STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE SERVICES UNIT

In Re the Certificate of Need Applications of:	)	
	)	Docket No. 05-06-C-2001CN (Lead)
SWEDISH HEALTH SERVICES, and OVERLAKE HOSPITAL ASSOCIATION	)	FINDINGS OF FACT, CONCLUSIONS OF LAW AND FINAL ORDER
Petitioners.	)	

APPEARANCES:

Petitioner, Swedish Medical Center (Swedish), by
Dorsey & Whitney, per
Peter Ehrlichman and Brian Grimm, Attorneys at Law

Petitioner, Overlake Hospital Association (Overlake), by
Ogden, Murphy and Walllace, per
Donald Black and Jeffrey Dunbar, Attorneys at Law

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

PRESIDING OFFICER:

Zimmie Caner, Health Law Judge

This is a consolidated case of appeals regarding the Department of Health Certificate of Need Program's denial of Swedish Health Services and Overlake Hospital Association certificate of need applications for a new East King County hospital, and the Program's decision to include the Eastside Hospital beds in its analysis to determine whether a new east King County hospital is needed. Program Affirmed.

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ISSUES

Did the Department of Health Certificate of Need Program (the Program) err when it concluded that there is no need for additional acute care beds in East King County? [1]

In reaching this conclusion of no need, did the Program err in its needs analysis by:

1. Including Group Health Cooperative's Eastside Hospital beds after 2007 and/or

2. Rejecting Swedish Health Service's proposed outmigration adjustment in its application for a new East King County hospital?

SUMMARY OF THE EVIDENCE

During the hearing on January 17-20, 2006,[2] the Department of Health, Certificate of Need Program (Program) presented the testimony of Randall Huyck, Certificate of Need (CN) Program Analyst. Swedish Health Services (Swedish) presented the testimony of Janis Sigman, CN Program Manager, Nancy Auer, M.D., Heidi Aylsworth, Kevin Brown and Frank Fox, Ph.D. Overlake Hospital Association (Overlake) presented the testimony of Jody Corona and Caitlin Hilary.

The following exhibits were admitted:

Exhibit 1: The Program's 2,498 page administrative record (AR) regarding the Swedish and Overlake CN applications.

Exhibits 2-4: Were withdrawn or rejected.

Exhibit 5: April 7, 2005, letter from Kevin Brown.

Exhibit 6: April 21, 2005, letter from Stephen Pentz.

Exhibit 7: April 5, 1972, Group Health Cooperative (Group Health) CN for 150 acute care bed hospital.

Exhibit 8: April 5, 1972, memorandum regarding Group Health 1972 CN application.

Exhibit 9: May 17, 1973, John Beare, M.D. memorandum regarding Group Health's proposed change of its Eastside Hospital location.

Exhibit 10: May 21, 1973, Group Health CN reflecting the new location

[1] Prehearing Order No. 2 limited the scope of the adjudicative proceeding to the criterion upon which the Program denied the Swedish and Overlake applications, the question of need.
[2] Closing arguments were presented through briefs. The final briefs were filed on March 3, 2006.

Exhibit 11: Group Health– Overlake "Purchased Services Agreement".

Exhibit 11A: Group Health – Overlake "Purchased Services Agreement" filed with the Washington State Insurance Commissioner's office.

Exhibit 12: 1987 Washington State Health Plan.

Exhibit 13: Curriculum Vitae of Frank Fox, Ph.D.

Exhibit 14: Swedish and Overlake East King County hospital CN applications, Program's decisions, Swedish's Petition for Reconsideration, public comment documents, and correspondence with the Program.

Exhibit 15: Curriculum Vitae of Jody Carona.

Exhibit 16: Prior CN decisions issued by the Program and by Health Law Judges.

Exhibit 17: Chart entitled "East King County Planning Area".

Exhibit 18: Table entitled "Comparing Overlake and Swedish Health Services Zip Code Definitions of East King County Planning Area".

Exhibit 19: Rules, laws and history regarding certificate of need.

Exhibit 20: Maps with directions/distances between existing East King County hospitals and Issaquah.

Exhibit 21: King County map with Swedish and Overlake proposed service areas.

Exhibit 22: January 20, 2004, Group Health Cooperative news release.

Exhibit 23: Group Health Cooperative web page entitled "Group Health Cooperative Resolution: Eastside Hospital".

Exhibit 24: March 2, 2005, Issaquah Press Report.

Exhibit 25: Stipulation of Facts regarding the testimony of Karen Nidermayer.

Exhibit 26: Curriculum vitae of Nancy Auer, M.D.

Exhibit 27: Charts and graphs prepared by Frank Fox, Ph.D. regarding East King County's population, out migration to non-East King County hospitals and projected need for acute care hospital beds.

I. FINDINGS OF FACT

1.1 During the summer of 2004, Swedish Health Services (Swedish) and Overlake Hospital Association (Overlake) each filed a CN application for the establishment of a new hospital in Issaquah, within the East King County service area of Washington State. Overlake proposed to open an 86 bed facility by 2009, adding 34 beds by 2014 for a total of 120 beds. Overlake currently operates a hospital in Bellevue that is licensed for 257 beds.[3] Swedish proposed to open an 80 acute care bed facility in 2009, adding 40 beds by 2012 and 55 beds by 2015, for a total of 175 beds. Swedish currently operates a hospital with three campuses in Seattle that are licensed for 1,245 beds.[4]

1.2 In May 2005, the Program denied the applications concluding there is not a need for a new hospital in either Swedish's or Overlake's proposed East King County service areas.

The applicants identified proposed service areas in the East King County region.

1.3 A service area is the geographic area appropriate for effective health planning in which a facility provides or proposed facility would provide health care services. In this case, Overlake and Swedish proposed slightly different service areas that their proposed hospital in East King County would serve. Historically, service areas have been identified by zip codes and/or geographic descriptors, such as East King County, to identify patients who will be served by a new proposed facility. The Swedish and Overlake CN applications propose service areas that are identified through zip codes.[5] The applicants' proposed service areas contain 22 common zip codes and each contain three different zip codes. The Program

[3] Swedish and Overlake propose three phases in the construction and operation of their proposed Issaquah hospitals with construction commencing in 2006. AR 44 and 553
[4] AR 493 and 471
[5] Exhibit 21

correctly concluded that these differences do not significantly change the conclusions reached in the needs analysis at this time.

1.4 Hospital service areas are not limited to a city or town. Swedish and Overlake recognize this fact in their applications by proposing service areas that generally encompass East King County therefore encompassing several cities located in this region including but not limited to Bellevue, Redmond, Kirkland and Issaquah.

1.5 It is clear that the Issaquah-Sammamish Plateau community desires a local hospital whether it is provided by Swedish or Overlake. The CN process does encourage public comment and input, but the key question is whether a new hospital would create an excess of acute care beds resulting in destabilization of existing hospitals in the service area as a result of an oversupply. The Program correctly concluded that hospitals in the service area already operate below occupancy standards utilized to determine need for a new hospital, therefore indicating additional beds would destabilize the existing facilities.[6] Hospitals are extremely expensive to build and operate.[7] A new hospital without established needs would result in unnecessary duplication of services, unnecessary costs that may drive up the costs of healthcare, and adversely affect existing hospitals in this service area.

The Program correctly counted the existing acute care beds within the proposed East King County service areas.

1.6 Swedish and Overlake proposed East King County service areas encompass four existing hospitals: Eastside Hospital, Overlake Hospital, Evergreen Hospital, and

[6] "In developing baseline forecasts of future bed needs, the occupancy standards for existing hospitals in planning areas shall not be less than: 50% for hospitals with 1-49 beds, 65% for hospitals with 50-99 beds, 70% for hospitals with 100-199 beds, 75% for hospitals with 200-299 beds, (and) 80% for hospitals with 300 or more (beds). Exhibit 12 at C-37

[7] The projected cost of the new hospital is approximately $184 million for Overlake and $200 million for Swedish.

Snoqualmie Valley Hospital. These hospitals currently provide 587 acute care beds. In 2007, the number of acute care hospital beds will increase to 677, when Overlake completes its addition of 80 acute care beds and Evergreen completes its addition of 15 acute care beds.

1.7 Eastside Hospital is located in Redmond approximately 11.7 miles northeast of Issaquah. It is currently licensed for 179 acute care beds, with 132 of the beds set up and operational. Eastside primarily treats Group Health Cooperative HMO patients. It also treats non-HMO patients in low numbers primarily through its emergency department. Even though Eastside treats few non-HMO patients, a new operator of Eastside may treat more non-HMO patients after 2007 if Eastside Hospital is leased or sold by Group Health.

1.8 Overlake Hospital is located in Bellevue approximately 11.1 miles northwest of Issaquah. Overlake Hospital has 220 acute care beds and 37 beds dedicated to psychiatric care. Upon the expected completion of its new addition in 2007, Overlake Hospital will have 300 acute care beds.

1.9 Snoqualmie Valley Hospital is approximately 11 miles east of Issaquah. Snoqualmie Hospital has 18 acute care beds and 10 beds dedicated to psychiatric care. This hospital primarily treats psychiatric patients. Acute care patients in the vicinity of Snoqualmie Hospital tend to use other hospitals for acute care.

1.10 Evergreen Hospital is located in Kirkland approximately 17.7 miles from Issaquah. Evergreen Hospital is licensed for 244 acute care beds with 212 of those beds available for acute care use.[8] In addition, Evergreen has 15 beds dedicated to hospice care and 17 beds for long term care. In 2004, Evergreen Hospital obtained a certificate of need to remove the limitation on the 15 hospice beds so they may be used for general acute care. That

[8] AR 504

conversion must occur prior to January 31, 2007. Therefore, the Program correctly projected that 227 acute care beds will be available at Evergreen Hospital from the beginning of 2007.

***In its needs analysis, the Program correctly included the Eastside Hospital beds* after 2007.**

1.11 The key issue is whether to include the 132 Group Health's Eastside Hospital beds after 2007 when Group Health will transfers all of its in-patient care to Overlake Hospital. Swedish and Overlake included the Eastside Hospital beds in their applications' initial hospital bed count. In light of Group Health's contract to transfer its in-patient care to Overlake, Swedish began excluding the Eastside beds in 2007, and Overlake began excluding the Eastside beds in 2008. During the Program's review of the Swedish and Overlake applications, Group Health stated that its Eastside beds should continued to be counted after 2007 because it hopes to sell or lease its Eastside Hospital beds prior to its transfer of its in-patient care to Overlake.[9]

1.12 Group Health is a health management organization (HMO) that owns and operates Eastside Hospital in Redmond. In 2004, Group Health and Overlake entered into a written contract. Group Health agreed to stop admitting/treating its HMO members at Eastside Hospital, and that its patients would be treated at Overlake's 80 bed addition (the Tower) that is presently under construction. Through the contract, Group Health agreed to utilize Overlake's in-patient hospital services to ensure that its HMO members have acute care

[9] In Program's decision to issue Evergreen Hospital's July 2004 CN (15 bed addition) and Overlake's 2002 CN (80 bed addition), Program did not count Group Health's Eastside Hospital beds after 2007. Program assumed Eastside would close with Group Health's transfer of its HMO in-patient care to Overlake. In October 2004, Group Health informed Program that it was not abandoning its right to sell/lease these beds. Program would not have excluded the Eastside beds from its analysis of the Overlake and Evergreen expansions if it had been informed of Group Health's position prior to the issuance of those CNs. AR 1089

hospital services within East King County.[10] The Overlake Tower must be constructed and ready to admit and treat Group Health patients no later than March 31, 2008. Group Health must relocate the last of its in-patient services from Eastside Hospital to the Overlake Tower, 90 days after the Tower's opening.[11]

1.13 In addition, Group Health purchased land from Overlake adjacent to the Tower where it is constructing a new specialty center that will house its out-patient and ambulatory specialty services. Group Health predicts that an increasing number of procedures/surgeries/care will be done in out-patient and ambulatory settings rather than within the hospital, therefore, it is investing in state-of-the-art ambulatory systems within its new specialty center.[12]

1.14 Group Health's contract with Overlake does not preclude Group Health from selling or leasing Eastside Hospital, which Group Health is considering, as Eastside Hospital is a valuable asset. It is unknown at this time whether Group Health will succeed in locating a lessee or buyer who will continue the operation of Eastside Hospital services. If a lessee or buyer is located, the party must first obtain a CN before it may operate Eastside Hospital, *and* before Group Health ceases operation of the hospital.

1.15 As a Group Health HMO hospital, Eastside primarily serves Group Health HMO members and not the general population.[13] Eastside Hospital is not precluded from treating non-HMO patients because Group Health obtained the initial Eastside CN in 1972, and an

[10] AR 1087
[11] The agreement encompasses a few caveats regarding cessation date of in-patient operations by Group Health at Eastside Hospital, but in terms of the question of a need for a new east King County hospital, these facts are not significant.
[12] AR 1087
[13] In approximately 2004, Group Health served over 85,000 east King County members. AR 1084

amended CN for a change of location within Redmond in 1974. At that time, the HMO exemption under RCW 70.38.111 did not exist. This exemption permits HMO hospitals to bypass the CN requirement if it solely treats HMO patients.

1.16 A CN application by a lessee or buyer of Eastside Hospital does not have to establish need, since need was established by Group Health prior to the issuance of the 1972 Eastside Hospital CN. A lessee or buyer must establish the remaining CN qualifying criteria in its application before taking over the operation of Eastside Hospital's acute care beds.[14] The Program, therefore, correctly included the Eastside beds in the "need" analysis available bed count after 2007. This conclusion is consistent with the Washington State Health Plan hospital bed forecasting need methodology.

The Program correctly analyzed the need for a new hospital under the Washington State Health Plan

1.17 Pursuant to the Program's standard practice, it utilized the 1987 Washington State Health Plan's hospital bed need for forecasting methodology to determine whether there is a need for a new hospital in the proposed East King County service areas. Under Chapter 70.38 RCW, the State Health Coordinating Council developed the Washington Health Plan methodology as a tool for long-term strategic planning of health care resources.[15] The Washington Health Plan did "sunset" (lapse) in 1989, but its methodology for hospital bed need forecasting remains a reliable tool for predicting baseline need for acute care beds.

[14] The remaining CN criteria are financial feasibility, structure and process (quality) of care and cost containment. WAC 246-310-220 through WAC 246-310-240
[15] This Plan was approved by the Governor in 1987. Exhibit 12

1.18 Swedish or Overlake did not recommend alternative methodology other than those regularly used by the Program through its application of the State Health Plan.[16] The dispute lies in the application of the Plan's methodology.

1.19 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 following 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. Step 12 allows for necessary adjustments in the methodology to reflect the special circumstances of a service area.[17]

1.20 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 proceeding the base year.[18].
>
> 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.[19]
>
> 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.

[16] These modifications are: 1. Data prior to 1996 is not used in step 4 due to the significant decrease in utilization following changes in government reimbursement for hospital acute care services, and 2. Occupancy standards as outlined in step 10 of the methodology are adjusted downward by 5% for all but the smallest hospitals (1-49 beds) because Program determined in previous evaluations that the occupancy standards used in step 10 "are higher than can be maintained by hospitals under the current models for provision of care". AR 483 (The occupancy standards are set forth in footnote 6.)

[17] Exhibit 12, C-22 through C-63

[18] The base year is the "most recent year about which data is collected as the basis for a set of forecasts." Exhibit 12 C-25

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

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 appropriate health planning region's ten-year use rate trend, whichever trend would result in the smaller adjustment…[20]

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.[21] This should be based on the total number of beds in each hospital (Standard 11.b[22]), 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-state use and occupancy rates...[23]

1.21 In projecting need for additional acute care beds, the State Health Plan's methodology evaluates the historical utilization data of three geographic areas: the state, the

[20] Step 7B is an alternative to step 7A, and does not apply to the facts at hand.
[21] Standard 11f states: "The occupancy standard applied to each planning area…shall be based, for forecasting purposes, on the current weighted average of the appropriate occupancy standard for each facility in the planning area. This is calculated as the sum, across all hospitals in the planning area, of each hospital's occupancy rates times that hospital's percentage of total beds in the area..." Exhibit 12 at C-39.
[22] Standard 11b provides the hospital occupancy standards used in forecasting need. (See footnote 6.) Exhibit 12, C-37
[23] Exhibit 12, C-41-43

health service region (the state is divided into four regions) and the proposed service area (the two different East King County regions proposed by the applicants)[24]. The utilization rates for these three areas are analyzed through two age groups: 65 and older and under 65.[25] For example, during 2003, approximately 177 patient days were utilized for every 1,000 East King County residents under the age of 65 and approximately 1,011 patient days were utilized for every 1,000 residents 65 years old or older. These utilization rates are then applied to projected populations.[26]

1.22 In determining whether the existing hospital will meet the projected populations' needs, the total number of available beds in the proposed service area must be calculated. The State Health Plan outlines which acute care beds should be included in the count of present and future available beds in the proposed service area.

1.23 Under step 10, the Program correctly included the Eastside Hospital's beds after 2007.[27] The Program's decision is consistent with the State Health Plan Standard 12.a that outlines which beds should be counted in the need analysis:

a. The count of future bed capacity should separately identify:

[24] Program and the applicants used the data provided by the Department of Health's Office of Hospital and Patient Data Systems Comprehensive Hospital Abstract Reporting Systems database (CHARS).
[25] During the hearing, Swedish presented evidence regarding surge capacity without sufficient data and analysis. Surge capacity is a region's ability to respond to bioterrorist attack, natural disasters or pandemics such as influenza. This is an issue that should not be lightly addressed. This issue was not addressed as a rational for a new hospital by either Swedish or Overlake in their applications, and Swedish did not adequately address the issue during the hearing.
[26] Exhibit 12, Step 7A
[27] HMO facilities are generally exempt from CN review. RCW 70.38.111 and WAC 246-310-404. When a HMO hospital is exempt, its HMO patients and beds are excluded from the needs analysis in the "existing" bed count. In this case, Group Health obtained its Eastside CN before the exemption applied, and, therefore, Eastside is not an "exempt" facility. As a result, Group Health does treat non HMO patients, and more importantly Group Health may exercise it legal right to lease or sell its 179 licensed Eastside acute care beds. That transaction would be subject to CN review and approval requirements set forth in RCW 70.38.111 and 70.38.105

1. Beds which are currently licensed and physically could be set up without significant capital expenditure requiring new state approval;
2. Beds which do not physically exist but are authorized unless for some reason it seems certain those beds will never be built;
3. Beds which are in the current license but physically could not be set up (e.g., beds which have been converted to other uses with no realistic chance they could be converted back to beds);
4. Beds which will be eliminated;

b. Occupancy standards for forecasting are computed based on beds which are licensed and physically could be set up, plus beds which do not physically exist, but which are authorized.[28]

1.24 Even under the State Health Plan's methodology for assessing the need for a hospital's expansions rather than the need for a new hospital, the applications would be denied. As stated in the State Heath Plan:

b. Under certain conditions, institutions may be allowed to expand even though the bed need forecasts indicate that there are underutilized facilities in the area. The conditions might include the following:
- The proposed development would significantly improve the accessibility or acceptability of services for underserved groups; or
- The proposed development would allow expansion or maintenance of an institution which has staff who have greater training or skill, or which has a wider range of important services, or whose programs have evidence or better results than do neighboring and comparable institutions; or
- The proposed development would allow expansion of a crowded institution which has good cost, efficiency, or productivity measure of its performance while underutilized services are located in neighboring and comparable institutions with higher cost, less efficient operations or lower productivity.

In such cases, the benefits of expansion are judged to outweigh the potential costs of possible additional surplus.[29]

None of these hospital expansion exceptions are present in the case at hand. The existing providers in this service area are accessible to the East King County population that includes the Issaquah community. "Underserved" refers to disabled, elderly or minorities in a planning area. Swedish and Overlake did not identify an "underserved" group in their proposed East

[28] Exhibit 12 at C-39
[29] Exhibit 12 at C-28

King County service areas. Decreasing the driving time for a portion of a population in a service area that has a bed surplus and hospitals within reasonable distances is not sufficient grounds for a new facility under the State Health Plan.

1.25 If a new lessee or purchaser is approved for Eastside Hospital and its beds remain available after 2007, the need for additional acute care beds would not arise until approximately 2025. If Swedish's application were approved, there would approximately be a surplus of 201 acute care beds in 2009, 189 acute care beds in 2012, 176 acute care beds in 2016, and 8 acute care beds in 2025.[30]

1.26 Even without the Eastside Hospital beds, a need for 16 beds would first arise in approximately 2010.[31] This is a relatively small need when one considers that the need analysis under the State Health Plan is based on the existing hospitals operating at only a 70% capacity.[32] The 80 beds that Swedish proposes to include in the first stage of its three stage Issaquah hospital would not be needed until approximately 2014.[33] Therefore, there should be sufficient time for the CN application process and construction of a new facility if the Eastside Hospital acute care beds cease to exist in 2007 or 2008.[34]

1.27 On the other hand, if the Eastside Hospital beds do not cease to exist, there will be a surplus of acute care beds for a number of years. In addition, 79 inactive licensed acute care beds under the Evergreen Hospital and Eastside Hospital existing CNs could be added to the active supply of available beds, therefore, creating an even greater surplus. The Swedish

[30] These projected figures do not include an adjustment for outmigration. Outmigration is addressed below. AR 536
[31] AR 535
[32] AR 535 and Exhibit 12. (The State Health Plan's occupancy standards are set forth in footnote 6.)
[33] AR 535
[34] Swedish stated in its application that the hospital design would be completed in May 2006, the first phase of construction would commence in September 2006 and 80 beds would be operational in January 2009.

and Overlake applications to build a new hospital in the East King County service area are premature until the uncertainty of the Eastside Hospital beds is known.

1.28 Do these findings still hold true if a trend adjustment is applied under step 12 of the State Health Plan methodology? Step 12 adjusts the calculations performed in the State Health Plan's prior steps to reflect changing trends in factors such as population. Step 12 prevents the prior steps from under or over estimating the need for acute care beds. The prior steps do not tailor the need analysis to the changing trends in a specific service area. Step 12 permits such adjustments when the unique characteristics of a service area are measurable through reliable trend data and analysis. Swedish argues that an adjustment should be made for the decreasing rate of outmigration. The Program concluded in its analysis that no Step 12 adjustment should be made for outmigration.

Swedish's proposed outmigration adjustment is inflated and does not support the need for a new East King County Hospital.

1.29 Outmigration is the number of patient days residents of the planning area leave the service area for treatment elsewhere. Outmigration is the inverse of market share which is the number of patient days provided in a service area and the percentages provided by each hospital within a service area. The State Health Plan considers market share and outmigration in calculating a service area's present and future need. Step 9 of the State Health Plan methodology evaluates the "latest statewide patient origin study" to project the number of days expected to be spent in East King County hospitals. The Program argues that outmigration is addressed in Step 9 and not in Step 12; therefore, trend adjustments should not be made for outmigration under the State Health Plan methodology.

1.30 Even if Step 12 of the State Health Plan applied, the adjustments for changing trends are conservatively calculated. The State Health Plan advises that trend calculations should be limited to seven year projections in light of the difficulty of projecting too many years in the future. As the State Health Plan explains there are many changing factors to consider:

> Because medical terminology and standards of practice change rapidly, because medical facilities and equipment become obsolete quickly, because communities and their goals change, and because in general, long-range forecasts are unreliable, forecasts should go only as far into the future as need to answer the type of policy question being asked.[35]

1.31 What adjustments if any, should be made for outmigration if it were permitted under Step 12? Swedish's reliance on the 1995-2003 CHARS[36] data for the East King county planning area only demonstrates a gradual decrease in outmigration for these years from 49 to 46 percentage points.[37] This three percentage gradual decrease over eight years does not support Swedish's proposed 20 percent adjustment to outmigration even with the additional patient choice/competition from a new Issaquah Hospital.[38] The outmigration trend does support the need for a hospital earlier than projected by the Program, but not early enough to justify the issuance of a CN for a new hospital at this time. If the three percent adjustment for outmigration is made and the Eastside Hospital beds are included in the available bed count, need would not arise for a new hospital until approximately 2015.[39]

[35] Exhibit 12 at C-30
[36] See footnote 24 regarding CHARS data.
[37] AR 2368
[38] Exhibit 27
[39] Exhibit 27 Charts A and B

1.32 Swedish argues, without sufficient supporting evidence, that traffic will worsen therefore, further decreasing outmigration for a long period of time.[40] Swedish applied a constant outmigration rate over an extended period of time, from 2003 through 2025.[41] Even if outmigration trend adjustment was permitted under the State Health Plan, Swedish applied the trend many years beyond the seven year maximum recommended in the Plan for trend adjustments.[42] In addition, Swedish's extended trend application compounds the potential problem of inflating the utilization trend rates calculated in the earlier steps of the methodology.

1.33 Swedish's projection that it will capture a significant market share (therefore decreasing outmigration) is too speculative. Swedish predicts that it will capture a market share that is much larger than Providence Everett Hospital's market share, the hospital with the highest market percentage in the Puget Sound area.[43] Providence Everett is the sole acute care provider in Snohomish County service area. Providence Everett has approximately 51 percent of its service area market.[44] In contrast, Swedish would be introducing a new hospital in a service area with four competing hospitals unlike Providence Everett's sole provider status within its service area. Therefore it is unrealistic for Swedish to predict

[40] Swedish failed to address the inverse pattern that would logically arise from traffic problems discouraging outmigration of East King County residents; that non-East King County residents may, in similarly decreasing numbers, stop in-migrating into the East King County service area. In 2003, approximately 51,000 East King County residents left the East King County service area for treatment, while approximately 41,000 non East King County residents entered East King County service area for care. AR 531-534

[41] Exhibit 27 Charts I and II

[42] Program has applied a constant outmigration percentage based on the most recent available CHARS data since 2001 in other cases except for the *Legacy Health System and Southwest Washington Medical Center* 2002 evaluation. The *Legacy* case is distinguishable upon its facts; there was only one hospital in the service area, the public had concerns with that sole provider, and Program did not have to take into account adverse effects on the adjoining service area since that area was located in Oregon, outside Program's jurisdiction.

[43] In 2002-2003, Issaquah residents sought care at the following facilities: 51% Overlake Hospital, 9% Evergreen Hospital, 7% Eastside Hospital, 3% Snoqualmie Valley Hospital, 13% Swedish and 15% at other Seattle hospitals. Swedish proposes to capture approximately 80% of this Issaquah market.

[44] AR 1891

capturing a large majority of the out migrating residents especially when approximately 20% of the out migrating residents seek tertiary care that will not be offered in Swedish's proposed Issaquah hospital.[45]

1.34 In addition to seeking tertiary care not offered in the service area, patients out-migrate for various reasons including hospital's reputation, hospital's proximity to patients, and the location and privileges of the physician selected by patients. It is therefore logical to assume that very heavy traffic/travel times will effects hospital choice of some East King County residents, but not all of the residents who seek care outside of the East King County service area. The addition of choice through a new Issaquah hospital in East King County service area will effect outmigration, but to what degree is unknown; therefore, a conservative rather than a large unsupported projection is more in keeping with the State Health Plan's conservative approach.[46] Even if outmigration trend adjustment were permitted under Step 12, the trend does not support the need for a new hospital.

II. CONCLUSIONS OF LAW

2.1 In response to the 1974 National Health Planning and Resources Development Act, the Washington State Legislature adopted Washington's 1979 Health Planning & Development Act. This act created the Certificate of Need Program. Chapter 70.38 RCW and St*. Joseph Hospital & Health Care Center v. Department of Health*, 125 Wn2d 733, 735-736 (1995). One of the purposes of the federal and state health care planning acts was to control health care costs. *Id.* Both legislative bodies were concerned that competition in health care

[45] These tertiary services are primarily provided by large regional facilities in Seattle within the West King County service area; Children's Hospital, University of Washington's Hospital, Virginia Mason Hospital and Swedish Medical Center's First Hill and Providence Campuses. East King County is east of Seattle. Lake Washington divides east and west King County. AR 1880-1905

[46] Exhibit 12 at C-30

"had a tendency to drive health care cost up rather than down, and government therefore needed to restrain market place forces. *Id* at 741. The CN statutory scheme is designed in part to control rapid rising health care cost by limiting competition within the health care industry and therefore protects existing facilities from competition "unless a need for additional services" can be demonstrated. *Id.* at 742.

2.2 The CN statutory requirements limit provider entry into health care markets so the development of health care resources is "accomplished in a planned, orderly fashion, consistent with identified priorities and without unnecessary duplication or fragmentation". RCW 70.38.015(2). This health planning process strives to provide accessible health care services while avoiding unnecessary duplication and unnecessary costs that may drive up health care costs. RCW 70.38.015(1) and (5). Unnecessary duplication such as an unneeded hospital should be avoided to prevent the potential increase in health care costs.

2.3 Patient choice may be considered when evidence demonstrates a public need for a new hospital, and that a new facility will not adversely affect the existing facilities. *St. Joseph* at 742. In the case at hand, the evidence did not demonstrate a need for an additional East King County hospital. The evidence did demonstrate that such a new facility may adversely affect the existing facilities by the creation of a surplus bed supply that would last for a number of years.[47]

[47] Swedish cites the *Olympic Peninsula Kidney Center* Docket No. 04-06-C-2003CN (2005). The decision held that patient choice is a legitimate CN factor in the review of CN applications whenever there is need and the facilities would provide patients with a realistic choice. In the *Olympic* case, the geographic distance between the dialysis facilities in question precluded a realistic patient choice. Therefore, competition/patient choice was found to be unsupported by the facts. The case at hand is distinguishable factually from the *Olympic* case because there are four hospitals in the service area and driving distances are not unreasonable for the Issaquah area population. In addition, dialysis patients must receive dialysis three to four times a week, unlike in-patient care. Also, unlike kidney dialysis, the frequency of use of

2.4 The Department of Health, Certificate of Need Program is responsible for implementing this statute. RCW 70.38.105(1). Certificates of Need shall be issued or denied in accordance with Health Planning and Development Act and the Department of Health rules on which establish the review procedures and criteria for the Certificate of Need Program in Chapter 246-310 WAC. RCW 70.38.115(1).

2.5 The general Certificate of Need criteria apply to a new hospital application. RCW 70.38.115(2) and WAC 246-310-200 outline the criteria that the Program must address in determining whether it should grant or deny a certificate of need. Those criteria are "need" (WAC 246-310-210), "financial feasibility" (WAC 246-310-220), "structure and process (quality) of care" (WAC 246-310-230), and "cost containment" (WAC 246-310-240). As stated before, the question at hand is limited to the need criterion.

2.6 The CN rules contain methodologies for determining need of some types of new facilities or services, but not for new hospitals or for additional acute care beds and services. RCW 70.38.115(2)(a) and Chapter 246-310 WAC. The Program, therefore, turns to "applicable standards" developed by other "organizations with recognized expertise". WAC 246-310-200(2)(b). Swedish and Overlake do not object to the Program's use of the 1987 State Health Plan's methodology but do object to the Program's application of the methodology to the facts at hand. The Program did not err in its application of the methodology to its needs analysis and conclusion that there is not a need for additional acute care hospital beds in the proposed service areas.

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acute care beds is relatively low; for ages 65 and above, the average number of patient days per 1,000 people are 177 and for ages 64 and below it is one patient day per 1,000.

2.7 An applicant denied a certificate of need has the right to an adjudicative proceeding. RCW 34.05.413. In the adjudicative proceeding, the applicant has the burden to demonstrate that it meets all applicable criteria. WAC 246-10-606. The standard of proof is a preponderance of the evidence. WAC 246-10-606. Evidence should be the kind that "reasonably prudent persons are accustomed to rely in the conduct of their affairs." RCW 34.05.461(4). The applicants (petitioners) failed to present a preponderance of evidence that supports their appeals; that there is a need for a new hospital in their proposed East King County service areas. The evidence demonstrates that the existing hospitals in the proposed service areas are "sufficiently available or accessible to meet the need" of the population in this service area. WAC 246-310-210(1).

III. ORDER

Based on the Findings of Fact and Conclusions of Law, Program's decision that a new East King County hospital is not needed is AFFIRMED; and therefore, Program's denials of the Swedish and Overlake Certificate of Need applications are AFFIRMED.

Dated this _27___ day of April, 2006.

/s/
ZIMMIE CANER, 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/national reporting requirements. If adverse action 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
PO Box 47879
Olympia, WA 98504-7879

and a copy must be sent to:

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

The request must state the specific grounds upon which reconsideration is requested and the relief requested. The petition for reconsideration is considered denied 20 days after the petition is filed if the Adjudicative Service Unit has not responded to the petition or served written notice of the date by which action will be taken on 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, however, the 30-day period will begin to run upon the resolution of that petition. RCW 34.05.470(3).

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