STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE SERVICE UNIT

In Re: EVALUATION FOR THE CERTIFICATE OF NEED APPLICATION SUBMITTED BY SW BEHAVIORAL, LLC PROPOSING TO ADD PSYCHIATRIC BED CAPACITY TO KING COUNTY, BHC FAIRFAX HOSPITAL, INC., AND UNIVERSAL HEALTH SERVICES, INC., Petitioner.	Master Case No. M2013-1283 FINDINGS OF FACT, CONCLUSIONS OF LAW, AND INITIAL ORDER

APPEARANCES:

Petitioner: BHC Fairfax Hospital, Inc., and Universal Health Systems, Inc. (BHC Fairfax), by
Foster Pepper, PLLC, per
Christopher Emch and Lori Nomura, Attorneys at Law

Intervenor: SW Behavioral, LLC, a/k/a Cascade Behavioral Hospital (Cascade), by
Davis Wright Tremaine, LLP, per
Brad Fisher and Lisa Rediger Hayward, Attorneys at Law

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

PRESIDING OFFICER: Frank Lockhart, Health Law Judge

A hearing was held in this matter on August 28-29, 2014, regarding Cascade's application for a Certificate of Need (CN) to establish a new 135-bed psychiatric hospital to King County. CN GRANTED to Cascade.

ISSUES

Does Cascade's application to establish a new 135-bed psychiatric hospital in King County meet the relevant CN criteria in WAC 246-310-210, WAC 246-310-220, WAC 246-310-230, and WAC 246-310-240?

SUMMARY OF PROCEEDINGS

At the hearing, Cascade presented the testimony of Jay Kellison, former Division President, Cascade; Dwight Willingham, CFO, Cascade; Jody Carona, consultant for Cascade; and Bart Eggen, CN Program.

BHC Fairfax presented the testimony of Frank Fox, Ph.D., consultant for Fairfax; and Ron Escarda, CEO of BHC Fairfax.

The Program presented the testimony of Bart Eggen, CN Program.

The Presiding Officer admitted following exhibits as numbered:

Exhibit D-1: The Application Record.

Exhibit P-1: The Washington State Health Plan, 1987, Volume II.

Exhibit P-12: Curriculum vitae of Frank Fox, Ph.D.

PROCEDURAL HISTORY

On April 9, 2013, Cascade[1] applied for a CN from the Program to establish a new 135-bed psychiatric hospital.

[1] At the time of application, the legal name of the applicant was SW Behavioral, LLC, owned by Acadia Healthcare Company, Inc., which operated 44 behavioral health facilities in 21 states. (AR 4-5.) During the application process, the applicant changed its name to Cascade Behavioral Hospital. SW Behavioral had previously filed a CN application in November 2012 to acquire the Highline Medical Center specialty campus, but withdrew that application in order to file this application. This application therefore becomes Cascade's first venture into Washington State, seeking to be licensed as a private psychiatric hospital.

During the review process, BHC Fairfax applied for, and was granted, "affected person" status pursuant to WAC 246-310-010(2).[2]

On September 6, 2013, the Program issued a letter to Cascade indicating that it was prepared to issue a CN to Cascade pursuant to certain conditions. On September 12, 2013, Cascade sent a letter to the Program accepting the conditions as set forth in the Program's letter of September 6, 2013. The Program awarded the CN to Cascade on September 20, 2013.

On October 17, 2013, BHC Fairfax filed its Application for an Adjudicative Proceeding. Cascade was granted intervenor status on January 24, 2014. The adjudicative hearing was held August 28-29, 2014. Pursuant to RCW 34.05.461(7), and by agreement of the parties, closing arguments were filed by briefs.

CITATIONS

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

I. FINDINGS OF FACT

1.1 On April 9, 2013, Cascade filed an application to establish a new 135-bed psychiatric hospital in King County. The proposed project would offer both psychiatric and chemical dependency services to adult patients. The proposed project does not

[2] Obtaining "affected person" status depends, in part, on being located in the same planning area as the applicant. The planning area for psychiatric beds is defined as the county. (*See* page B-20, State Health Plan, Exhibit P-1.)

involve building a new facility; rather, Cascade proposed to acquire Highline Medical Center's Specialty Campus (Highline) in Tukwila, Washington.[3]

1.2 Highline had been operating a 21-bed geriatric psychiatric inpatient program, an 18-bed chemical dependency detox inpatient unit, and a 24-bed chemical dependency treatment inpatient program, for a total of 63 beds at the Specialty Campus.[4] Cascade's application proposes retaining and expanding those programs,[5] and in fact, the Program's approval of the project required Cascade to retain those programs.[6] Cascade's project envisions renovating a vacant nursing unit and then adding 22 psychiatric beds in a first phase of its project, and then adding an additional 50 psychiatric beds to another renovated nursing unit in a second phase. Thus, in simple terms, Cascade's project is to acquire 63 beds from Highline and to add a total of 72 psychiatric beds. The question then becomes, is there a need for an additional 72 psychiatric beds in the planning area?

WAC 246-310-210 "Determination of Need"

1.3 Pursuant to WAC 246-310-210, an applicant for a CN must demonstrate a need for the proposed services. WAC 246-310 does not contain a psychiatric bed forecasting method. However, both the State Health Plan[7] (SHP) and

[3] AR 6-8.

[4] AR 353.

[5] AR 7.

[6] AR 353.

[7] The Program traditionally utilizes the forecasting methods and definitions contained in the 1987 Washington State Health Plan (Exhibit P-1). Although the State Health Plan was "sunset" in 1989, the concepts and methodology it contains remain reliable tools for managing the growth of health care services.

RCW 70.38.115(5) allow for discretion for selecting and applying evaluation methods to determine need. The Program has traditionally examined the number of psychiatric beds per 100,000 persons as the lens through which to calculate bed need, that is: how many beds per 100,000 persons in the planning area should be allotted as psychiatric beds? The 1987 SHP recommended a level of 13 psychiatric beds per 100,000 persons.[8] However, the 2009 National Report Card on the State of Emergency Medicine (2009 National Report) recommended[9] a level of 27.3 beds per 100,000 persons for the northwestern states of this country. Once an appropriate bed ratio is determined, "need" is then calculated by multiplying that ratio times the anticipated population growth of the area and then deducting the known existing beds.

1.4 In its application, Cascade calculated bed need using both ratios (the 13 bed per 100,000 ratio and the 27.3 bed per 100,000 ratio). The 13 bed per 100,000 person calculation predicted no need for psychiatric beds in King County by 2018.[10]

[8] However, the current view is that the 1987 SHP recommendation of 13 psychiatric beds per 100,000 persons ratio is too low. In its July 24, 2013 rebuttal to the public comments, BHC Fairfax agreed that the ratio of 13 beds ratio was too low to address the needs of King County. AR 245. Even BHC Fairfax's own expert preferred a ratio of 27.3 beds (with 7.3 of those beds allotted for psychiatric cases with patients with comorbidity.) TR 447. Cascade advocated the 27.3 ratio in its application (AR 33), and the Program in its analysis compared figures using both a ratio of 19 beds and a ratio of 27.3 beds. (AR 356 *et seq*.)

[9] AR 361. The word "recommended" is used advisedly. The 2009 National Report determined that the average use rate of psychiatric beds in the Northwestern states (excluding Washington) was 27.3 psychiatric beds per 100,000 persons. Washington State, on the other hand, only had 8.2 psychiatric beds per 100,000 persons. (AR 22). Over time, the statistical rate of 27.3 has been treated by parties as a recommendation.

[10] Cascade's calculations did project a statewide need for 171 additional beds by 2018 using the 13 bed per 100,000 person method. AR33.

However, by using the 27.3 beds per 100,000 person method, Cascade calculated there would be a need for 81.7 additional beds in King County by 2018.[11]

1.5 In its evaluation, the Program calculated bed need using a "low" figure of 19 beds[12] per 100,000 persons for King County multiplied by the anticipated population growth just within King County, and then deducting the anticipated supply of existing beds.[13] Similar to Cascade's finding, the Program found that using a low bed ratio and only looking within King County, there was no numeric need for psychiatric beds by the year 2018. However, when the Program substituted its "high" figure calculation of 27.3 beds per 100,000 persons, it calculated a need for 121 additional psychiatric beds in King County by 2018.[14]

1.6 Whether a "low" or "high" multiplier is used makes an obvious numeric difference. The Presiding Officer determines that the "high" ratio of 27.3 beds per 100,000 persons is the most reliable figure available for the following three reasons: (a) it is the average ratio of all the other Northwestern states excluding Washington, (b) it compensates for the in-migration factor (discussed in Paragraph 1.7 below), and (c) it could absorb the "suppressed need" that exists in Washington (discussed in Paragraph 1.8 below).

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[11] AR 32.

[12] AR 364. The Program had determined that the figure of 13 simply was no longer viable. They used the rate of 19 as a low figure only because it had been used in another recent CN analysis. TR 280.

[13] BHC Fairfax contends that both the Program and Cascade undercounted the existing beds. *See* discussion in Paragraphs 1.10–1.13.

[14] AR 365. Compare to Cascade's calculation of 81.7 bed need using the same approach.

1.7 The in-migration of psychiatric patients into King County impacts bed use. Psychiatric beds are different than acute care beds because psychiatric beds normally serve a population from counties outside of their planning area.[15] A full 30% of the existing King County psychiatric beds serve residents from outside King County.[16] Of the existing Highline programs that Cascade would take over, 48% of the patients come from residents of other counties.[17] Highline's historical data shows that 20% of its psychiatric and chemical dependency patients are from Pierce County and 27.2% come from a mix of other counties including Snohomish, Kitsap, Thurston, and Clallam.[18] These in-migration figures support the use of the 27.3 beds per 100,000 person ratio for calculating the need for psychiatric beds.

1.8 "Suppressed need" is the unmeasured need for psychiatric beds. It is unmeasured because there is no agency tracking the number of persons who would go to psychiatric beds or services if such beds or services existed. Suppressed need is partially manifested in Washington's "psychiatric patient boarding" problem (the housing of psychiatric patients at emergency rooms because no psychiatric beds are available). Many of these psychiatric boarded patients are involuntarily committed to psychiatric

[15] The SHP recognizes this difference. If Cascade's CN application were only for acute care beds, for example, its planning area would have been limited to the Southwest King County Hospital Planning Area. But because the CN is for psychiatric beds, the planning area is expanded to include the entire county. The reader should note, however, that the calculations used by both Cascade and the Program did not take in-migration into account – they used the population of King County for their calculations. However, the statistics cited above show a strong in-migration of psychiatric patients from other counties. This becomes another reason that supports the use of the "higher" multiplier of 27.3 (although the use of the term "higher" is misleading – it is simply the average of the other Pacific Northwest states).

[16] AR 33 and 363.

[17] AR 33, 363, and TR 194.

[18] AR 7 and AR 363.

hospitals under RCW 71.05, the Involuntary Treatment Act (ITA). Psychiatric facilities must be certified to accept these patients. The Department of Social and Health Services (DSHS), not the Department of Health, certifies psychiatric facilities to receive ITA patients. BHC Fairfax makes 40 of its beds available for ITA patients.[19] In response to the Program's screening questions, Cascade proposed to certify 18 ITA beds.[20] While there is an absence of statistical data on the psychiatric boarding issue, it does add pressure to create more beds (e.g., many of the letters of support for Cascade cited the psychiatric boarding issue). However, the numeric need for psychiatric beds is clear even without the psychiatric boarding issue. But the fact that there is suppressed need again supports the use of the 27.3 beds per 100,000 person ratio for calculating the need for psychiatric beds. Whatever numeric figure that suppressed need translates to, the higher ratio could absorb it, while the lower ratio could not.

1.9 As indicated, Cascade's CN request (albeit for 135 beds) would in actuality only add 72 beds to the planning area (because the other 63 Highline beds they would be acquiring were already being counted). Thus, Cascade's request for 72 additional beds is still less than either the Program's "high" need calculation of 121 beds by 2018, or Cascade's "high" need calculation of 81.7 beds by 2018.

1.10 However, BHC Fairfax challenges not only Cascade's use of the high bed ratio, but also the bed count that both Cascade and the Program used. (Recall that once the bed ratio is selected and multiplied times the projected county growth to

[19] TR 530.

[20] AR 221.

determine gross need, "actual" need is then determined by subtracting the "available" beds already in the county. The shortage of available beds to fill the gross need for beds then becomes the "actual" or net need for beds.) The problem in this case is the definition of "available" beds. Both Cascade and the Program counted the beds that were actually set up and ready for use (as reflected in area hospital's annual reports or in the Program's bed surveys) as opposed to beds that a hospital is licensed for and that could be set up if all the facilities in the planning area actually utilized their full licensed capacity for beds. For example, BHC Fairfax is licensed for 133 psychiatric beds, but only has psychiatric 83 beds actually set up.[21] BHC Fairfax's count of licensed beds in the whole county is 437 beds, while the Program's count of set up beds in the county is 335. BHC Fairfax argues that had the Program counted the number of licensed beds in the county (irrespective of whether they were actually set up), then there would not be sufficient net need to justify Cascade's project.

1.11 The evidence does not fully explain why existing facilities are not using their current unused bed capacity to satisfy the need for more beds. There are a number of factors that may explain this. For example, the fact that a facility has a license for X number of beds does not mean that it is easy or profitable to set up those beds, especially in an aging facility. Original bed capacity licenses may have been granted assuming three beds to a room, a situation that patients and staff nowadays find unacceptable.[22] Aging facilities may not have the physical space for modern

[21] BHC Fairfax's spokesperson claimed that more than 83 beds were utilized at times (TR 485), but the BHC Fairfax's year-end report reflects 83 psychiatric beds set up (TR 210, AR 335).

[22] TR 484.

psychiatric rooms.[23] It may be cost-prohibitive to set up secure beds for involuntary patients (who require more equipment and additional staff), given the low Medicaid reimbursement such patients generate.[24] Whatever the reasons, the fact that current psychiatric facilities have unused capacity cannot be used as an argument against granting Cascade a CN when the existing facilities cannot or will not use that capacity.

1.12 BHC Fairfax also argues that psychiatric beds should be counted the same way as acute care beds are counted. (With acute care beds, the Program does count the licensed beds that are set up plus the ones that could be set up without significant capital expenditure.[25]) However, there is no comparable regulatory methodology for counting psychiatric beds, and no tradition of counting potential beds in a manner similar to acute care beds for determining psychiatric bed need.[26] For that reason, when calculating psychiatric bed need, the Program's policy is to count only the actual beds that are set up.[27]

1.13 The Presiding Officer determines that the psychiatric bed need methodology properly counts only existing beds in the planning area (the number of beds that are set up and ready for use). There is a clear demand for psychiatric beds, plus an urgent need for beds for psychiatric boarded patients. The fact that existing

[23] TR 489.

[24] TR 453-5.

[25] This is the procedure that has been adopted from the 1987 SHP. As indicated, there is not a corresponding usable counting method in the SHP regarding psychiatric beds.

[26] TR 261, AR 361.

[27] For example, on the Program's bed survey form for hospitals, only the acute care bed count has a separate line for listing beds that are not set-up but could be set up. AR 312.

facilities cannot utilize their licensed capacity due to physical limitations or financial constraints, renders the "capacity" argument meaningless.

1.14 WAC 246-310-210(2) addresses the accessibility of the proposed health care services to the public.[28] Because this is Cascade's first project in Washington, it does not have a track record in the state.[29] As part of the application process, Cascade provided its admission policy (indicating that patients would be admitted without regard to race, religion, ethnicity, culture, language, socioeconomic status, sex, sexual orientation, national origin, or gender identity expression); plus documents indicating it intended to become Medicare-certified; and a proposed charity care policy. The Program conditioned the CN award with the reasonable requirement that Cascade match or exceed the percentage of charity care provided by other King County Hospitals (1.68% of gross revenue), a condition that Cascade accepted.[30]

1.15 As indicated, the Presiding Officer determines that there is numeric need for psychiatric beds in King County, and that the methodology used to determine that need by the Program was correct. The Presiding Officer also concludes that Cascade fulfills the accessibility criterion of WAC 246-310-210(2). Based on the Application Record and the testimony at hearing, the Presiding Officer finds that Cascade fulfills the need determination criteria of WAC 246-310-210.

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[28] WAC 246-310-210(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."

[29] AR 366-7.

[30] AR 380.

WAC 246-310-220 "Financial Feasibility"

1.16 Pursuant to WAC 246-310-220, an applicant for a CN must demonstrate that the project is financially feasible. Specifically, an applicant must demonstrate that the capital and operating costs can be met; that the costs of the project will probably not result in an unreasonable impact on the costs for health services; and that the project can be appropriately financed.

1.17 Cascade provided pro forma financial statements and supporting documents for the years 2015 – 2018, which projected profitability by the second year of operation.[31] The estimated capital expenditure for the project is $43,323,000, which would be entirely funded by reserves provided by Cascade's parent company Acadia Healthcare Company, Inc. (Acadia). The Department's Hospital and Patient Data System (HPDS) reviewed Acadia's balance sheet and determined that there were sufficient assets to easily cover this project.[32]

1.18 BHC Fairfax's main criticism of Cascade's financial model had to do with the aggressive growth in patient days that has to be assumed to achieve profitability. BHC Fairfax complained that Cascade's expectation of 37 percent growth rate per year in patient days was unsupported and unreasonable.[33] BHC Fairfax pointed to the HPDS's analysis of Cascade's pro forma, which concluded that Cascade's financial projections could be met "if the patient volume is realized."[34]

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[31] AR 368-9.

[32] AR 370.

[33] TR 365, AR 305.

[34] AR 391, TR 372-3.

1.19 It is true that Cascade's profitability depends on filling its beds, but given the need for psychiatric beds in King County and the fact that Cascade was setting up fewer beds than the need calculation indicates are needed, Cascade's growth rates are reasonable. The Application Record and testimony at hearing support the conclusion that Cascade does have the experience and expertise to establish a facility to meet its financial projections. While this would be Cascade's first venture into Washington, its parent company Acadia has owned and operated approximately 44 hospitals in the United States and is experienced in this process.[35] Their business plan includes taking over an established inpatient base, expanding the facility's existing bed capacity, developing staff from the existing Highline organization, adding a 24-hour intake operation, utilizing business development staff to network with referral agencies, and working with insurers (including Tricare for military personnel).[36]

1.20 Based on the Application Record and the testimony at hearing, the Presiding Officer finds that Cascade fulfilled the financial feasibility criteria of WAC 246-310-220.

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

1.21 The criteria for structure and process of care, spelled out in WAC 246-310-230, includes five areas that must be considered when reviewing a CN Application, to wit: adequate staffing, appropriate organizational structure and support,

[35] TR 53-7, TR 118-119, AR 5, AR 52-54.

[36] TR 59-60, 84, 118-119, and 123-125.

conformity with licensing requirements, continuity of health care, and the provision of safe and adequate care.

1.22 As indicated, Cascade is acquiring the Highline facility with its existing 63 beds and its existing staff. Plus, Cascade has access to Highline Medical Center's ancillary service personnel.[37] Cascade thus starts out with an experienced staff and an opening census of patients.[38] In addition, Cascade indicated in its application that it would use a similar recruitment and retention strategy that it has employed in its previous locations, utilizing competitive wages, nationwide recruitment, job fairs, continuing education, and employee referral programs to recruit, train, and maintain qualified staff.[39] Cascade intends to continue Highline's treatment programs, which will provide continuity of care with existing patients and the community.

1.23 The only complaint raised at hearing regarding fragmentation of services was BHC Fairfax's concern that if Cascade did not admit its fair share of ITA patients, the burden to handle all the ITA patients would be placed on BHC Fairfax and the other area hospitals.[40] Cascade has indicated it will certify 18 ITA beds.[41] Doing so would be a benefit to the planning area and would not fragment services.

[37] TR 59.

[38] AR 373.

[39] AR 45.

[40] TR 458-459.

[41] AR 221.

1.24 With its background in managing hospitals, and with acquiring an established facility, Cascade is well positioned to meet the requirements of WAC 246-310-230.

WAC 246-310-240 "Cost Containment"

1.25 The final criteria for analyzing the viability of a CN Application is a determination of cost containment, as described in WAC 246-310-240, which includes an analysis of whether there are superior alternatives to the proposed project in terms of cost, efficiency, or effectiveness.

1.26 In cases involving only one application, the applicant traditionally lists whatever other alternatives they considered and rejected. In this case, Cascade considered the alternative of building a new building from the ground up, but rejected that alternative as too expensive.

1.27 In actuality, acquiring the Highline building and establishing a new hospital is the best alternative open to Cascade. Highline wanted to divest itself of the campus, and Cascade wanted a base on which to build. There would not have been a more cost-effective or superior alternative. Cascade's pro forma budgets were analyzed under WAC 246-310-220 (financial feasibility) and found to be reasonable. The Presiding Officer finds that Cascade fulfilled the criteria of WAC 246-310-240.

1.28 In consideration of the above, the Presiding Officer finds that Cascade meets the requirements of WAC 246-310-210, WAC 246-310-220, WAC 246-310-230, and WAC 246-310-240. The Presiding Officer further finds that, given the fact that this is Cascade's first hospital in Washington; the conditions set out by the Program in its

September 12, 2013 letter[42] to Cascade are reasonable and should be imposed. Those conditions include continuing to operate the Highline programs that Cascade acquired; increasing the psychiatric beds in two specific phases; providing charity care at or above 1.68% of gross revenue; providing an approved charity care policy to the Department; and allowing the Regional Hospital for Respiratory and Complex Care to occupy their existing space on the specialty campus until December 2014.

II. CONCLUSIONS OF LAW

2.1 The Department of Health is authorized and directed to implement the certificate of need program. RCW 70.38.105(1). Establishment of a psychiatric hospital requires a certificate of need. RCW 70.38.105(4)(a). The applicant must show or establish that its application meets all of the applicable criteria. WAC 246-10-606. The Admissible evidence in certificate of need hearings is the kind of evidence on which reasonably prudent persons are accustomed to rely in the conduct of their affairs. RCW 34.05.452(1). The standard of proof is preponderance of the evidence. WAC 246-10-606.

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

[42] AR 379-380.

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

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

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

> (1) The findings of the department's review of certificate of need applications and the action of the secretary's designee on such applications shall, with the exceptions provided for in WAC 246-310-470 and 246-310-480 be based on determinations as to:
>
> (a) Whether the proposed project is needed;
>
> (b) Whether the proposed project will foster containment of the costs of health care;
>
> (c) Whether the proposed project is financially feasible; and
>
> (d) Whether the proposed project will meet the criteria for structure and process of care identified in WAC 246-310-230.
>
> (2) Criteria contained in this section and in WAC 246-310-210, 246-310-220, 246-310-230, and 246-310-240 shall be used by the department in making the required determinations.

2.5 WAC 246-310-210 defines the "determination of need" in evaluating CN Applications, to wit:

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

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

. . . .

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

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

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

(b) The past performance of the applicant in meeting obligations, if any, under any applicable federal regulations requiring provision of uncompensated care, community service, or access by minorities and

handicapped persons to programs receiving federal financial assistance (including the existence of any unresolved civil rights access complaints against the applicant);

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

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

2.6 Based on the above Findings of Fact, the Presiding Officer determines that Cascade's application meets the criteria for CN set forth in WAC 246-310-210.

2.7 WAC 246-310-220 sets forth the "determination of financial feasibility" criteria to be considered in reviewing CN Applications, to wit:

> The determination of financial feasibility of a project shall be based on the following criteria.
>
> (1) The immediate and long-range capital and operating costs of the project can be met.
>
> (2) The costs of the project, including any construction costs, will probably not result in an unreasonable impact on the costs and charges for health services.
>
> (3) The project can be appropriately financed.

2.8 Based on the above Findings of Fact, the Presiding Officer determines that Cascade's application meets the criteria for CN set forth in WAC 246-310-220.

2.9 WAC 246-310-230 sets forth the "criteria for structure and process of care" to be used in evaluating CN Applications, to wit:

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

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

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

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

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

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

2.10 Based on the above Findings of Fact, the Presiding Officer determines that Cascade's application meets the criteria for CN set forth in WAC 246-310-230.

2.11 WAC 246-310-240 sets forth the "determination of cost containment" criteria to be used in evaluation a CN Application, to wit:

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

2.12 Based on the above Findings of Fact, the Presiding Officer determines that Cascade's application meets the criteria for CN set forth in WAC 246-310-210, WAC 246-310-220, WAC 246-310-230, and WAC 246-310-240, and that the CN should be awarded to Cascade. The Presiding Officer further finds the conditions that Program placed on Cascade in its letter of September 12, 2013, to be reasonable and valuable.

2.13 Because Cascade committed in its application to designate a certain number of ITA beds, Cascade must obtain DSHS ITA certification. However, BHC Fairfax and the Program requested, as a condition of any CN awarded to Cascade, that Cascade be required to accept a certain percentage of ITA patients.[43] The Presiding Officer declines to do this. There is no statutory or regulatory requirement for an Applicant to meet a specific ITA bed level.[44]

[43] TR 28, 549.

[44] Much discussion was had at hearing on the ITA problem, and clearly the parties and the Program agree that it is an important social problem. However, the proposals made at hearing were not specific, and the Application Record lacks sufficient data to adequately address this issue. Nothing precludes the Program from issuing policy or regulations clarifying how the ITA bed issue specifically impacts future psychiatric facility CN applications.

III. ORDER

Based on the foregoing Procedural History and Findings of Fact, and Conclusions of Law, Cascade's CN application to establish a new 135-bed psychiatric hospital to King County is GRANTED subject to the conditions of the Program's September 12, 2013 letter to Cascade.

Dated this ____ day of November, 2014.

_____
FRANK LOCKHART, Health Law Judge
Presiding Officer

NOTICE TO PARTIES

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

Any party may file a written petition for administrative review of this initial order stating the specific grounds upon which exception is taken and the relief requested. WAC 246-10-701(1). A petition for administrative review must be served upon the opposing party and filed with the Adjudicative Clerk Office within 21 days of service of the initial order. WAC 246-10-701(3).

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

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

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

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

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

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

For more information, visit our website at:
http://www.doh.wa.gov/PublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/Hearings.aspx