Washington law does not require that a hospital include an intensive care unit. Multicare's failure to include an intensive care unit does

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[28] *See* Black's Law Dictionary, Sixth Edition, page 1212 (1990).

not automatically disqualify it from obtaining a CN for acute care beds. It is merely one factor to consider. Not having an intensive care unit does not make the Valley or Auburn facilities superior to Multicare's project.

1.130 Multicare's current business model anticipates that it will provide services to 96 percent of the discharges for the planning area residents. AR 478. Multicare will transfer those patients requiring tertiary health services[29] to other facilities. Under this business model, patients could be transferred to Valley, Auburn, or to Multicare's tertiary facilities in Tacoma and Seattle. According to Dr. Stover, Multicare's business model anticipates that its patients will have access to the full scope of services at its other facilities.

1.131 Although it is not a party to the matter, the Program permitted Premera Blue Cross Insurance (Premera) to submit rebuttal information regarding the Multicare application. See AR 1697–1700. Premera contends that Multicare is a very high cost provider based on its operating expenses using a Department statistical measure known as an Adjusted Case Mix Value Unit (ACMVU). *Id*. Premera provides evidence that Multicare has a higher ACMVU cost when compared to Valley or Auburn in 2008. *See* AR 1698 (operating expenses per ACMVU) and AR 1699 (net patient service revenues per ACMVU.)

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[29] "Tertiary health services" means a specialized service of complicated medical needs of people and requires sufficient patient volume to optimize provider effectiveness, quality of service, and improved outcome of care". WAC 246-310-010(58).

1.132 Not every patient who is admitted to a hospital requires complex care at the same level (for example open heart surgery requires more complex care than the birth of a normal newborn). In the simplest terms, the ACMVU measuring tool compares the income and expenses of various hospitals. It does so by examining the types of patients (that is, the severity of the treatment required by the patient) using medical codes known as diagnostic related grouping (DRG).

1.133 The ACMVU measure is a statistical tool. The ACMVU measure can provide some basis for analyzing and comparing the expenses of hospitals. To be useful in this concurrent review situation, it would require comparing the ACMVU measure for Valley, Auburn, and Multicare by examining each facilities level of patient care. Department employee Richard Ordos (the employee who collects patient-level diagnosis and procedure information for Washington inpatients) did not perform any comparison of the three facilities because he was specifically instructed by Program analyst Mark Thomas not to. TR Vol. 5, page 1234, line 15 to page 1235, line 5. Even if Mr. Ordos had been instructed to perform a comparative review of the three facilities, he could not have done so given that the Covington facility had no patient-level data necessary to create a case mix to get an ACMVU. Premera's argument is unsupported by the totality of the evidence in the record and the testimony of Mr. Ordos.

Outmigration

1.134 Another factor useful in determining which facility or facilities is superior is outpatient migration or outmigration. Outmigration represents the number of patients (current patients or the anticipated increased number of patients due to population

growth in the planning area) that leave the Southeast King County planning area to obtain hospital care. *See generally* AR 563 – 564.

1.135 Past outmigration statistics exist for the Southeast King County planning area. Future outmigration statistics can be calculated based on the projected population for the Southeast King County planning area. While the numbers are available, the exact cause for the outmigration is less clear. There are several causes for outmigration. *See* Findings of Fact 1.24 and 1.25. Causes include (but are not limited to): the unavailability of treatment services at a specific hospital; and whether a patient's insurance coverage requires he or she receive treatment at a specific facility.

1.136 Auburn experiences outmigration, at least in part, because it does not always have an acute care bed available. There is undisputed evidence that Auburn is at over-capacity, particularly in its emergency room and intensive care units. *See* AR 641-649, and AR 1679-1681. This results in diverting patients from the emergency room or patients waiting for beds to become available. Id. Auburn believes it can address its outmigration issue, at least in part, by capturing a percentage of the increased number of patients (represented by hospital patient days) in the Southeast King County service area within the planning horizon (2009-2014). Auburn forecasts an increase of 6.15 percent of future resident and hospital patient days following the increase in the Southeast King County population growth, which will work to reduce the outmigration. *See* AR 562 – 563.

1.137 There are no outmigration statistics for Multicare's yet to be constructed Covington facility. Multicare's business models of an integrated health care system.

Some of the patients who currently leave Southeast King County to obtain care within Multicare's integrated system (that is, patients who are required by their insurance coverage to obtain hospital care at a Multicare facility in Pierce County) will receive inpatient care at the Covington hospital.

1.138 Multicare anticipates capturing or reducing the Southeast King County planning area outmigration by building its Covington facility. Some of the patients will still "outmigrate," as Multicare's integrated system anticipates transferring the more complex patient care to its Tacoma or Puyallup facilities.) Assuming it begins services in July 2015, Multicare forecasts it will capture at least 5.44 percent of the increased population growth (that is, recapture the out-migration of these patients) from the second year (2016) of operation to third (2017) year of operation. The percentage appears reasonable when compared to other new hospital facilities.

1.139 Like Auburn, Valley anticipates it will capture some of the increased population growth in Southeast King County planning area. *See* AR 562 – 563. Valley anticipates capturing 6.47 percent of the increased population growth, which would mitigate the outmigration of patients for the area. *Id.* Although Valley's projected rate of recapture of the increased population for Southeast King County is higher than that of Multicare and Auburn, it is not so high that it disqualifies Valley as a superior alternative under WAC 246-310-240(1).

1.140 As previously stated, outmigration can be measured. Without more information on the root causes of the outmigration, the Presiding Officer finds the

outmigration issue neither helps nor hurts any of the applicants in the concurrent review process under WAC 246-310-240(1).

<u>Charity Care Statistics</u>

1.141 A review of the application record shows that Multicare and Valley each meet the King County charity care statistics criteria under WAC 246-310-210(2). Auburn has not. In fact, Auburn admits that it has not met the charity care statistics for some time. Auburn has failed to meet the charity care statistic for at least ten years. *See* testimony of Bart Eggen. Auburn is willing to include a charity care condition if awarded a CN here. On its face, either Valley or Multicare can be considered a superior alternative regarding the charity care requirement.

1.142 An applicant can be required to meet specified conditions to qualify for a CN. *See* RCW 70.38.115(4). Some confusion occurred in this matter because the Program stating in its evaluation that Auburn would qualify by agreeing to meet the charity care condition (*see* AR 566) but arguing at hearing that Auburn's failure to meet the charity care condition for ten years disqualifies Auburn under WAC 246-310-210(2). The inconsistency of the Program's position in its evaluation and at hearing is immaterial. Auburn must comply with the WAC 246-310-210(2) charity care requirement to qualify for a CN, assuming it meets all other CN criteria.

<u>Occupancy Standards</u>

1.143 The State Health Plan specifies that hospital bed capacity should be utilized efficiently and without compromising access to services. *See* Exhibit M-2, page C-37. To accurately calculate bed need, the State Health Plan set occupancy

standards for hospitals depending on size. *Id.*

1.144 For a hospital with 283 acute care beds, the State Health Plan sets the appropriate occupancy rate for Valley's acute care bed at 70 percent. *See* Exhibit M-2, page C-37.[30] Valley's occupancy rate in 2009 was 52.5 percent for its 283 acute care beds. AR 575 and AR 1679. In 2009, Valley's occupancy rate is lower than the other two comparable Southeast King county hospitals (Auburn at 69 percent, which is approximately 4 percent above its target occupancy; and St Francis at 61 percent, which is approximately 4 percent below its target occupancy). AR 1679. This translates to 135 empty beds at Valley's hospital on any given day.

1.145 If Valley were awarded additional acute care beds, it is logical to assume that Valley's occupancy rate would decrease even further. Valley anticipates that it will capture 6.47 percent of the increased patient days available from the Southeast King County during the planning horizon (2009-2019). Even if it captures the increased patient days from the increased population, and at the anticipated 6.47 percent rate, Valley's occupancy rate will still decline.

1.146 The underutilization of beds in an existing facility does not preclude the approval of new beds in a planning area. This is because the State Health Plan methodology does not measure whether additional beds are currently needed. Rather,

[30] The rate in the State Health Plan is 75 percent for hospitals with 200-299 beds. There was testimony at the hearing that the Department adjusted all of the occupancy rates downward by 5 percent for all hospitals except for hospitals with 1-49 beds.

the State Health Plan methodology measures whether there is a future need for acute care beds.

1.147 Since Auburn currently is above its occupancy rate and demonstrates the greater need for additional acute care beds and Valley is below its occupancy rate, Auburn is the superior candidate on this issue. This is particularly true since Valley acknowledges that granting additional beds to its facility will not improve the patient access issue. The largest increase in patient need is in the Covington area. Those patients must first travel southwest down State Route 18, then north up State Route 167 (a heavily traveled corridor of traffic) to receive treatment at Valley. *See* Findings of Fact 1.118–1.120.

1.148 When compared to the other hospitals currently in Southeast King County, Auburn's market share has grown more rapidly over the past decade. See AR 48 (Table 10). In 2009, Auburn's actual occupancy rate has exceeded its target occupancy rate by 4.3 percent. AR 1679. Between the Valley and Auburn facilities, Auburn is the more deserving recipient of additional acute care beds.

<u>Concurrent Review of Parties</u>

1.149 Based on a review of the above concurrent review factors, Multicare's application shows positive or superior performance in the following areas: patient access; charity care (based on a comparison of the Pierce and King county charity care figures); and the cost of construction (comparable to other new hospitals). It is comparable to Valley and Auburn in the areas of outmigration and occupancy rates.

The patient access Multicare will be able to provide to the Covington area supports granting its application for a 58-bed facility.

1.150 Based on a review of the above concurrent review factors, Auburn's application shows positive or superior performance in the following areas: patient access (Covington area patients can more easily access the Auburn facility when compared to Valley); occupancy rate; and acuity of care (an on-site intensive care unit). Before it can be awarded a CN, Auburn must accept a condition that it will comply with the WAC 246-310-210(2) charity care condition requirement. That condition must more vigorously address the steps it will take to ensure that compliance.

1.151 Based on a review of the above concurrent review factors, Valley's application shows positive or superior performance in the following areas: charity care; and the cost of construction (the ability and cost to create a 30-bed increase in a short period of time). Valley's application does not address how it will address the outmigration issue it currently faces. This is a factor against awarding Valley a CN. The biggest factors weighing against Valley receiving a CN is the low occupancy rate and the reduced patient access (when compared to Auburn's and Multicare's location to the greatest increase in patients arising in the Covington area).

1.152 Given the above analysis, Multicare will be awarded its 58 acute care bed application.

1.153 Given the above analysis, Auburn will be awarded the 51 remaining acute care beds, subject to its acceptance of a charity care requirement.

II. CONCLUSIONS OF LAW

Evidence in Certificate of Need Decisions

2.1 The Department of Health is authorized and directed to implement the CN program. RCW 70.38.105(1). The applicant must show or establish that its application meets all of the applicable criteria. WAC 246-10-606(2). The standard of proof in this case is preponderance of the evidence. *See* WAC 246-10-606. Admissible evidence in CN hearings is the kind of evidence on which reasonably prudent persons are accustomed to rely in the conduct of their affairs. *See* RCW 34.05.452(1).

Presiding Officer as Agency Fact-Finder

2.2 The Presiding Officer (on delegated authority from the Secretary of Health) is the agency's fact-finder and final decision maker. *DaVita v. Department of Health*, 137 Wn. App. 174, 182 (2007) (*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. The appeal process does not begin the application process anew. *University of Washington v. Department of Health*, 164 Wn.2d 95, 104 (2008).

2.3 In acting as the Department's final decision maker, the Presiding Officer reviewed the application record (including any supporting documentation such as HPDS and Comprehensive Hospital Abstract Reporting System (CHARS) data provided as part of 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).

Use of Bed Need Methodology

2.4 To evaluate whether need exists for additional beds, the Department relies on the 10-step bed methodology set forth in the State Health Plan. The State Health Plan was only effective until June 30, 1990:

> For the purpose of supporting the certificate of need process, the state health plan developed in accordance with RCW 70.38.065 and in effect on July 1, 1989, shall remain effective until June 30, 1990, or until superseded by rules adopted by the department of health for this purpose. The governor may amend the state health plan, as the governor finds appropriate, until the final expiration of the plan.

RCW 70.38.919.

In 2007, the Legislature repealed RCW 70.38.919. *See* E2SSB 5930. The Office of Financial Management was required to develop a statewide health care strategy to include a new plan to assess and direct certificate of need determinations. While the plan was to be ready by January 1, 2010, no such plan exists now.

2.5 The Department may consider other non-codified standards developed by other organizations with recognized expertise related to a proposed undertaking. *See* WAC 246-310-200(2)(b)(v). In the absence of any statutory or regulatory bed need methodology, and pursuant to its authority under WAC 246-310-200(2)(b)(v), the Presiding Officer uses the State Health Plan methodology as an analytical tool in review of the Auburn, Valley, and Multicare applications.

Certificate of Need Criteria

2.6 Whether a CN should be issued to an applicant is based on a determination that the proposed CN project is:

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

WAC 246-310-200(1).

Need

2.7 To prove that need exists for additional acute care hospital beds, the applicant must meet the criteria in WAC 246-310-210.[31] The criteria are:

> (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 the need.

WAC 246-310-210.

2.8 The State Health Plan methodology contains a 12-step analysis to forecast acute care bed need. The first four steps develop trend information regarding utilization of hospital beds to evaluate the need of additional beds in a service area. The next six steps calculate the baseline for calculating the need for non-psychiatric beds. Step 11 addresses short stay psychiatric beds that are not at issue here.

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[31] Some of the WAC 246-310-210 sub-criteria are not discussed in this decision because they are not relevant to the Auburn, Valley, or Multicare projects. *See* WAC 246-310-210(3), (4), (5), and (6).

Step 12 allows for necessary adjustments in the methodology to reflect the special circumstances of a service area

2.9 The State Health Plan 12-step methodology to forecast need for non-psychiatric acute care hospital beds is as follows:

Develop trend information on hospital utilization

Step 1: Compile state historical utilization data (i.e., patient days within major service categories) for at least ten years preceding the base year.[32]

Step 2: Subtract psychiatric patient days from each year's historical data.

Step 3: For each year, compute the statewide and HSA (health service area) average use rates.[33]

Step 4: Using the ten-year history of use rates, compute the use rate trend line, and its slope, for each HSA and for the state as a whole.

Calculate baseline non-psychiatric bed need forecasts

Step 5: Using the latest statewide patient origin study, allocate non-psychiatric patient days reported in hospitals back to the hospital planning areas where the patients live.

Step 6: Compute each hospital planning area's use rate (excluding psychiatric services) for each of the age groups considered (at a minimum, ages 0-64 and 65+.)

Step 7A: Forecast each hospital planning area's use rates for the target year by "trend-adjusting" each age-specific use rate. The use rates are adjusted upward or downward in proportion to the slope of either the statewide ten-year use rate trend or the

[32] The base year is the "most recent year about which data is collected as the basis for a set of forecasts." Exhibit D-1, Page 1859 (State Health Plan Page C-25).

[33] The state of Washington is divided into four health service areas.

appropriate health planning region's ten-year use rate trend, whichever trend would result in the smaller adjustment.[34]

Step 8: Forecast non-psychiatric patient days for each hospital planning area by multiplying the area's trend-adjusted use rates for the age groups by the area's forecasted population in each age group at the target year. Add patient days in each age group to determine total forecasted patient days.

Step 9: Allocate the forecasted non-psychiatric patient days to the planning areas where services are expected to be provided in accordance with (a) the hospital market shares and (b) the percent of out-of-state use of Washington hospitals, both derived from the latest statewide patient origin study.

Step 10: Applying the weighted average occupancy standards, and determine each planning area's non-psychiatric bed need. Calculate the weighted average occupancy standard as described in the Hospital Forecasting Standard 11.f. This should be based on the total number of beds in each hospital (Standard 11.b[35]), including any short-stay psychiatric beds in general acute-care hospitals. Psychiatric hospitals with no other services should be excluded from the occupancy calculation.

Determine total baseline hospital bed need forecasts

Step 11: To obtain a bed need forecast for all hospital services, including psychiatric, add the non-psychiatric bed need from Step 10 above to the psychiatric in-patient bed need from Step 11 of the short-stay psychiatric hospital bed need forecasting method.

Step 12: Determine and carry out any necessary adjustments in population, use rates, market shares, out-of-area use and occupancy rates.

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[34] Step 7B is an alternative to step 7A, and does not apply to the facts at hand.

[35] Standard 11.b provides the hospital occupancy standards used in forecasting need. (See footnote 6.) Exhibit D-1 Page 1871 (State Health Plan Page C-37).

2.10 Based on Findings of Fact 1.1 through 1.31, Auburn meets the need requirement set forth in WAC 246-310-210(1).

2.11 Based on Findings of Fact 1.1 through 1.26 and Findings of Fact 1.55 though 1.59, Multicare meets the need requirements set forth in WAC 246-310-210(1).

2.12 Based on Findings of Fact 1.1 through 1.26 and Findings of Fact 1.83 through 1.86, Valley meets the need requirements set forth in WAC 246-310-210(1).

Charity Care

2.13 To prove that need exists for additional acute care hospital beds, the applicant must also prove that it meets the criteria set forth in WAC 246-310-210(2). Those criteria are:

> (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.

WAC 246-310-210.

2.14 The Program raised an issue at hearing regarding Auburn's application that it had not addressed in its evaluation. While Auburn does provide charity care, the Program determined that Auburn had historically provided less than the average charity care provided in the King County Region. AR 565. Despite Auburn's providing charity care at an percentage below the three-year average for charity care for 2006-2008, the Program indicated that Auburn would meet the WAC 246-310-210(2) sub-criteria so long as it agreed to a condition to use reasonable efforts to provide charity care with CN. The use of a condition to use reasonable efforts to provide charity care is

consistent with the Program's still an acceptable approach, so long as Auburn creates a plan of action with specific benchmarks to allow the Program to monitor Auburn's progress on this issue.

2.15 Based on Findings of Fact 1.32 through 1.33, Auburn meets the charity care requirements set forth in WAC 246-310-210(2).

2.16 Based on Findings of Fact 1.60 through 1.61, Multicare meets the charity care requirements set forth in WAC 246-310-210(2).

2.17 Based on Findings of Fact 1.87 through 1.88, Valley meets the charity care requirements set forth in WAC 246-310-210(2).

Financial Feasibility

2.18 To obtain a CN for additional hospital beds, an applicant must show that its project is financially feasible under WAC 246-310-220. That regulation requires a showing that:

> (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 is appropriately financed.

WAC 246-310-220.

2.19 Based on Findings of Fact 1.34 through 1.38, Auburn meets the financial feasibility requirements set forth in WAC 246-310-220(1), (2), and (3).

2.20 Based on Findings of Fact 1.89 through 1.94, Valley meets the financial feasibility requirements set forth in WAC 246-310-220(1), (2), and (3).

2.21 Based on Findings of Fact 1.62 through1.66, Multicare meets the financial feasibility requirements set forth in WAC 246-310-220(1), (2), and (3).

Structure and Process (Quality) of Care

2.22 An applicant must show that its hospital bed project meets the structure and process of care requirements as set forth in WAC 246-310-230. That regulation provides:

> 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 an organizational relationship, to ancillary and support services, and ancillary and support services that will be sufficient to support any health services including 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 of 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 and to be served in accordance 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 whether:

(a) The applicant or licensee has no history, in this state or elsewhere, of a criminal conviction which is reasonably related to the applicant's competency to exercise responsibility for the ownership or operation of a health care facility, a denial or revocation of a license to operate a health care facility, a revocation of a license to practice a health care profession, or a decertification as a provider of services in the medicare or medicaid program because of a failure to comply with applicable federal conditions or participation; or

(b) If the applicant or licensee has such a history, whether the applicant has affirmatively established to the department's satisfaction by clear, cogent and convincing evidence that the applicant can and will operate the proposed project for which the CN is sought in a manner that ensures safe and adequate care to the public to be served and conforms to applicable federal and state requirements.

2.23 Based on Findings of Fact 1.39 through 1.45, Auburn meets the requirements set forth in WAC 246-310-230(1), (2), (3), (4), and (5).

2.24 Based on Findings of Fact 1.67 through 1.75, Multicare meets the requirements set forth in WAC 246-310-230(1), (2), (3), (4), and (5).

2.25 Based on Findings of Fact 1.95 through 1.102, Valley meets the requirements set forth in WAC 246-310-230(1), (2), (3), (4), and (5).

Determination of Cost Containment

2.26 To obtain additional hospital beds, an applicant must show that it meets the determination of cost containment set forth in WAC 246-310-240. That regulation provides:

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

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

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

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

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

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

WAC 246-310-240.

Superior Alternatives

2.27 It is appropriate to use the same planning horizon in the concurrent review of applications where the applications include existing facilities and new facilities. In this case it is a ten-year planning horizon. Using the same planning horizon for all applicants, Auburn and Valley were not automatically disqualified under the WAC 246-310-210(1) need requirement. This required a concurrent review of the three applications under the WAC 246-310-240(1) superior alternative requirement. Given the need for 102 beds within the ten-year planning horizon (by 2019) meant that there was sufficient bed need to approve two of the three applications for an acute care bed CN. Of the three applicants, Multicare and Auburn are the superior alternatives under

WAC 246-310-240(1). Multicare, Auburn, and Valley did meet the requirements under WAC 246-310-240(2) and (3).

2.28 Based on Findings of Fact 1.46 through 1.49 and Findings of Fact 1.114 through 1.153, Auburn meets the criteria set forth in WAC 246-310-240(1).

2.29 Based on Findings of Fact 1.76 through1.78 and Findings of Fact 1.114 through 1.153, Multicare meets the criteria set forth in WAC 246-310-240(1).

2.30 Based on Findings of Fact 1.103 through 1.105 and Findings of Fact 1.114 through 1.153, Valley does not meet the criteria set forth in WAC 246-310-240(1).

Construction and Delivery of Health Services

2.31 Based on Findings of Fact 1.50 through 1.54, Auburn meets the criteria set forth in WAC 246-310-240(2) and (3).

2.32 Based on Findings of Fact 1.79 through1.82, Multicare meets the criteria set forth in WAC 246-310-240(2) and (3).

2.33 Based on Findings of Fact 1.106 through1.108, Valley meets the criteria set forth in WAC 246-310-240(2) and (3).

Request for Reconsideration under WAC 246-310-560

2.34 WAC 246-310-560 provides:

> (2) The department shall conduct a reconsideration hearing if it finds the request is in accord with the following requirements:
>
> (a) The request for a reconsideration shall be written, be received by the department within 28 days of the department's decision on the certificate of need application or withdrawal of the certificate of need, state in detail the grounds which the person requesting the hearing believes to

show good cause, and be signed by the person making the request.

(b) Grounds which the department may deem to show good cause for a reconsideration hearing shall include but not be limited to the following:

(i) Significant relevant information not previously considered by the department which, with reasonable diligence, could not have been presented before the department made it decision;

(ii) Information on significant changes in factors or circumstances relied upon by the department in making its findings and decisions; or

(iii) Evidence the department materially failed to follow adopted procedures in reaching a decision.

. . . .

(6) The secretary's designee may, upon the basis of the department's findings on a reconsideration hearing, issue or reissue, amend, revoke, or withdraw a certificate of need or impose or modify conditions on a certificate of need for the project about which the reconsideration hearing was conducted.

WAC 246-310-560.

2.35 Valley argued that reconsideration was warranted because the Program failed to meaningfully complete a comparative review of the Valley, Auburn, and Multicare applications. More specifically, Valley argued the Program:

A. Failed to evaluate Multicare's and Valley's applications using the same planning horizon and weighted occupancy standards;

B. Based its decision using 2009 CHARS dates that was not available to Valley at the time it filed its application;

C. Failed to conduct any meaningful review or comparative review of CN criteria regarding financial feasibility, structure and process of care, and cost containment; and

D. Made a series of errors that resulted in an inaccurate need calculation.

2.36 Valley's request for reconsideration, on the grounds that the same planning horizon should be used for all three applicants, was supported by the testimony of the three experts appearing for the applicants. *See* Findings of Fact 1.19. Valley's request should have been granted reconsideration on this issue. Given that the Presiding Officer addressed this issue at hearing, no remand is necessary.

2.37 Valley's request for reconsideration, on the grounds that is was improper to use 2009 CHARS data in determining need, is denied. The Program's standard practice includes the use of the most recent CHARS data (that is, CHARS data from the year immediately following the application period.) This does not constitute a significant change in circumstances.

2.38 Valley's request for reconsideration, on the grounds that there was no concurrent review, is granted. *See* Finding of Fact 1.114 – 1.116. Valley should have been granted reconsideration on this issue. Given that the Presiding Officer addressed this issue at hearing, no remand is necessary.

III. ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is ORDERED:

3.1 Auburn's application to add acute care beds to its facility under Master Case No. M2011-253 is GRANTED. Auburn will be granted 51 acute care beds,

consistent with the undisputed calculations in the Program evaluation, so long as it accepts the following charity care condition:

> Auburn will provide charity care in compliance with the charity care policies provided in this CN application, or any subsequent policies reviewed and approved by the Department of Health. Auburn will use reasonable efforts to provide charity care in an amount comparable to or exceeding the average amount of charity care provided by hospitals in the King County Region. Currently, this amount is 2.42% of adjusted revenue. Auburn will maintain records documenting the amount of charity it provides and demonstrating its compliance with its charity care policies. Auburn's reasonable efforts to provide charity care must include a written plan showing how it intends to comply with the charity care policies, with sufficient benchmarks to allow the Department to track Auburn's performance with this condition.

3.2 Multicare's application to establish 58 acute care beds in its facility under Master Case No. M2011-254 is GRANTED.

3.3 The Valley application to add 60 acute care beds to its facility under Master Case No. M2011-731 is DENIED.

Dated this ___13_ day of February, 2012.

__________________/s/________________
JOHN F. KUNTZ, Health Law Judge
Presiding Officer

NOTICE TO PARTIES

This Order is subject to the reporting requirements of RCW 18.130.110, Section 1128E of the Social Security Act, and any other applicable interstate or national reporting requirements. If discipline is taken, it must be reported to the Healthcare Integrity Protection Data Bank.

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

Adjudicative Service Unit
P.O. Box 47879
Olympia, WA 98504-7879

and a copy must be sent to:

Certificate of Need Program
P.O. Box 47852
Olympia, WA 98504-7852

The petition must state the specific grounds for reconsideration and what relief is requested. WAC 246-10-704. The petition is denied if the Adjudicative Service Unit does not respond in writing within 20 days of the filing of the petition.

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

The order is in effect while a petition for reconsideration or review is filed. "Filing" means actual receipt of the document by the Adjudicative Service Unit. RCW 34.05.010(6). This order is "served" the day it is deposited in the United States mail. RCW 34.05.010(19).

For more information, visit our website at http://www.doh.wa.gov/hearings.