ANALYSIS SUPPORTING THE NEWCO

CERTIFICATE OF NEED #675

FINAL DECISION

July 6, 2017

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I. INTRODUCTION

A. Overview of applicable law

Criteria for reviewing this project are provided in OAR 333-580-0040, 333-580-0050 and 333-580-0060. The specific need methodology and standards for demonstration of need for acute inpatient beds and facilities are found in division 590 of OAR chapter 333. The specific need methodology and standards for demonstration of need for psychiatric inpatient beds are found in division 615 of OAR chapter 333. The Oregon Health Authority, Public Health Division (Division) makes findings and bases its decision on the extent to which the applicant demonstrates that these criteria and standards are met. Criteria will be considered to be met if the applicant can demonstrate that the questions posed in the criteria can be answered in the affirmative.

B. The application and review process

On January 5, 2016, NEWCO Oregon, Inc. (NEWCO) submitted an application for a 100-bed freestanding psychiatric hospital to be located at 9500 SW Day Road in Wilsonville. Project costs are estimated at $35,834,324. NEWCO is a wholly owned subsidiary of Universal Health Services, Inc. (UHS). The application was determined to be complete on October 20, 2016, and review began on October 21, 2016. A public meeting was held on November 17, 2016.

In response to questions from the Division, the applicant has made significant changes to the project from what it proposed in the original application submitted on January 5, 2016. It originally posited that it could establish need for a facility with 50 child/adolescent beds, 25 adult beds and 25 geriatric beds. During the course of the Division's review of the application for completeness it then changed this number to 20 child/adolescent beds, 60 adult beds and 20 geriatric beds. By letter dated September 29, 2016, the Division raised concerns about the failure of the design of the hospital to provide for visual and physical separation of child and adolescent care units from each other and from adult units as required by OAR 333-535-0061(8)(d). Subsequently by letter dated October 5, 2016, the applicant wrote that: "UHS has determined that inpatient care for children, persons 5-11 years old, will not be included at this time, due to space configurations and treatment modality requirements for the different age cohort groups." With that change, it now proposes that 24 beds be dedicated to adolescent care, with 52 beds for adults and 24 beds for geriatric patients.

II. APPLICABLE CRITERIA[1]

A. Need: OAR 333-580-0040

1. Does the service area population need the proposed project.[2]

The applicant must:

- Identify the service area's need for the proposal in the past, present and future; and

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[1] Only the criterion applicable to this application will be addressed in the analysis.

[2] OAR 333-580-0040(1). References related to bed need analysis:

1. La EM, Lich KH, Wells R, et al. Increasing access to state psychiatric hospital beds: exploring supply-side solutions. **Psychiatric Services**. 2015.
2. Torrey EF. **The Insanity Offense**. New York: Norton; 2012:192-196.
3. Glick ID, Sharfstein SS, Schwartz HI. Inpatient psychiatric care in the 21st century: the need for reform. **Psychiatric Services**. 2011;62(2):206–209.
4. Capdevielle D , Ritchie K : The long and the short of it: are shorter periods of hospitalization beneficial? **British Journal of Psychiatry** 192:164–165, 2008.
5. Bray I, Gunnell D. Suicide rates, life satisfaction and happiness as markers for population mental health. **Social Psychiatry and Psychiatric Epidemiology**. 2006 May 1;41(5):333-7.
6. Ruaño G, Szarek BL, Villagra D, Gorowski K, Kocherla M, Seip RL, Goethe JW, Schwartz HI. Length of psychiatric hospitalization is correlated with CYP2D6 functional status in inpatients with major depressive disorder. **Biomarkers.** 2013 Jun 4;7(3):429-39.
7. Pirkola S, Sund R, Sailas E, Wahlbeck K. Community mental-health services and suicide rate in Finland: a nationwide small-area analysis. **The Lancet**. 2009 Jan 16;373(9658):147-53.
8. Mojtabai R. Unmet need for treatment of major depression in the United States. **Psychiatric Services**. 2009 Mar; 60(3):297-305.
9. Cooper J, Stagman S. Children's mental health: What every policymaker should know. Columbia University, New York NY. 2010 Funk, Michelle and Drew, Natalie and Knapp, Martin (2012) Mental health, poverty and development. **Journal of Public Mental Health**, 11 (4). pp. 166-185.
10. Swartz MS, Wilder CM, Swanson JW, Van Dorn RA, Robbins PC, Steadman HJ, Moser LL, Gilbert AR, Monahan J. Assessing outcomes for consumers in New York's assisted outpatient treatment program. **Psychiatric Services**. 2010 Oct;61(10):976-81.
11. Creed F et al. Randomized controlled trial of day patients vs. inpatient psychiatric treatment. **BMJ** 1990 Apr 21:300(1033):1037.
12. Creed F, Mbaya P, Lancashire S, Tomenson B, Williams B, Holme S. Cost effectiveness of day and inpatient psychiatric treatment: results of a randomised controlled trial. **BMJ**. 1997 May 10;314(7091):1381.
13. Schene AH, Wijngaarden BV, Poelijoe NW, Gersons BP. The Utrecht comparative study on psychiatric day treatment and inpatient treatment. **Acta Psychiatrica Scandinavica**. 1993 Jun 1;87(6):427-36.
14. Marshall M, Crowther R, Sledge WH, Rathbone J, Soares-Weiser, K. Day hospital versus admission for acute psychiatric disorders. **The Cochrane Library**. 2011 Jan 1.
15. Thornicroft G, Tansella M. The balanced care model for global mental health**. Psychological Medicine**. 2013 Apr 1;43(04):849-63.
16. Lester H, Glasby J. Mental health policy and practice. *Palgrave Macmillan*; 2010 Apr 29.
17. Conley J, O'Brien CW, Leff BA, Bolen S, Zulman D. Alternative Strategies to Inpatient Hospitalization for Acute Medical Conditions: A Systematic Review. **JAMA Internal Medicine**. 2016 Nov 1;176(11):1693-702.
18. Kilian R, Becker T, Frasch K. Effectiveness and cost-effectiveness of home treatment compared with inpatient care for patients with acute mental disorders in a rural catchment area in Germany. **Neurology, Psychiatry and Brain Research**. 2016 Jun 30;22(2):81-6

- Establish the present and future need for the project.[3] In determining need, the applicant must also:
- Use appropriate indicators of a population's need (i.e. population-based use-rates, population-based "medical necessity" rates, or established productivity standards); and
- Use the standards and need methodologies specified in divisions 585 through 645 of OAR chapter 333 applicable to the services or facilities being proposed and consider industry standards and historical experience as appropriate where plans are silent.[4]

As is described in OAR 333-580-0040(1)(b)(A) and (B), the specific standards and methodology contained in OAR 333-590-0000 through 333-590-0060 for general hospital bed-need are used to determine whether the criterion in OAR 333-580-0040(1) can be met. In addition, since this application is for psychiatric services, the standards and methodology specific to psychiatric bed-need contained in OAR 333-615 must be addressed.

a. Rationale for determining hospital bed need

The CN program established a rational approach for determining hospital bed need over 30 years ago. The central concern in the origin of CN rules was to promote effective, lower cost healthcare, through encouraging less expensive and more accessible alternatives to what was perceived as resource-intensive and over-used hospital care. OAR 333-545-0000. The CN approach was a regulatory precursor to the modern adoption of the Triple Aim, and of the Oregon Health Plan's emphasis on rational and effective medical modalities.

A stated priority in the CN rules is to encourage meeting inpatient psychiatric need within existing community hospital settings. OAR 333-615-0020.

b. Service area

An issue for both applicants and reviewers in the case of proposals for new psychiatric facilities is how to interpret the separate service area definitions contained in the general bed need rules (OAR 333-590) and the psychiatric bed need rules (OAR 333-615). The applicant has in this instance opted to apply the larger, Health Service Area (HSA) based definition found in the psychiatric rules, to both sections. This service area as used by the applicant is comprised of the entire counties of Multnomah, Clackamas, and Washington. However this is not the appropriate service area for demonstrating general bed need under OAR 333-590, as a small, general hospital would be expected to only draw from their local population. Thus a smaller, zip code-based service area should be applied, with a concomitantly reduced population base and calculated service area need, supported by a well-argued rationale. In this instance the requirements of OAR 333-615-0030(1)(d) require that the service area be calculated

[3] OAR 333-580-0040(1)(a) and (b).
[4] OAR 333-580-0040(1)(b)(A)and (B).

separately by both the OAR 333-590-0050(1) and OAR 333-615-0030(1) methodologies. Additional analysis related to service area is set out below.

c. General bed need related to proposed NEWCO facility

The proposed 100 bed inpatient psychiatric facility is intended to serve the needs of the tri-county area consisting of Multnomah, Washington and Clackamas counties for inpatient psychiatric services. The application is required to meet standards both for general bed need and for specific psychiatric bed need. OAR 333-615-0000(5) (a) and (b). With regard to the issue of general bed need, the applicant has stated that it does not believe that a general bed need exists in the tri-county area, but that its project may move forward due to specific consideration of psychiatric need under provisions for the consideration of alternatives to the proposed project. A similar approach was taken under CN rules for approving the applicant's one existing Oregon psychiatric facility, Cedar Hills Hospital (CHH), roughly a decade ago. However the current situation is not comparable to 2008, due to a variety of factors. Since the time of the CHH review, the landscape for health and mental care services has undergone evolutionary changes, led by managed care expansions, joint area provider projects such as Unity and in particular by the creation of Coordinated Care Organizations (CCOs). In 2008 such alternatives to short-stay inpatient psychiatric services were undeveloped. Additionally, since the 2008 decision, further evidence of the suitability of alternatives to short stay inpatient psychiatric services has emerged in the medical literature, providing a more solid evidence base for CN review (see footnote 14). Finally, another factor that was not present in 2008 but is present today is the existence of CHH itself- which is well-positioned to serve the metropolitan Portland area. CHH could expand its psychiatric bed capacity at any time without requiring CN approval and, in fact, representatives of CHH met with the OHA's Facilities Planning & Safety team on June 5, 2017 for a pre-design conference for plans that would result in the addition of 8 inpatient beds at that facility.

CN rules generally do not differentiate between types of intended inpatient beds. All proposals for new inpatient beds are required by the CN rules to demonstrate a need for general medical/surgical beds without regard to differentiation. In the case of psychiatric beds, the additional bed need rules contained in OAR 333-615 are applied along with the determination of general bed need as specified under OAR 333-590. A broad description of CN bed need for specialized beds is that a project must demonstrate a need for general inpatient beds within a reasonable service area. If such a need is established, then specialty beds can be developed from the general total. The principle is that a stock of approved hospital beds exists without differentiation under license or rule, out of which needed specialty services will pull or convert beds from the total. This approach is analogous to a competitive market mechanism; where different needs for types of inpatient beds are in competition with all other potential uses of a general bed total, and where it is expected that the assigned amounts among different and competing needs will come to an equilibrium over time. This equilibrium, as for most markets, is likely then to reflect an efficient balancing of need and supply, though factors of differential reimbursement levels among service types may somewhat skew the outcomes. As noted previously however, psychiatric beds that are placed into new,

dedicated psychiatric facilities are not readily convertible back to general need for cost and licensure reasons, unless located in acute care hospitals- introducing a skew to the consideration of a market-based equilibrium among different types of inpatient needs. For this reason, CN rules contain a bias toward hospital-based psychiatric beds, which are more readily convertible to other purposes, or useable to meet some excess surge scenarios. However the current reimbursement system is biased against the provision of inpatient psychiatric care at regular hospitals.

With regard to the general need for inpatient hospital beds, one of the intended purposes of the CN bed need methodology was to match the number of allowed local hospital beds to foreseeable surge needs. At the time that CN rules were adopted there was both evidence for and concern about the tendency of the medical system to implement more expensive care modalities such as hospital services when outpatient or other alternative modes of care of lesser cost were effective. The applicant has, in its supporting analyses for CN, focused at times on the current capacity based on staffed inpatient beds as indicating potential need. Yet CN inpatient bed need is based on licensed bed totals, rather than staffed beds. For the greater Portland area that the current application is based upon, there is no foreseeable general inpatient bed need based on CN bed methodology and current licensed hospital bed capacity, for at least the next decade. A consideration of recent inpatient experience suggests that dynamic changes in Oregon's population have led to periods where hospitals may lack sufficient staffed beds to accommodate surge needs within normal hospital operations, both across Oregon and in the proposed service area. Foreseeable events such as yearly influenza outbreaks have grown alongside Oregon's population to the point where as of early January of 2017 virtually all Oregon hospital were filled to capacity. Similarly the ongoing spike in the migration of retiring seniors to Oregon and the Portland area will affect hospital service demand in the future. However potential surge needs above the total of currently staffed beds can be accommodated within present licensed bed capacity, and this point should be held in mind while assessing any proposed evidence related to occupancy or unmet inpatient need. Current levels of available beds and resulting occupancy levels for both general inpatient and psychiatric beds in the tri-county area reflect the business decisions of area providers, rather than CN limitations to bed supply, because existing facilities can expand without going through the CN process.

While an application for a psychiatric hospital as in the present instance is required to address the extensive CN methodological criteria for general inpatient bed need, approval may still be granted in specific circumstances regardless of the findings of general bed need under ORS 333-590. Psychiatric care is substantially different than general acute medical care; however the applicant's statements that the need of a population for psychiatric care cannot be addressed through general inpatient bed capacity is arguable given Oregon experience. Thus if a population need for psychiatric services can be shown, a heavier weight is placed upon the consideration of the practicalities of alternatives to the proposal that exist through different care modalities, conversions of existing general bed capacity, or by configurations of existing resources; and the applicant is expected to provide a strong base of evidence that such alternatives cannot reasonably provide better access to services for unmet need, improve outcomes, or provide lower costs. As CN rules specify a moderate psychiatric

bed need threshold as less than 40 beds per 100,000 population compared to the current 9 beds per 100,000 in Oregon, some degree of potential unmet inpatient psychiatric need may exist across the state. However under CN psychiatric rules contained in ORS 333-615-0020(5), the finding of moderate existing capacity is intended to lead to a discussion of best ways to meet need rather than to automatic approval of new beds.

d. Specific methodology for determination of bed need under OAR 333-590-0050

The specific methodology for the determination of need for new, general hospital beds is contained in OAR 333-590-0050. To satisfy the requirements of this section, applicants are required to follow a multi-step calculation of bed need delineated below in this section. With regard to the present NEWCO application, this process is applied as if the application was for a general hospital without regard to the proposed specialization of the applicant's proposed facility.

i. Determination of the Service Area

Under OAR 333-590-0050(1) the service area of a proposal is defined as those zip codes from which either 10% or more of the hospital's discharges are reasonably expected to originate from, or in which the hospital would have at least a 20% market share. The applicant has proposed that the service area for the OAR 333-590-0050 methodology should be the three county region consisting of Multnomah, Clackamas and Washington Counties, as is consistent with OAR 333-615-0030. However a distinct zip code based service area is specified under OAR 333-590-0050(1) for the analysis of bed need for OAR 333-590-0050. The CN psychiatric bed need specified service area is not related to zip codes or contiguous groups of zip codes in which the proposed facility is likely to achieve either a 20% market share or 10% of its own discharges, as is required by OAR 333-590-0050(1).

Based on patient origin data from the applicant's other psychiatric facility in Oregon, CHH, as supplied by the applicant, it is unlikely that the proposed facility will achieve a 20% market share of acute hospital services in any single or contiguous group of zip code areas. However it is likely that some group of contiguous zip codes centered on the proposed facility site and within the proposed three county service area would account for 10% or more of facility discharges. As previously noted, for comparability to general community hospitals, the applicant has not properly identified the service area for the proposed facility, which would be a smaller group of zip code areas immediately accessible from the proposed site. For many residents of the proposed three county service area, access to the proposed site is likely to be limited due to transportation and location issues. In the prior CN process for the applicant's CHH, it was stated that a county-level service area was roughly comparable to a smaller, zip code area base when combined with adjustments for out of area patient draw; however in the present circumstance, given the existence of the applicant's CHH facility in Washington County and the location of the Unity facility in Multnomah County, it is no longer clear that county-level service areas are comparable to the specified zip code service areas

consistent with OAR 333-590-0050(1). Similarly it is not clear that patient origin data from the applicant's CHH facility, which is located in Washington County, would be a guide to where patients for the proposed facility in outer Clackamas County would originate.

ii. Determination of the Service Area Population

The applicant has provided population data from Portland State University's Population Research Center for 2004 to 2014, along with Census data from 1990 through 2010. Requiring data extending further into the past, as specifically listed in CN rules, is analytically misleading at best for understanding future hospital demand in Oregon. A concern here is that the supplied data, while judged sufficient by this analysis to meet the regulatory CN requirement, is not adequate for understanding current, dynamic population trends that are affecting Oregon and in particular the greater Portland area. The senior age 65+ population in the proposed service area is currently undergoing a rapid expansion, which due to higher health care needs of an aging cohort is likely to strain existing hospital resources in the future. To the extent that this population change is not reflected within the historical data used by the applicant to forecast need, the need forecast by the applicant is likely to understate true future need expected here.

iii. Determination of Discharge and Use Rates for the Proposed Service area

The applicant has provided information on current and projected rates for their proposed tri-county service area in compliance with the requirements of OAR 333-590-0050(3).

iv. Estimation of Future Service Area Utilization

The applicant has provided the required analysis for OAR 333-590-0050(3)(b) for their proposed tri-county service area. The applicant has proposed applying 2014 age-gender cohort usage rates to projected populations. This analysis emphasizes that modeling future need with an assumption of no change in current cohort utilization is a reasonable methodology in this instance, despite that OAR 333-590-0050(1) directs that a declining usage rate be applied to inpatient utilization forecasts. However the above referenced decline reflects a forecast period that is already historical. As the outdated standard of declining utilization cannot with any accuracy be applied at this time, it is appropriate to apply flat usage rates within age categories. However a concern is that the available age categories may mask changing utilization patterns. For example, if the average age of those who are in the category of 65+ is increasing, their service utilization rate will also be increasing.

v. New Versus Replacement Utilization

OAR 333-590-0050(4) and (5) direct the applicant to evaluate the extent to which the proposed facility will meet new demand for hospital services, as opposed to replacing hospital need presently serviced by other facilities. The applicant has noted that the

proposed facility may decrease ER usage for mental health needs at other facilities; however this is not likely to represent a change in inpatient utilization. Thus the proposal will be considered as being for new utilization.

With regard to the requirement of assessing new versus replacement utilization relative to ORS 442.025, as required under OAR 333-590-0050(5), the applicant states it is not aware of an alternative to a new facility. The focus of this rule section is whether existing beds could be used to meet the proposed need. It is likely that some portion of the proposed need could be accommodated using existing licensed hospital capacity, as demonstrated by the 2017 opening of the Unity psychiatric facility in Portland, which is a collaborative use of existing licensed capacity. Similarly the applicant could expand bed capacity at its existing CHH facility outside of CN review, creating licensed bed capacity at an existing site, and use that to meet need instead of proposing a new facility. As stated above, it appears that CHH is looking at expanding its bed capacity.

vi. Calculation of Future Patient Days at the Proposed Facility

The applicant has calculated a range of future patient days relative to its proposal and to the standards of OAR 333-590-0050(6). The applicant's use of a 10 year forecast window is reasonable in this instance, given the lower levels of capitalization, construction and complexity attendant on a psychiatric versus a general hospital.

vii. Calculation of Bed Need

The applicant has applied the specified methodologies of OAR 333-590-0050(6) for its proposed tri-county service area, demonstrating that for the next ten years there is expected to be a general bed surplus in the proposed three county service area. The applicant has also employed an alternative method of calculating general bed need, based on average daily censuses, which indicates that a small (61 bed) need may exist in the service area in 10 years assuming no other hospital beds are added. In both of their methodology calculations the applicant has used a total number of beds that appears to be based on staffed rather than licensed capacity. Using licensed bed totals instead of staffed totals under the methodology OAR 333-590-0050(6)-(11) does not change that a surplus of general hospital beds is expected for the next ten years in the service area.

viii. Determination of Available Beds Within 50 miles

OAR-333-590-0050(12) directs the applicant, if a need is demonstrated under OAR-333-590-0050(11), to evaluate the availability of beds within 50 miles. As a surplus of general beds is expected to exist for the next 10 years, no general bed need has been demonstrated. Thus the standard of evaluation of beds within 50 miles does not apply.

ix. Infeasibility of Conversion of Existing Beds for Specialty Purposes

According to OAR-333-590-0050(14), if a need for new beds is not justified, a CN will not be issued unless conversion of existing beds is not architecturally or

economically feasible. The applicant has stated in its application that general and psychiatric inpatient facilities are not easily convertible between the two modalities; however no evidence was provided in support of this statement and the possibility of using existing licensed but currently unstaffed capacity cannot be excluded.

x. Conclusions Under OAR-333-590-0050

The applicant has not demonstrated under the methodology of OAR-333-590-0050(1) to (11) that a general bed need currently exists, or will exist within 10 years of the opening of the proposed facility. Based on CN rules, there is an excess of general inpatient hospital beds in the proposed service area that is sufficient in scope to meet projected need for at least the next 10 years. While this analysis notes that recent inpatient hospital surges may indicate that the forecasting models included in the CN process are restrictive, the limitation of capacity is due in part to the proportion of licensed bed capacity which area providers are choosing to setup and staff. Under the CN rules, there is no general bed need. The applicant has proposed that the need for a large inpatient psychiatric hospital, even at a time of potential bed surpluses, is supported by the high occupancy of its one existing facility in the area, CHH. However CN rules require a population-based consideration of need, rather than facility-based consideration. Additionally, the high occupancy at CHH is at least in part a result of the applicant's business decisions regarding the number of built-out and staffed beds at this facility. By adding a small number of beds to CHH the applicant could readily reduce occupancy and remove the appearance of unmet need. This is illustrated by recent CHH plans to expand bed capacity.

e. Determining relationship of proposed new hospital to existing health care system under OAR 333-590-0060

Under OAR 333-590-0060, the applicant is required to apply a specified methodology for determining the relationship between its proposal and existing service area hospital resources. The applicant has applied this methodology to existing facilities within the service area. The analysis under OAR 333-590-0060 is relative to the requirements of OAR 333-590-0050(12) and is used to answer the question of the availability of alternatives to the proposed facility. As noted for the analysis under OAR 333-590-0050, the applicant used staffed bed counts as opposed to licensed bed counts in its analysis, and did not adequately specify facilities outside of the proposed service area but within 50 miles.

i. Identification of Other Service Area Providers

The applicant has identified other providers per OAR 333-590-0060(1) for use in the calculations of OAR 333-590-0060(1) through (11).

ii. Estimation of Commitment Ratios

The applicant has determined the estimated commitment ratio for other facilities as specified under OAR 333-590-0060(2).

iii. Calculation of First Year Average Daily Censuses

The applicant has calculated the expected ADCs among significant providers for the proposed first full year of operation.

iv. Calculation of Peak Daily Censuses

The applicant has calculated the expected peak daily censuses for other significant facilities per the specification under OAR 333-590-0060(4).

v. Estimation of Commitment of Beds By Facility

The applicant has calculated the commitment of beds by each significant facility toward the peak occupancy as specified under OAR 333-590-0060(5).

vi. Estimation of Available Beds By Facility

The applicant has followed the methodology of OAR 333-590-0060(6) in determining the availability of beds beyond peak census needs at each facility for the proposed first year of operation.

vii. Estimation of Excess Beds Available for the Service Area

The applicant has followed the methodology of OAR 333-590-0060(7) in determining the availability of beds beyond peak census needs.

viii. Evaluation of the Feasibility and Cost of Using Other Facilities for Need

Under the general bed methodology of OAR 333-590-0050, there is no need for additional inpatient beds in the tri-county area. Thus it is a moot point as to whether other facilities could be used to meet need per OAR 333-590-0060(8), as no need was identified. The purpose of this evaluation is to consider whether an identified general inpatient need cannot be reasonably met at existing inpatient facilities. If a small need for general beds does evolve in the future, it is expected that existing facilities will expand capacity as CN review is not required for expansions of bed capacity at existing facilities. Any such hypothetical need can reasonably be expected to be met in existing facilities. While the applicant provides arguments as to why psychiatric need cannot be met at existing facilities, such arguments are not relevant to this section of the general bed need methodology, and should be considered in relation to psychiatric bed need under OAR 333-615 instead.

ix. Evaluation of Alternative Health Facilities

Under OAR 333-590-0060(9) the applicant is required to evaluate the use of non-inpatient alternatives for its proposal when general inpatient bed need is not shown under

OAR 333-590-0050 or under OAR 333-590-0060. The applicant has stated that relative to psychiatric need, there are no feasible non-inpatient alternatives. The applicant does not however provide evidence to support that non-inpatient services or facilities could not meet need. OHA notes that an extensive set of existing, outpatient behavioral health service providers already exist in the service area. *See* Exhibit 10. OHA's review of current medical literature has found support in general for developing non-inpatient alternatives to inpatient services (see footnote 17), as well as support specifically for meeting some amount of current inpatient psychiatric care in non-inpatient settings (see footnotes 10-16, 18). In addition, the expansion of services at particular specialty, non-general inpatient facilities, including the applicant's own CHH, could reasonably be expected to provide for lower cost ways of meeting the need proposed by the applicant.

x. Needs of Members of Special Organizations

The standards of OAR 333-590-0060(10) do not apply to the present application, as the proposed facility would serve the general public.

xi. Conclusions Under OAR 333-590-0060

For the methodology contained in OAR 333-590-0060, the applicant has compared the proposed new facility to existing area facilities. It is not in dispute that substantial unused hospital bed capacity, both licensed and staffed, exists within the proposed service area. Thus there is no general inpatient need for which, under the inpatient bed CN rules, additional general inpatient beds are required. With no identified general inpatient need, there is no basis for determining whether general need can be met at other inpatient facilities. Additionally CN rules direct that alternative methods of meeting the proposed need be examined. The applicant has stated that no other methods of meeting need exist beyond adding a new inpatient facility; however there is an insufficiency of evidence in support of such an argument. Literature exists regarding the potential for meeting a substantial component of inpatient psychiatric need through alternatives. In line with evolving Oregon CCO and managed care practice, the literature supports that outpatient and residential services are practical modes of providing mental health care services for much of the population in need, instead of short-stay inpatient care.[5] In contrast the applicant has not provided a discussion relative to what sort of mix of inpatient, outpatient and other modalities of care is ideal or that currently exists; instead the applicant has stated that the proposed need can only be met through the addition of a new inpatient facility. The applicant's arguments for such an exclusive modality are based on its own experience at CHH, and the evidence of the existing psychiatric bed to population ratio; however such arguments are not compelling as CHH can and is expanding; excess general bed capacity exists in the service area; and bed to population ratios do not provide any evidence relative to alternative modalities of care.

f. Psychiatric inpatient need, generally

Applications for psychiatric inpatient beds are required to apply the standards and

[5] See references 2,3 & 10 to 14 in footnote 2.

methods delineated in OAR 333-615-0020 and 0030. In general, psychiatric bed need is based on population ratios of available beds in larger service areas, though existing alternative modes of meeting or preventing such need also are factored into the analysis. An issue in the current case is that, when general inpatient bed cannot be established, CN rules specify that only when unusual circumstances can be shown will an application for a new psychiatric inpatient facility be approved. Similarly CN rules use a psychiatric bed to population ratio of under .4 beds per 1,000 population as indicating that a potential need may exist- however the burden of demonstrating that such a potential need is both real and is best met through the applicant's proposal rests upon the applicant. Applicants are instructed to demonstrate need and the superiority of their proposal relative to alternatives through a combination of data-based evidence and scientific/medical literature. CN rules also contain preferences for locating psychiatric services at community hospitals, ensuring local access and the availability of medical services for dual-need clients. The burden for demonstrating why such localization of psychiatric services to community hospitals is not feasible also rests upon the applicant.

With regard to the specific determination of need for psychiatric beds addressed under CN psychiatric bed need there are multiple issues that affect a potential finding of need for the proposed project, and whether superior or existing alternatives exist to serve psychiatric need apart from the proposal. One such issue is whether the entire tri-county area is a reasonable service area for the proposal. Another issue is that while the range of population-based projections of psychiatric bed need that are available both from CN and from the medical literature support a possible need in Oregon for additional beds, a substantial amount of such unmet need is likely concentrated among a population requiring more intense care and longer stays than the applicant is proposing, as was historically were provided at state facilities.[6] While financial pressure and an emphasis on stabilization and safety have dropped typical inpatient psychiatric lengths of stay from months to days across the last several decades, there is an insufficiency of evidence from the applicant, such as from controlled studies, that would provide guidance on whether the shortening of care that has led to what is labeled in the psychiatric literature as ultra-short stays are effective.[7] The service as proposed by the applicant falls under this heading of short or ultra-short stays. Similarly while recommendations exist in the literature for the substitution of outpatient and residential services for some amount of inpatient psychiatric needs with regard to assessment and stabilization, no evidence has been provided by the applicant that would bear on this issue. Nor has the applicant addressed the studies that have pointed to issues with the short stay model in practice.[8]

While the applicant has pointed out that a prior CN review led to the approval of Cedar Hills Hospital, a number of factors have changed between 2008 and the current time. One change is that more rigorous medical literature exists with regard to the suitability of non-inpatient modalities for meeting behavioral health needs (see footnote 17 in particular). Another is that the development of community based mental health practice, such as integration of medical and mental treatment under Oregon CCO's, means that concrete alternatives for substantial portions of need now exist that in 2008 were

[6] See references 1 and 2 in footnote 2.
[7] See reference 3 in footnote 2.
[8] See reference 4 & 6 in footnote 2.

speculative. In addition CHH did not exist in 2008 prior to its approval- yet its current existence opens up another set of feasible alternatives to meet community need, such as either expanding or moving CHH. As noted the burden for addressing these and other issues under CN rules falls upon the applicant.

Psychiatric inpatient need is typically concentrated among lower-income populations, and a majority of unmet need among non-senior populations typically occurs among Medicaid-eligible populations.[9] In Oregon the development of Coordinated Care Organizations (CCOs) has promoted the integration of physical and mental health needs for Medicaid populations, with a goal of reducing the need for emergent and inpatient psychiatric usage through better medication adherence and the provision of more regular or innovative care services. Based on experience in other urban area outpatient mental health programs, Oregon CCOs and the practice of community integration of medical and behavioral needs are moving the curve of how much unmet need should be met, for example, in short-stay inpatient psychiatric facilities versus the amount of need that can be met at lower cost and with better access through other modalities. This Oregon experience reinforces CN rule perspectives that determinations of need based solely on bed to population ratios are not a reasonable guide to unmet need.[10] As CCOs in Oregon emphasize the coordination of care across a spectrum of possible care providers, addressing unmet need among CCO populations requires an applicant to demonstrate that their proposal would be an integral part of the care services that CCOs contract with and depend upon. The applicant has not provided evidence of support from the community of CCOs for its proposal. Thus the potential population served by the proposal would likely not include Medicaid eligibles that are deliberately placed at the proposed facility by CCOs. Similarly the market penetration of managed care and health maintenance organizations apart from CCOs in the proposed service area is relatively high, and no evidence of support for the proposal has been submitted by such organizations. It is not likely that groups such as Kaiser will direct substantial numbers of their enrollees to the proposed facility as opposed to their current usage of alternative and residential programs. This analysis then indicates that the actual population to be served by the proposed facility is smaller than proposed, and that a smaller facility size may be warranted.

That over the course of the CN process the applicant has substantially changed the composition of the population to be served by the proposal without changing the effective design of the proposed facility is another indication of the difficulty in determining the specifics of population and need that should be attributed to the project. Nationally, a significant source of inpatient psychiatric admissions, regardless of age, is from screenings for suicidal ideation, with the goal of providing safety and stabilization. To the extent that suicide rates are one proxy measure for unmet psychiatric needs, a relatively high suicide rate in Oregon is another potential indicator of unmet psychiatric inpatient need. However an issue to consider here is that suicide rates in the proposed service area are substantially lower than for the rest of Oregon.[11] As one potential

[9] See references 8 and 9 in footnote 2.
[10] See reference 10 in footnote 2.
[11] See Exhibit #1, Figure 1.

indicator of inpatient need, the higher prevalence of suicide across other regions of the state implies that facilities such as proposed would better serve the health of Oregonians if alternatively placed in Southern or Eastern Oregon. From this perspective, the low rate of inpatient psychiatric beds per capita in Oregon as a whole, as pointed out by the applicant, is misleading for unmet need in the proposed service area. As a caveat here according to the current medical literature, defining population mental health need by measures such as suicide rates is not comprehensive. However the applicant in this case has not supplied evidence-based information that approving the proposed facility would improve population-based measures such as suicide rates, and evidence to date from other locales supports that non-inpatient services may better reduce such measures of psychiatric unmet need.[12]

Importantly, lower cost and potentially more effective alternatives to a substantial amount of the proposed need NEWCO is proposing to serve are possible or under development; including meeting some amount of psychiatric service need through a combination of medication adherence programs and increased outpatient psychiatric services, as noted in the literature.[13] CCO's are taking innovative approaches to integrated physical and mental health in an effort to reduce emergency department and hospitalization needs through the use of such lower cost alternatives. The potential for integration with CCO and managed health care organizations can also be judged by how the applicant's existing facility in the area, CHH, has integrated into existing inpatient care systems. Despite the applicant's statements that the proposed facility will reduce mental health ED burden, its existing CHH facility across the decade of its existence has only signed one hospital transfer agreement, with one of the smaller entities in its market. Instead of support, substantial opposition has been expressed to the proposed facility by other major health systems, which are collectively working to establish a shared facility to serve low-income populations with mental health inpatient needs in Portland.

CN rules specify the burden for demonstrating unusual circumstances related to access or cost fall upon the applicant. OAR 333-615-0030(4)(a). The applicant also bears the burden of addressing through evidence and literature, the non-feasibility of alternatives to the proposed new facility, including beds at other facilities, alternative modalities, and expanding or moving its existing CHH facility. The applicant has not provided medical science or evidence-based information related to these questions. In consideration of these and the doubts raised through the above issues regarding access and availability of alternatives of lower cost, it is not possible to affirm that there is a need for the proposed facility in its current size, location and configuration.

g. Analysis of bed-need under OAR 333-615-0020

OAR 333-615-0020(5)(a) through (f) requires an applicant to address a list of standards, as presented below.

[12] See reference 7 in footnote 2.
[13] See references 2, 10 & 18 in footnote 2.

i. Historical Usage in the Service Area

OAR 333-615-0020(5)(a) requires applicants to provided historical data relative to population and utilization of psychiatric services in the proposed service area. The applicant noted elsewhere in the application that such historical data is generally not available, and initially instead supplied present data on psychiatric inpatient beds usage at its CHH, without meeting the standard of OAR 333-615-0020(5)(a). The applicant subsequently has provided historical inpatient occupancy data to address this criteria.

ii. Historical Usage in Other Service Areas

The applicant has subsequent to initial review provided historical usage data to address the standards of OAR 333-615-0020(5)(b).

iii. Short Term Bed Need and Lengths of Stay

OAR 333-615-0020(5)(c) directs the applicant to demonstrate that standards for short-term placement of patients into psychiatric beds will be met, while OAR 333-615-0020(5)(d) delineates a standard length of stay as being under 15 days for most patients. The applicant has stated that their expected lengths of stay will conform to this standard.

iv. Listing Non-Inpatient Providers

The applicant did, subsequent to OHA's initial review of its application, provide a list of non-inpatient providers derived from SAMHSA data for the tri-county area. This list does not include non-facility based treatment programs, or programs located on hospital campuses, that could serve as alternatives to the proposal. Many outpatient behavioral health services known by OHA similarly did not make it on the list provided by the applicant. *See* Exhibit 10. Thus the criteria specified in OAR 333-615-0020(5)(f) of delineating all non-inpatient service alternatives in the proposed facility's service area cannot be answered in the affirmative.

v. Determination of Service Area for Psychiatric Beds

The applicant has proposed that the service area for its psychiatric facility consist of Multnomah, Clackamas, and Washington Counties.

vi. Evaluation of Alternatives

The applicant has supplied information on area inpatient psychiatric service providers as delineated in OAR 333-615-0030(1). However the applicant has not supplied comprehensive information on alternatives per OAR 333-615-0010. The CN rules for psychiatric beds apply a different approach than the general methodology of OAR 333-590-0050 for interpretation of findings about bed to population ratios. Within OAR 333-590-0050, with the exception of OAR 333-590-0050(14), a finding that existing bed inventories are sufficient for projected population need would preclude approval of the proposed project; whereas a finding of a need for additional beds would

support approval. In contrast, according to the standard of OAR 333-615-0020(5), a bed to population ratio of below .4 per thousand cannot be taken by itself as evidence of need for proposed additional psychiatric beds, nor does a ratio of greater than .4 per thousand preclude approval. In the present instance the lack of evidence-based or literature-based evaluations of non-hospital alternatives, including the applicant's options to expand CHH, along with concerns regarding access and the population to be served supports a conclusion that the applicant has not met the standard of a moderate degree of supporting evidence. One component of the moderate standard as contained in OAR 333-615-0030(2)(a) is "...there shall be substantial evidence that further development of less costly or more effective alternatives by any other prospective provider is not feasible". The applicant has not supplied such substantial evidence regarding non-hospital alternatives. In addition while it is possible that the applicant will achieve a status to take or bill for Medicaid clients, the extent to which the applicant will fit into the CCO framework on continuity of care, and into ongoing efforts to avoid hospitalization of Medicaid participants, is unknown and not supported by the application. In addition given current practice trends to treat psychiatric needs in outpatient settings where possible and to reserve inpatient services for those with truly substantial need, only a limited portion of Medicaid clients can be expected to have any potential to use the proposed facility, and it is arguable that these likely would benefit from longer stays than the applicant is proposing based on current reimbursement streams.

vii. Determination of Bed Need

As the proposal is for a new facility, rather than an expansion or conversion of an existing facility, the methodology set forth in OAR 333-615-0030(3) for determining psychiatric bed need is not required.

viii. Net Addition of Inpatient Beds to the Service Area

OAR 333-615-0030(4)(a) and (b) direct that except under unusual circumstances of non-availability, access, and less costly alternatives, additional psychiatric beds will not be approved if the project will increase licensed inpatient capacity in the service area. As no general inpatient need exists in the service, area, the applicant is required to demonstrate an unusual circumstance and to provide evidence as if there was a greater than .4 bed to population ratio. This higher standard of evidence includes substantial evidence, using data and literature, that alternatives are not feasible. This standard also obviates the use of current bed to population ratios as justifying a need. The applicant has provided an insufficiency of evidence related to alternatives or to the presence of unusual circumstances.

ix. Conclusions Under OAR 333-615-0020

The applicant has not demonstrated through the methodology of OAR-333-615-0020 that reasonable alternatives to the proposed psychiatric inpatient facility are not feasible or are not already in place in the proposed tri-county service area. The degree of true need among Oregonians for this service is also unclear from the application; given

that substantial population groups will not likely fully or at all utilize the proposed facility due to the availability of non-inpatient alternative services or who will be served by the Unity facility. The majority of need for the ultra-short stay inpatient format proposed by the applicant can also be addressed through lower cost non-inpatient services. Thus, need for the proposed facility has not been demonstrated.

h. Analysis of bed-need under OAR 333-615-0030

The applicant failed to provide specific responses to address OAR 333-615-0030, beyond noting that it supplied text to address listed standards elsewhere in its application. Such applicant-supplied materials outside of this section note that there is a low bed to population ratio, that the applicant's current facility has high occupancy levels, and based on a few opinions rather than data there are no feasible alternatives. As there is no general bed need in the proposed service area, a high standard of evidence from the applicant is required to meet criteria here, which excludes evidence based solely on bed to population ratios. The applicant's burden of demonstrating unusual circumstances, with substantial data and literature to support the non-feasibility of alternatives, has not been met. Instead there is an insufficiency of evidence except for the items noted above. For the same reasons stated above with regard to OAR 333-615-0020, the criteria relating to need for the proposed facility cannot be answered in the affirmative.

2. Will the proposed service result in an improvement in patients' reasonable access to services.[14]

Under this criterion the applicant must identify any potential problems of accessibility including traffic patterns; restrictive admissions policies; access to care for public-paid patients; and restrictive staff privileges or denial of privileges.

a. Traffic Patterns and Accessibility

The proposed facility would be located on a property at the intersection of Day Road and Boones Ferry. The application states that this location is "served by bus route 96 and is a no-cost, twenty (20) minute bus ride from the Smart Transit Center in Wilsonville, making the site easily accessible for patients needing transportation." The facts do not support the applicant's assertion that this site is easily accessible for patients needing transportation.

TriMet Bus 96 serves this location only on weekdays during rush hour. The South Metro Area Regional Transit (SMART) does not provide direct service to this location and neither does the weekday only rush hour WES Commuter train. On weekdays only, and not on weekends, the closest stop for both SMART and the WES Commuter train is Commerce Circle, approximately a ½ mile walk from the proposed location. Consequently, access to the proposed site is problematic for patients, visitors and staff who are dependent on public transportation especially for those of limited means who cannot afford alternative modes of transportation. Limited availability of public transportation will hinder patients' reasonable access to services. The proposed

[14] OAR 333-580-0040(3).

location is, according to the applicant, less than ½ mile from an Interstate 5 interchange making it easily accessible for the I-5 freeway.

b. Staff Privileges

The applicant states on page 89 of its March 11, 2016 letter to the agency that it has no restrictive staff privilege policies.

c. Access to Care for Patients: State Policy has Reshaped the Landscape for Mental Health Services

Outside the state hospital system, Oregon currently has one freestanding psychiatric hospital, CHH, now owned by UHS. It, like the proposed facility, is a for-profit freestanding psychiatric hospital. CHH received a Certificate of Need With Conditions in 2008. As discussed below, the landscape for mental health services has profoundly changed since 2008 but, then as now, the question of whether approval of this project would result in an improvement in patients' reasonable access to services is one of the pivotal questions raised by the present application.

In the years since approval of the CHH facility, the Oregon Health Authority (OHA) has engaged in a comprehensive public planning process for behavioral health services as evidenced by the Oregon Health Authority 2015-2018 Behavioral Health Strategic Plan, November 2014.[15] As detailed in a December 1, 2016 report to the Oregon Legislature titled "Investments in Community Behavioral Health, Health Systems Division Report" (The Investments Report), unprecedented investments were made in community behavioral health system during the 2013 legislative session with additional investments approved by the 2015 session.[16] As noted by The Investment Report: "Specific services and system expansions focused on promoting community health and wellness, keeping children healthy and helping adults with mental illness live successfully in the community." As explained in The Investment Report, outcome measures thus far indicate substantial progress towards OHA's investment goals that emphasize mental health promotion and prevention in the community as a means of avoiding the need for hospitalization or the high use of emergency departments. Oregon's investment in its community behavioral health system will help people avoid hospitalization or shorten hospital stays, resulting in less need for inpatient psychiatric beds.

Investments in the adult community mental health system has been guided by the March 13, 2007, "Community Services Workgroup Report for the Oregon State Hospital Master Plan."[17] The premise of this report is that there is one mental health system and the full continuum of mental health services needs to be enhanced to successfully improve the quality and efficiency of services. This report was cited as an excellent starting place to get a handle on the issues of patients' reasonable access to services in the Division's 2008 CHH decision. It has formed the basis of mental health investments since 2013. As noted by The Investment Report, the strategy for making investments

[15] See Exhibit #2, attached.
[16] See Exhibit #3, attached.
[17] See Exhibit #4, attached.

contemplated transformation efforts that have helped shape the health care system since the original workgroup report was developed, including the implementation of coordinated care organizations (CCOs) and the Affordable Care Act.

The 2017-19 OHA budget, approved by both the Oregon House and state Senate and headed for the Governor's desk for signature, reaffirms and continues Oregon's commitment to the community-based behavioral health system by providing $20 million for community-based behavioral health services. It also funds the Oregon State Hospital's Junction City campus.

Another development that has transformed the future landscape of mental health care in Oregon is the United States Department of Justice (USDOJ) Performance Plan.[18] Entered into after lengthy discussions with the Civil Rights Division of USDOJ, this plan cements OHA's commitment to improve mental health services for adults with serious and persistent mental illness (SPMI) by providing them with community services that will assist them in the most integrated setting appropriate to the their needs, help them achieve positive outcomes and prevent their unnecessary institutionalization. Among its many requirements, the plan requires OHA to explore the reasons for individuals with SPMI "boarding" in emergency departments and to provide solutions. The resulting analysis dated October 28, 2016, is the "ED Boarding of Psychiatric Patients in Oregon, A Report to the Oregon Health Authority" (The ED Boarding Report).[19] The OSDOJ Performance Plan requires OHA to reduce the rate of visits to emergency rooms by individuals with SPMI by 10% from baseline by the end of year one (June 30, 2017) and by the end of year two (June 30, 2018) by 20% from baseline.

d. <u>The Applicant's Reliance on ED Boarding and "High Occupancy Rates" at Existing Providers to Justify Construction of a New Facility</u>

The applicant repeatedly argues that there is 'high unmet need" in the service area as evidenced by ED boarding and high occupancy rates at existing providers of psychiatric beds. In its letter dated December 2, 2016 the applicant stated that: "There is a simple remedy to the current ER boarding crisis: provide enough inpatient mental health care options." In light of the findings of The ED Boarding Report, the applicant's "simple remedy" does not appear to be the only or even the best cure for ED boarding in Oregon. "Synthesis of the Literature, Stakeholder Interviews and Statistical Analysis of Quantitative Data" of The ED Boarding Report lists many other possible solutions to ED boarding in addition to increasing inpatient psychiatric care capacity, including, but not limited to, expanding comprehensive community-based mental health resources for persons with severe mental illness; expanding the availability of ED alternatives such as crisis centers or psychiatric emergency centers like the new Unity Center in Portland (discussed below); increasing alternatives to inpatient beds such as sub-acute beds and residential services; expanding community mental health services to reduce the number of psychiatric ED visits; addressing specific challenges for pediatric populations; and providing supportive services, such as housing in the community. It is interesting to note

[18] See Exhibit #5, attached.
[19] See Exhibit #6, attached.

that the main reason respondents[20] identified for the lack of inpatient psychiatric beds related to OSH capacity, not to a lack of bed capacity in the community. Please see page 54 of The ED Boarding Report. As evidenced by The Investment Report discussed above, Oregon has begun to actively pursue many of the solutions to ED boarding suggested by The ED Boarding Report and is actually required to reduce ED boarding by the terms of the OSDOJ Performance Plan.

In a memorandum from Michael Morris, OHA's Behavioral Health Policy Administrator (January 13, 2017), Exhibit 11, he drew upon the lessons learned in Washington State and noted that: "The experience in Washington has demonstrated that expanding psychiatric bed capacity does not resolve the problem of psychiatric boarding in EDs." Washington State has a significant problem with ED psychiatric boarding and was sued over this issue. In response, the state invested in the expansion of psychiatric bed capacity. Washington issues periodic reports regarding the progress to reduce Single Bed Certification (SBC), the process the state has to approve an individual to remain in the ED while a psychiatric bed is located. Mr. Morris quoted from the Washington 2016 Single Bed Certification Quarterly Report:

> It is notable that while King County has increased psychiatric bed capacity from 377 to about 421, the increased capacity has not slowed the growth in the use of SBCs. This reflects the complexity of psychiatric bed use not only in King County but across the state.

Disability Rights Oregon (DRO) is a nonprofit that is the Governor's designated protection and advocacy system for the State of Oregon. It is funded by the federal government to provide legal advocacy services for the people with disabilities across the state, including individuals with psychiatric disabilities. DRO has been granted affected party status. Bob Joondeph, its executive director, has been an advocate for people with psychiatric disabilities for 30 years. He has served on numerous planning processes, task forces, and workgroups that have tried to improve services for people with psychiatric disabilities in the State of Oregon including the Behavioral Health Strategic Plan Work Group that helped to formulate the "Oregon Health Authority 2015-2018 Behavioral Health Strategic Plan, November 2014." In a letter dated November 23, 2016, he noted that:

> The question of whether the Portland region needs another private, for-profit psychiatric facility should depend on broad-based planning that encompasses all aspects of mental health funding and services. Unlike some areas of medical and social services, behavioral health resources can be effectively targeted to preventative and crisis response services for the purpose of maintaining health and safety and preventing the greater expense of inpatient treatment. When public and private insurance dollars are unnecessarily

[20] "Respondents" are individuals that participated in stakeholder interviews.

> spent on institutional care, the cost of insurance increases and the allocation of public resources for other purposes decreases. On the public side, Oregon has already attracted criticism from the U.S. Department of Justice for spending a high percentage of its behavioral health dollar on institutional care.
>
> The NEWCO proposal has not been considered within the context of the Oregon Health Authority's public planning process for behavioral health services. Its model of services has apparently not been tailored to meet public need in the manner that the new Unity Center developers undertook when consolidating institutional level care. It seems to present itself along the model of an antiquated stand alone psychiatric facility that is large (100 beds), sited near a prison, and presented as not an ingredient in a continuum of care, but as a solitary player that promises to cooperate with others in the future.
>
> NEWCO contends that its facility will address the 'boarding' problem in Oregon. In public planning processes that in which I have participated, building new inpatient beds has not been raised as an option to solve the problem. Instead, planners are creating new crisis services, diversion systems, supported and supportive housing, police training and facility models like the Unity Center to lessen the demand on hospital emergency departments. As in Oregon's health care reform efforts generally, more attention is being given to managing chronic conditions in the community rather than constructing more expensive and less desired facilities that respond to the failures of community treatment. As noted above, the NEWCO approach appears to be "old school" and expensive for the public and insurance purchasers.

As evidenced by the discussion of the various documents discussed above, Mr. Joondeph's comments are reflective of the direction that the State of Oregon is taking to improve patients' reasonable access to services as evidenced by the various reports and documents cited above.

NAMI Oregon, also an affected party, is a grassroots, membership-governed organization that offers free education, support and advocacy services to individuals living with mental illness and their families and other loved ones. It has 15 chapters across Oregon that annually serve about 8,000 Oregonians. It members have direct lived experience with mental illness, as individuals living with an illness, as family members or friends of individuals living with mental illness, or as both. NAMI Oregon's executive director, Chris Bouneff, testified at the public meeting that:

> We also believe that the financial impact on the rest of our treatment system and support system needs to be taken into account. We learned through the state hospital system, and many of us warned lawmakers that it's coming, but we learned you can't build your way of out of this problem. You can't have a disproportion share of resources going to the most expensive levels of care while not having a concurrent significant investment in the rest of the treatment system, otherwise you don't prevent the crises that lead to hospitalization, and you quickly overwhelm the services you have in the hospital.

e. Improving Access to Services Through Alternatives to Hospitalization

The Unity Center for Behavioral Health (Unity) began operations in February 2017. Legacy Health, Kaiser Permanente, Adventist Health and Oregon Health & Science University have come together to create an innovative model of care by creating a facility that has the goal of providing care for all those in need through a combination of emergency, inpatient and outpatient services. Inspired by the John George "Alameda Model", but also providing a "warm hand off" to needed supports, this facility will provide a dedicated psychiatric emergency room to reduce ED boarding. It will operate 24/7 and will be staffed with psychiatrists, social workers, ARNPs and peer support counselors. Unlike the proposed NEWCO facility, this facility is a community based project made possible by donors such as the City of Portland, Multnomah, Clackamas and Washington Counties as well as individual and institutional donors in the community. It is the result of a community wide effort involving many stakeholders. It will consolidate the current inpatient beds at Legacy Health, Adventist Health and Oregon Health & Science University at the site of the former Holiday Park Hospital in NE Portland. The inpatient program will include 101 inpatient beds (22 child and adolescent and 79 adult). This is an 11- bed reduction of the current number of adult beds operated by the partners but an increase of six beds for the pediatric population. It seeks to de-criminalize mental illness by getting police away from transporting patients with mental illness.

Unity has collocated with CareOregon, NAMI, HSO Multnomah Intensive Transition Team, Western Psychological, and the Cascadia ED Divert Team. There are plans for Family Care and NARA to also collocate. This helps patients to make successful transitions.

It is highly likely that other facilities around the state that offer inpatient psychiatric services will add psychiatric emergency rooms to their complement of services. In Exhibit 11, Mike Morris explained that Oregon has invested in the development of psychiatric emergency services across the state, developing standards and providing additional funding for the Medicaid Fee-For-Service payment of this service. He wrote that:

> The Unity program is the most publicized psychiatric emergency service program, but other hospitals are also planning to implement this service. While psychiatric

emergency services are not the only answer to improve access to ED and acute care services, they are one approach that reduce hospitalizations and reduce repeated visits to the ED.

Legacy Health, Providence Health & Services – Oregon, (Providence) and Kaiser Permanente Northwest (Kaiser) have been granted affected party status. They, along with Adventist Medical Center, submitted a joint letter (The Joint Letter) dated December 1, 2016 in which they, for the reasons stated in that letter, conclude that the NEWCO project "represents a diminution of care in our community, not an advancement" and "respectfully request that the Division deny the application." Each of these entities is an existing health provider in the Portland region that collectively provide the majority of acute mental health care in the region. While not a partner, Providence has actively supported the development of the Unity Center and this model of innovative care. In relation to patients' reasonable access to services, The Joint Letter provides the following information:

> We anticipate caring for 44-55 patients on an average day in the ED. Mr. Escarda's November 17 public comment letter (p.5) states that 'the new or additional care offered by the Unity Center will be emergency services, which will not address the more acute psychiatric patients who will still require inpatient stabilization and care'. This statement is both uninformed and inaccurate. Our analysis strongly suggests that the Unity Center's ED will reduce demand for inpatient beds: today we know that many psychiatric inpatients are admitted for very short stays simply so they do not board in an acute care hospital ED. For example, over the last 30 months at Legacy's Good Samaritan and Emanuel Adult Psychiatric units, 185 patients were discharged in less than 24 hours and another 230 discharged in less than 48 hours. Collectively, this represents 20% of the total admissions to these two units. Unity's planning suggests strongly that the initiation of the Psychiatric ED service will significantly reduce the percentage of patients being admitted for 24-48 hours.This, of course, reduces the need for inpatient beds. Unity is a true community partnership and needs and deserves time to open and stabilize before another provider is added.

SEIU Locals 49 and 503 (SEIU) were granted affected party status. SEIU members represent one of the largest classes of healthcare consumers in the state and are impacted as purchasers, patients and providers. In a letter dated November 21, 2016 it also urged the Division to deny the NEWCO application and noted that the Unity Center "is a proven successful model that aims to avoid psychiatric hospitalization altogether by focusing on immediate treatment at the outpatient level of care." It also wrote that: "In fact, academic studies have found that the availability of inpatient beds is not the sole factor in determining whether behavioral health patients receive the optimum level of

care best suited to their needs." It stated that:

> As the state continues to adopt new and innovative treatment initiatives like the Alameda Model and other regional dedicated psychiatric EDs, resident populations can receive treatment for mental and behavioral health needs earlier in the continuum of care process, before their behavioral health needs manifest into more serious conditions. These innovations will allow Oregon to maintain a balanced system of care.

Adventist Medical Center, one of the Unity Center partners, opened an Emotional Wellness Center in May 2017. This new outpatient mental health service is designed to complement Unity Center by providing patients with the skills needed to successfully recover and avoid hospitalizations. It will help to fill care gaps and is one example of the "warm hand off" referenced above. Additionally, there are 67 adult residential mental health facilities currently operating in Multnomah, Washington and Clackamas Counties that provide needed services at a lower cost than inpatient hospitalization. Exhibit 10. Mr Morris noted that :

Oregon has implemented the coordinated care model that provides better health, better care and lower cost. A significant component of this approach is to support individuals so they do not need or rely on higher levels of care to receive their healthcare. The latest focus for this model is to realize the integration of behavioral healthcare for individuals. OHA is concluding the Behavioral Health Collaborative (BHC) that is providing recommendations to support integration and improve behavioral health for Oregonians. The coordinated care model with the intense focus of the BHC will improve services for individuals and decrease the reliance on Emergency Department (ED) visits and psychiatric acute care.

Exhibit 11. Mr. Morris also addressed the 2012 voluntary agreement that Oregon entered into with US Department of Justice that led to the development of the Oregon Performance Plan ("OPP"). Mr. Morris noted that part of the focus of the OPP is to decrease use of EDs and acute care hospitalization. He wrote that: "Increasing the availability of acute care service would be counter to the overall direction of the OPP." He stated that Oregon has; instead, focused on efforts to improve community based services with greater coordination across systems.

f. Reasonable Access to Services Affected by Location of Facilities

The proposed NEWCO facility will be located in a suburban area of the Portland tri-county region without adequate access to public transportation. In his November 29, 2016 letter, NAMI's executive director, Mr. Bouneff, emphasized the importance of having a proposed hospital located within a reasonable distance to the home communities of the people that the applicant intends to serve. He notes that "individuals and families travel long distances to access inpatient care, which precludes families and other support networks from even visiting a loved one" and this can prevent coordination with

community care providers. At the public meeting Mr. Bouneff testified that his organization does not favor large institutions and that it would be "more enthusiastic about capacity being added when we're talking about 5 to 10 to 15 beds."

In its December 2, 2016 rebuttal comments (The Rebuttal letter) the applicant stated that:

> There were some persons in the public hearing who stated a better solution would be community services or facilities of 10-16 beds. This is not economically feasible and would not solve the large bed shortages. No community, especially heavily rural areas, has ever been able the solve this issue due to the inability to build, staff and run 5-10 bed inpatient programs. While in theory it would be preferable for patients to get the care that they need close to home as possible, it is not feasible, economically & operationally and the reason why this model or idea or idea has never gained traction or been more fully explored as a viable option by healthcare systems and community providers.

The facts do not support the applicant's dismissal of the possibility of small closer-to-home facilities that are integrated into the community that they serve. The Division is currently considering an application for a proposed 16-bed psychiatric hospital to be located on property adjacent to Good Shepherd Medical Center in Hermiston. It is designed as a secure emergency and hold facility set to serve Eastern Oregon, a heavily rural area, and it expects that approximately 70% of patients will be funded through two CCOs. It has received a grant from the Eastern Oregon Human Services Consortium for $500,000 and Good Shepherd Health System is leasing the land for the project for $1 per year for 30 years. If approved, the patients that it serves will not have to travel to other regions of the state such as the Portland area for inpatient psychiatric services. Geriatric patients are included in its intended patient population.

g. Reasonable Access to Services, Geriatric Patients, Restrictive Admission Policies and the Role of Emergency Rooms

Tuality Healthcare has been granted affected party status. Tuality Forest Grove operates a 22-bed geriatric psychiatry unit. In its letter dated November 28, 2016 regarding the NEWCO application, it expresses "significant concerns about this proposed facility's ability to truly meet the mental health needs of the Geriatric Oregonian population." One of these concerns is as follows:

> Finally, the state should consider the disbursement of services statewide when evaluating the need for additional geriatric inpatient psychiatric services for Oregonians. While the workforce and population is centered in the Willamette Valley, Oregonians around the rest of the state

> do not have any Geriatric Psychiatric inpatient beds. The Three existing programs all are centered in the Portland metropolitan area. We believe that a hospital either at the western side of the state or the southern area would better serve Oregon geographically or avoid concentrating all of this geriatric care within 20 miles of the Portland metro area.

The proposed NEWCO facility will not operate an emergency room. Since access to an emergency room often serves as a safety net for individuals without health insurance or who are under-insured, lack of an emergency room has the potential to leave the majority of uninsured or under-insured patients to be cared for by established general acute care providers. It is important to note that this facility could reasonably be expected to serve far fewer "no pay or slow pay" and Medicaid patients than existing community based hospital psychiatric units. For the reasons noted above, this is especially true given the location of the proposed facility. Since comprehensive medical care will not be available at the facility, patients who require emergency care beyond the facility's scope of services will not be able to access its services. These patients are often the individuals most acutely in need of services and their reasonable access to services will not be improved by this project. They are also often the most costly patients to treat. The importance of being able to serve this population is recognized by the Division's administrative rules. Please see OAR 333-615-0020(4).

Geriatric patients are particularly likely to have serious medical conditions. In its letter dated November 28, 2016, Tuality Healthcare offered the following observation:

> Second, as you can imagine the geriatric population due to their age has many serious medical conditions particularly the geriatric psychiatric population. At Tuality Forest Grove we have been able to care for these difficult patients since there is an emergency room onsite in the facility. Any emergency medical treatment can be quickly diagnosed and treated so the patient can remain at the facility when appropriate. The proposed NEWCO facility will not have these needed Emergency Services, which means they will only take the patients needing minimal care, the easiest and lease (sic) expensive to provide care. Therefore leaving the more difficult and expensive patients for the Tuality Forest Grove facility, or NEWCO will be taking patients for which care cannot be safely provided.

In a letter dated April 26, 2016, the Division asked the applicant to address how it would ensure that geriatric patients received proper care:

> Many, if not most, geriatric patients have numerous medical complications such as diabetes, high blood pressure and cardiac diseases. As a group, many of them

> have not had healthy lifestyles and may have a long history of illnesses. Please provide a detailed discussion of the appropriateness and logistics of treating such patients in a freestanding psychiatric hospital that lacks an emergency department and the ability to provide the acute care services that they may need.

On June 28, 2016, the applicant responded:

> Medical co-morbidity is an increasingly common health management issue for all of our patient population, not just geriatric patients. We develop clear exclusion criteria that account for facility-specific attributes and identify the threshold of our ability to safely manage a patient's medical co-morbidity in a free-standing setting. We also have an internal medicine function to assisting the Psychiatric providers in their care management. When it is determined that a patient's medical needs require more interventions and care we cannot provide we would transfer the patient to an appropriate medical facility for those services.

The applicant's response bolsters the concerns expressed by Mr. Berman about the applicant taking patients with less complicated needs and leaving more difficult patients for community based hospital inpatient psychiatric units to treat. Since they will provide less comprehensive services than existing hospitals (with the exception of CHH), it will increase the acuity in the patient mix at other hospitals, placing an increased burden on community based hospital inpatient units. As the applicant notes, medical co-morbidity is an increasing commonly health management issue for all its patient population. The "exclusion criteria" will prevent the NEWCO facility from treating many individuals regularly seen in general hospital emergency rooms every day but that will be beyond the ability of this facility to treat, necessitating their transfer by ambulance to the nearest hospital, Legacy Meridian Park Medical Center.

h. Acute Care Hospitals Increasing Supply of Inpatient Psychiatric Beds

Belying the applicant's assertion in its January 5, 2016 application that: "based on available information, there is no indication acute care hospitals are increasing supply of inpatient psychiatric beds" is the following statement from Tuality Healthcare's November 28, 2016 letter:

> Tuality Forest Grove has added additional beds as the need has become necessary in a sequential order supplementing what is needed. Most recently about five years ago was the addition of 4 new beds. Additional space exists in Tuality Forest Grove that should the need continue to grow in Oregon as the "Baby Boomer" population ages, Tuality

> Forest Grove intends to add more beds in a sequential fashion to allow them to occur in the least costly and most productive manor (sic).

In this regard it is also important to note that Providence recently opened a new 19-bed inpatient geriatric psychiatric unit at Providence Milwaukie Hospital. By letter dated December 1, 2016, the CEO of Willamette Valley Medical Center, Peter Hofstetter, wrote to the Division requesting that it deny the NEWCO application with respect to geriatric psychiatric services as it "operates a geriatric psychiatric unit only 28 miles from the proposed new hospital and our unit has capacity averaging only 70% occupancy" and because of concern about the "impact that this CON would have on what is already a very fragile delivery system for geriatric mental health services and how those needs will be met in the immediate future."

i. Priority for Units at General Community Hospitals

It is important to highlight that OAR 333-615-0020 recognizes that it is state policy to encourage and assist general community hospitals to establish psychiatric services and that priority under OAR 333, Division 615 is to be given to the establishment of access to local hospitalization in geographically distributed, quality psychiatric units, within community hospitals and that hospitalization is to be utilized only when an individual's needs cannot be safely and effectively met by less costly alternatives. Section (4) of that rule provides that the development of a number of psychiatric units, of economically and programmatically viable size, in general hospitals is to be favored over development of freestanding facilities. Further under OAR 333-615-0000, the applicant bears the burden of showing that other aspects of its proposal compensate for its lower priority status. For all of the reasons discussed in the review of this criterion, the applicant has failed to bear its burden of showing that other aspects of its proposal compensates for its lower priority status.

j. Reasonable Access to Services and ED Transfer Agreements

The comments received from Washington County, Department of Health & Human Services via letter dated December 5, 2016 emphasized the need for the proposed hospital, if approved, to: "have clear *Letters of Agreement* with area Emergency Departments for NEWCO patient experiencing a medical episode requiring emergency care." The County has extensive experience working with metro area hospitals, including CHH. The applicant has stated in numerous contexts that the proposed NEWCO facility will be similar in form and function to CHH. Consequently, it is important to note that Providence St. Vincent is the closest facility equipped to provide acute medical care for CHH and, in its nine years of operation, CHH has not yet reached a transfer agreement with this facility. When questioned by the Division about this, the applicant replied that: "discussions are still-in process" with this facility. CHH does not have an ED transfer agreement with any facility other than Tuality Hospital; a facility located a considerable distance away in Hillsboro. In response to the Division's request for a detailed accounting of which hospital emergency rooms CHH has transferred patients experiencing medical emergencies to during the previous three years, the applicant

provided the following information:

> Of 49 patients admitted for further medical care in 2013, there were 47 admitted to Providence St. Vincent's Hospital; one admitted to Providence Portland, and one admitted to Legacy Meridian Park. Of 29 patients admitted for further medical care in 2014, there were 27 admitted to Providence St. Vincent's Hospital, and two patients admitted to OHSU. Of 44 patient admitted for further medical care in 2015, there were 42 admitted to Providence St. Vincent's Hospital, one admitted to OHSU, and one admitted to Adventist Medical Center.

It is interesting to note that Tuality Hospital does not appear on this list during any of the three years.

When asked by the Division in a letter dated April 26, 2016 whether the proposed hospital will have a transfer agreement with Legacy Meridian Park Medical Center, the closest facility equipped to provide acute medical care, the applicant responded:

> There have not been discussions to-date with Legacy Meridian Park Medical Center. We do anticipate having such discussions once this certificate of need process has been completed. It is our hope that such a transfer agreement can be put in-place.

The applicant's response validates Mr. Joondeph's concern, noted above, that this facility presents itself "along the model of an antiquated stand-alone psychiatric facility." The paucity of appropriate ED transfer agreements at the facility that NEWCO is modeling itself on and the applicant's response to the Division's inquiry not only calls into question whether the proposed hospital would have an appropriate relationship with its service area, discussed below, but also raises serious concerns about patients' reasonable access to services and whether that access will be improved as a result of this project.

In discussing the lack of an ED transfer agreement, SEIU, in its November 21, 2016 letter, observed that: "For these reasons, we are seriously concerned that UHS' proposed facility will not be equipped to deal with the medical emergencies and medical complexities that naturally arise in the populations it anticipates to serve, such as geriatric patients."

k. Restrictive Admission Policies, Reasonable Access to Services for Patients with IDD and Severe Mental Illness

When asked by the Division in its April 26, 2016 letter whether it would serve low-functioning patients (e.g. patients with IQ below 80) in any of the age cohorts, the applicant responded that it "will not serve patients who are not able to cognitively

participate in treatment groups." In response to this reply, Mr. Joondeph's November 23, 2016 letter stated that:

> NEWCO materials stated that the proposed facility would not serve individuals with intellectual disabilities because they wouldn't benefit from cognitive therapy. However, it does plan on serving individuals with dementia. I'm not sure that I appreciate the difference but am concerned that people with IDD will experience discrimination under this plan.

Based on the applicant's response to the Division's April 26, 2016 inquiry, there appears to be reason for concern that patients with Intellectual and Developmental Disabilities (IDD) may not enjoy access to the services of the proposed facility. Additionally, it appears that many of most seriously mentally ill patients will not be able to be admitted to this facility as the severity of their mental illness may prevent them from participating in therapy groups.

l. Scholarly Article Regarding Access for Patients including Public-Paid Patients

As noted above, the proposed facility is a for-profit venture. What impact this fact may have on patients' reasonable access to services in the subject of a frequently cited article in the February 2005 issue of Psychiatric Services entitled "A Comparison of the Performance of For-Profit and Nonprofit U.S. Psychiatric Inpatient Care Providers Since 1980." The authors of this article synthesized evidence from a systematic review of the literature reporting substantiated performance differences between private for-profit and private nonprofit psychiatric inpatient care providers in the United States since 1980. They also compared differences in performance between nonprofit and for-profit inpatient psychiatric care providers with reported differences between nonprofit and for-profit providers for other types of health care. The authors concluded that on the basis of data collected since 1980, nonprofit psychiatric inpatient providers in the United States had superior performance on access, quality, cost-efficiency, and amount of charity care. They found that caution is warranted in pursuing public policies that permit or encourage the replacement of nonprofit psychiatric inpatient providers with for-profit providers of these services. All of the existing inpatient psychiatric providers in the service area, except UHS owned Cedar Hills Hospital, are hospital-based units operated by community hospitals that are nonprofit charitable organizations.

m. Reasonable Access to Services for the Population Most Needing Services

Data provided in The Joint Letter shows that the largest segment of current inpatient psychiatric patients in the proposed service area are those age 18 to 64 representing nearly 82% of the total psychiatric discharges of residents from the three county area in 2015 and that just under 56% of all discharges for the age 18-64 population in 2015 were Medicaid or uninsured. The letter states that:

> Based on the above, if NEWCO were intending to serve ***all*** **Service Area** residents in need of care, one would expect that 81% of its requested beds (81) would be for adults and of this, at least 50% would be made available to Medicaid and insured patients (40+ beds). However, NEWCO is projecting only 52 beds for adults and their commitment to serving Medicaid is not evident.
>
> As shown in Figure 3, based on 2015, the most recent Oregon inpatient utilization data available, for psychiatric patients between the ages of 18 to 64, Medicaid paid 51% of the days. Medicaid days as a percentage of total paid days has increased from 25% as recently as 2013 to over 50% in 2015.
>
> While NEWCO states in its application that it expects the vast majority of the population they will serve in the 18 to 64 age group will be Medicaid eligible, absolutely no documentation is provided in its pro-forma to support how revenue will flow for these patients.

n. Track Record of UHS Owned CHH in Relation to Reasonable Access to Services for Public-Paid and Uninsured Patients

The Joint Letter raises concerns about CHH's compliance with the conditions of approval of its Certificate of Need, as does SEIU's November 21, 2016 letter. The Certificate of Need program shares these concerns. In this context is important to again note that the applicant has made it clear that NEWCO will operate like CHH and UHS is the parent company of both entities. Applicable to this discussion are:

> Condition 1. The applicant will make reasonable efforts to make it widely known to the general public that emergency psychiatric treatment is available at this facility 24 hours a day, seven days a week, regardless of ability to pay or payor source, if a patient presents at the hospital and requires stabilization. Reasonable efforts include, but are not limited to: clearly posting this information on the web page for the facility . . ."
>
> Condition 5. The applicant will accept admissions and transfers of patients without quotas, limits or restrictions based upon payor source or the ability to pay. The applicant will also provide care to the uninsured in the same proportion as the psychiatric inpatient units of community hospitals located in the service area. Beginning one year after commencement of the operation of this facility, and on an annual basis thereafter, the applicant will

> submit a comprehensive report to the CN program detailing the amount of care provided to uninsured individuals and to Medicaid eligible individuals for whom the facility cannot receive payment because of the IMD exclusion. The department will evaluate this information against the experiences of other psychiatric inpatient units located in the service area."

As noted in The Joint Letter, because CHH does not participate in the OAHHS inpatient database, there is no public data to substantiate its ongoing conformance with Condition 5. While CHH has filed Medicare cost reports it is not possible to tell from a review of these reports whether it provided any uncompensated care during the year for which the cost report was filed since only hospitals paid through the Inpatient Prospective Payment System (for acute care) are required to file Worksheet S-10, its hospital uncompensated and indigent care data.

Although the program has repeatedly pointed out to CHH that the appropriate comparison required by Condition 5 is not against a community hospital as a whole but against its psychiatric inpatient unit, we continue to get information from the applicant such as that provided in Table 5 on page 33 of The Rebuttal Letter that measures its performance against community hospitals as a whole. Further, as pointed out in the Division's June 28, 2016 letter to the applicant, the web page for CHH states that: "We do not accept the Oregon Health Plan (Medicaid) or any Managed Medicaid through the Coordinated Care Organizations." This statement directly contravenes the intent of both Condition 1 and Condition 5 that was to ensure that CHH served its fair share of Medicaid patients despite the IMD exclusion. These conditions were meant to make sure that CHH did not shift the burden of caring for these patients on existing community providers while filling beds with more profitably insured patients. This statement, appearing on their web page, also evidences a failure to comply with the clear directive set out in Condition 1.

As reported on page 17 of the Division's 2008 "Final Order Issuing Certificate of Need With Conditions" for CHH: "The Ascend CN application (page 44) specifies that "all services will be adult psychiatric services and there will be no specialty units.'" This has not turned out to be the case. The website for the facility states that: "The specialty approach is what makes us different." Its inpatient specialty programs include Substance Abuse Treatment Program, Behavioral Pain Management Program, The Woman's Program, a Mental Health Unit, a 10-bed Crisis Stabilization Unit, and a Military Program that serves active duty military service members who are insured, predominately come from out-of-state and enjoy benefits that will cover the expected 7 to 45 day stay.

The proposed NEWCO facility proposes to follow the same specialty care model. SEIU, in its November 21, 2016 letter, states that:

> UHS' failure to include any substantive discussion of existing providers, other than those owned by UHS, is not entirely surprising given that the proposed facility will be

an outlier in a market otherwise filled with integrated care providers. UHS' proposed facility is a for-profit, standalone hospital offering specialty services.

o. OAR 333-615-0020(5) Requires that Need be Population Based Rather Than Facility Based

On page 18 of The Rebuttal Letter, the applicant posits that: "Cedar Hills' experience with high occupancy is a good 'barometer' of the inpatient psychiatric bed shortages in our region and we see the trend growing." This approach to planning for future behavioral health services is not in keeping what has been happening in Oregon, as extensively discussed above, and is not congruent with the principle that has informed and guided those efforts: there is one mental health system and the full continuum of mental health services needs to be enhanced to successfully improve the quality and efficiency of services. Please see the March 13, 2007, "Community Services Workgroup Report for the Oregon State Hospital Master Plan." It should also be noted that OAR 333-615-0020(5) requires that: "Demonstration of need for general psychiatric beds will be population based, rather than facility based."

CHH does not operate an emergency room, often has its beds filled with patients in specialty programs, offers a limited number of "crisis stabilization beds" and excludes many medically compromised patients. This facility also appears to be out of compliance with the conditions of approval of its Certificate of Need. It is also important to note that the proposed NEWCO facility, unlike CHH, will not provide a "Crisis Stabilization Unit" which the applicant described as having "specific programming that is designed to treat our patients who are possibility more aggressive or who are unable to interact with other patients in a larger milieu." This will leave the proposed hospital without a dedicated unit to treat these patients who, here again, are the types of patients seen and treated everyday in the EDs and inpatient psychiatric units of community based hospitals.

The "Burden of proof for justifying need and viability of a proposal rests with the applicant." OAR 333-580-0000(8). In addition "[a]pplicants must demonstrate to the Division that a proposal is approvable." OAR 333-580-0030(5). For the reasons explained above, the applicant has not met its burden to establish that the proposed hospital will result in an improvement in patients' reasonable access to services.[21]

B. Availability of Resources and Alternative Uses of those Resources: OAR 333-580-0050

1. Does the proposed project represent the most effective and least costly alternative, considering all appropriate and adequate ways of meeting identified needs?[22]

[21] Under OAR 333-580-0040(4), if the project proposes to serve the needs of members of a health maintenance organization, the applicant must address whether these members need the proposed project, considering the special needs and health care utilization rates of this population? This project does not propose to serve the needs of members of an HMO and therefore this criterion is not applicable.
[22] OAR 333-580-0050(1).

a. Best price

The applicant must demonstrate that the best price for the proposal has been sought and selected. The portion of the application that is supposed to address this item skips over it and does not address it. Please see pages 46 and 47 of the application.

b. Best solution among reasonable alternatives.

The applicant must demonstrate that proposed solutions to identified needs represent the best solution from among reasonable alternatives, including internal and external alternatives.[23]

i. Internal alternatives

This portion of the rule requires that the applicant:

- List the major internal operational adjustments considered which could lower the cost and improve efficiencies of offering the beds, equipment or service;
- Demonstrate that the alternatives considered represents the best solution for patients and discuss why other alternatives were rejected;
- If the proposal is for an inpatient service, demonstrate that this method of delivery is less costly than done on an outpatient basis; and
- Demonstrate that the selected architectural solution represents the most cost effective and efficient alternative to solving the identified need.

In this section of its January 5, 2016 application, the applicant offers two internal alternatives (1) expansion of existing facilities and/or (2) care redesign to redirect care to other, non-inpatient modalities. This section of the January 5, 2016 application states that UHS CHH has limited capacity for further expansion and "there is no indication that acute care hospitals are increasing supply of inpatient psychiatric beds". In regard to expansion of UHS CHH, as noted above, representatives of that facility met with the agency's Facilities Planning & Safety team on June 5, 2017 for a pre-design conference for plans that would result in the addition of 8 inpatient beds at that facility. In relation to increased use of outpatient services, the applicant states that: "Theoretically, if all needed psychiatric care could be delivered on an outpatient basis, we would expect to see providers moving that direction, given its much lower delivery cost." According to the applicant, the cost of expanding CHH would be roughly the same cost as building a new facility in Wilsonville.

As discussed above, what is actually happening in the service area is a move to decrease the need for inpatient beds both through the development of the Unity Center and other investments in the community behavioral health system such as Adventist Health's Emotional Wellness Center that will help people avoid hospitalization or shorten hospital stays, resulting in a need for less inpatient psychiatric beds in facilities such as

[23] OAR 333-580-0050(1)(b)(A) and (B).

NEWCO. Planning for future behavioral health services based on a perceived need at CHH is not in keeping what has been happening in Oregon and is not in keeping with the principle that there is one mental health system and the full continuum of mental health services needs to be enhanced to successfully improve the quality and efficiency of services.

As noted above, in a letter dated September 29, 2016, the Division raised concerns about the failure of the design of the hospital to provide for visual and physical separation of child and adolescent care units from each other and from adult units as required by Oregon administrative rule. Subsequently by letter dated October 5, 2016, the applicant wrote that: "UHS has determined that inpatient care for children, persons 5-11 years old, **will not be included at this time**, due to space configurations and treatment modality requirements for the different age cohort groups." (Emphasis added.) In The Rebuttal Letter, on page 50, the applicant discusses concerns raised about UHS' practices regarding boarding and co-mingling of patients in its facilities. It states that it is its policy to "fully and at all times comply with federal, state and local regulations governing the proper boarding of patients." However, it then goes on to state:

> As described above, in some isolated and rare emergent circumstances, it can become necessary to board a child patient on an adolescent unit or an adolescent on an adult unit. This typically occurs when a patient in active crisis arrives as one of our facilities in need of care. However, even in these rare circumstances boarding is only done with the full consent of the patient and the patient's guardian. If it does occur, the patient who is on another unit sleeps only on that unit. All clinical programming occurs on the age appropriate unit. During sleep hours, the patient is on a heightened level of supervision for safety purposes. As soon as there is a bed available in the intended unit, the boarded patient is promptly moved to the appropriate unit.

This response is concerning because OAR 333-535-0061(8)(d) related to building requirements requires that child and adolescent units are physically and visually separate and from each other and from adult units. This provision helps ensure the safety and wellbeing of patients cared for in the facility. It is concerning that even before the proposed facility is built, the applicant is justifying the need to inappropriately co-mingle patients in "isolated and rare emergent circumstances."

A project that does not conform to licensing rules does not satisfy the standard that the selected architectural solution represents the most cost effective and efficient alternative to solving the identified need

ii. External Alternatives:

If the proposed beds, equipment or services are currently being offered in the

service area, this portion of the rule requires that the applicant demonstrate:

- Why approval of the application will not constitute unnecessary duplication of the services;
- Why the proposal is an efficient solution to identified needs;
- Why the proposal represents the most effective method of providing the proposal; and
- That the applicant can provide this proposal at the same or lower cost to the patient than is currently available. If these factors cannot be demonstrated, the applicant must show that without the proposal, the health of the service area population will be seriously compromised.[24]

Much of what was written in response to the issue of internal alternatives is equally applicable here. There are inpatient psychiatric beds available in the service area and concerted efforts underway to provide community based alternatives designed to prevent the need for hospitalization and to shorten lengths of stay. For all the reasons discussed above, the development of a stand-alone, 100-bed psychiatric hospital, located in the suburbs of Portland without adequate access to public transportation, lacking an emergency room and not resulting from a larger broad-based planning effort, is not the most effective alternative considering all appropriate and adequate ways of meeting identified needs. It would add unneeded beds resulting in unnecessary duplication of services and the applicant has not demonstrated that without the proposal the health of the service area population will be seriously compromised.

iii. Less costly alternatives of adequate quality[25]

If a less costly and adequately effective alternative for the proposal is currently available in the area, this portion of the rule requires the applicant to demonstrate why the proposal is not an unnecessary duplication and why it a more efficient solution to the identified needs. This portion of the rule also requires the applicant to demonstrate that the identified needs of the population cannot be reasonably served under current conditions, or by alternative types of service or equipment of equal quality to the proposal.

Mr. Bouneff, NAMI's executive director, noted, in his letter dated November 29, 2016, that:

> Hospital care is a necessary service, but it represents the most expensive level of care in our mental health system. We already spend an inordinate amount on hospital-level of care. Would additional spending reduce our ability to maintain and expand community services that are less costly and critically necessary to keep people out of acute care? If it does reduce our ability to invest in community care, we will quickly overwhelm any capacity that the

[24] OAR 333-580-0050(1)(b)(B).
[25] OAR 333-580-0050(1)(b)(C).

proposed hospital adds.

As Mr. Joondeph, DRO's executive director, quoted earlier, observed:

> Unlike some areas of medical and social services, behavioral health resources can be effectively targeted to preventative and crisis response services for the purpose of maintaining health and safety and preventing the greater expense of inpatient treatment. When public and private insurance dollars are unnecessarily spent on institutional care, the cost of insurance increases and the allocation of public resources for other purposes decreases.

The Investment Report evidences the fact that Oregon's efforts to provide alternatives to expensive inpatient treatment are bearing fruit and will continue to restructure how behavioral health services are provided to the service area population. As Unity Center comes on line and other community hospitals add psychiatric emergency rooms to their complement of services, many hospitalizations will be avoided altogether by focusing on immediate treatment at the outpatient level of care. For residents of the service area, this will result in a less costly and more effective alternative to the building of more resource intensive inpatient psychiatric beds.

iv. If there are competing applications for the proposal, each applicant must demonstrate why theirs is the best solution, and why a certificate of need should be granted them.

No competing applications are being reviewed simultaneously with this proposal.

2. Will sufficient qualified personnel, adequate land, and adequate financing be available to develop and support the proposed project?[26]

This section of the rule requires the applicant to demonstrate that there are, or will be:

- Sufficient physicians in the area to support the proposal; sufficient nurses available to support the proposal;
- Sufficient technicians available to support the proposal;
- Adequate land available to develop the proposal and accommodate for further expansion; and
- Source(s) and availability of funds for the project.

The applicant has identified a site in the City of Wilsonville for the proposed facility and has signed a purchase and sale agreement. The proposed site location is an 8.7 acre vacant lot, allowing, according to the applicant, "sufficient space for the hospital and necessary parking, as required by zoning regulations."

[26] OAR 333-580-0050(2).

NEWCO has not provided any information on the ability to expand the facility in the future. The siting (position of the building on the plot of land) of the building on the plans provided to the CN program leave little room for horizontal expansion in the future and no information on construction type or zoning requirements have been given to indicate if vertical expansion is a possibility.

The applicant has entered into a signed purchase agreement for $2.98 million for the proposed hospital site. As noted above, total estimated capital expenditures, as verified by licensed architect or engineer for the construction of the proposed facility will be appropriately $35.8 million. UHS will fund the proposed project and working capital with no additional financing required. There appears to be adequate financing available to develop and support the proposed project.

As a public company, UHS is required by the Securities and Exchange Commission (SEC) to produce ongoing information of the company's performance. The Division obtained copies of this information. According to the SEC required annual comprehensive overview of UHS' business and financial condition which includes financial statements (referred to as a 10-K), the Company had $61.2 million in cash and cash equivalents as of December 31, 2015, which is an increase of ~91% from the prior year.

Cash and cash equivalents as of June 30, 2016, based on the quarterly information provided to the SEC (referred to as a 10-Q), noted continued strong cash position of $56.3 million. UHS has net cash provided by operating activities of over $1 billion for the previous two years ended December 31, 2015 and 2014 and is on track to meet or exceed this for the 2016 year-end based on June 30, 2016 cash provided by operating activities of $801.2 million. Without the proposed facility, UHS has working capital (current assets divided by current liabilities) as of December 31, 2015 and June 30, 2016 of 1.56 and 1.27 respectively which is a measure used to show a business's ability to pay for its current liabilities with its current assets. Taking into consideration the total expected capital expenditures for the proposed project, using December 31, 2015 and June 30, 2016 consolidated financial statements, the working capital of UHS would be and 1.24, both of which are in line with industry standards. Total equity of UHS is $4.3 billion and $4.4 billion as of December 31, 2015 and 2014.[27]

On September 14, 2016, the State of Oregon Office of Economic Analysis issued the Oregon Economic and Revenue Forecast[28] and noted within the report, Oregon is outpacing other states by a considerable margin today for both job and income gains, however, job gains have slowed somewhat in the most recent months, which is creating a tightening labor market across the state, which has increased the difficulty in finding qualified staff and an increase in wages.

The applicant noted 188 Full Time Equivalents ("FTE") for 100 beds or 1.9 Staff

[27] (Detailed financial statements can be found at: https://www.sec.gov/Archives/edgar/data/352915/000156459016022902/uhs-10q_20160630.htm#CONDENSED_CONSOLIDATED_BALANCE_SHEETS)

[28] (http://www.oregon.gov/das/OEA/Documents/oregon.pdf)

per Bed in year 5 of operations. It was questioned in a letter from an affected party as to whether the staffing ratios were appropriate (3.2 Staffing was noted as appropriate in the letter). We noted that recent newspaper articles in Washington noted similar staffing ratios for 2 recently proposed psychiatric hospitals:

- 150 Employees projected for a 75 bed facility in Lacey, Washington (2.0 Staffing Ratio): (http://www.thenewstribune.com/news/business/article69581157.html)
- 200 Employees projected for a 100 bed facility in Spokane, Washington (2.0 Staffing Ratio): (http://www.spokesman.com/stories/2017/jan/03/spokanes-new-psychiatric-hospital-will-help-meet-s/)

Since of the staffing can come from the parent company, it can be difficult to determine an appropriate staffing ratio, but the staffing ratio is consistent with other facilities proposed by UHS.

In relation to staffing the proposed hospital with sufficient qualified personnel, the applicant assures the Division in letters dated March 11 and June 28, 2016, that: "UHS has multiple resources available to assist with the recruitment and identification of appropriate and qualified personnel." It lists these resources as being web sites, UHS recruiters and nursing schools in the Puget Sound region. In its application, it writes that, given the fact that Cedar Hills Hospital is already in the service area and that "UHS has extensive experience and resources recruiting, employing and retaining skilled staff, including national recruitment programs", "We do not anticipate any difficulties undertaking the same actions at NEWCO." This stands in contrast to both Tuality Healthcare's experience, concerns expressed in The Joint Letter and the statements of UHS CFO Steve Filton at an UBS Conference on May 23, 2016. Tuality Healthcare reported on its experience in trying to recruit for a psychiatrist for its facility:

> Third, as I would expect you are aware, the State of Oregon does not have near the number of psychiatrists need (sic) to provide care for its mentally ill. This is especially true for inpatient facilities and even more so for Geriatric Psychiatry. The Tuality Forest Grove facility has had to recruit nationwide when a vacancy has occurred, and taken months to fill these vacancies. Creating another Geriatric Psychiatric facility will further exacerbate this problem and dilute the few Geriatric Psychiatry providers that do exist in the community. It would be better to allow the very few Geriatric Psychiatric facilities in Oregon (3 total) to use the few existing Geriatric Psychiatrists in the most productive way.

The Joint Letter expressed concern that the proposed facility "would dilute the already existing scarce resources of psychiatrists, psychiatric RN and therapists; leading to fragmentation of care and higher costs. The SEIU letter dated November 21, 2016 quotes UHS CFO Steve Filton on UHS' experience recruiting personnel for its hospitals (please see the footnotes in the SEIU letter for details):

> In many of our markets we're actually turning patients away, and we're turning them away because we simply don't have the number of qualified personnel, clinical personnel that would include psychiatrics, nurses, other clinical personnel that we need . . . the nursing shortage, I think on the behavioral side a little bit more problematic. First of all, physically, we don't have as many resources to replace nurses. We physically need nurses at the bedside . . . in some markets, that causing us to not be able to treat all the patients who present themselves for admission.

In a letter dated August 25, 2015, the applicant acknowledged that there is "a significant RN shortage that all providers are experiencing in the PNW." In response to a question from the Division, in its August 30, 2016 letter, the applicant reports a "48% turnover rate hospital-wide for the trailing 12 months" at Fairfax hospital, its freestanding psychiatric hospital located in Kirkland, Washington. According to Nursing Solution's 2016 National Healthcare Retention & RN Staffing Report, the 2015 national turnover rate for hospital nurses working in behavioral health was 26.5%.[29]

In relation to staffing and other issues, nationally there are ongoing quality concerns about UHS, NEWCO's parent organization. Both SEIU's November 21, 2016 letter and The Joint Letter outline quality and billing issues at UHS facilities in the recent past. In its most recent SEC filing Form 10K published on August 5, 2016, UHS revealed that it has been served with subpoenas and other requests for information from the Office of the Inspector General and the USDOJ's Criminal Frauds Section regarding a number of its facilities. UHS and its facilities has been the subject of investigative reports in the Boston Globe (March 7, 2016), the Dallas Morning News (March 18, 2016) and most recently in BuzzFeed News. (December 7, 2016).

The Division specifically questioned the applicant about the Dallas Morning News article and how, in light of the concerns about "dangerously poor care and unsafe conditions" at UHS facilities across the country, the proposed hospital would keep patients, staff and the public safe. After reviewing the applicant's response to concerns raised by the Division about reported problems at a number of its facilities, DRO's executive director, Mr. Joondeph drew the following conclusion:

> In reviewing the materials provided by OHA and NEWCO, I was unable to find a direct defense of the applicant's corporate facilities in other states. I would have preferred a direct explanation of the problems and how they were corrected, rather than pronouncements of general effectiveness, certification and recognition. This approach led me to not expect transparency and openness in the future.

[29] *Please see*: http://www.nsinursingsolutions.com/Files/assets/library/retention-institute/NationalHealthcareRNRetentionReport2016.pdf

The Division shares Mr. Joondeph's assessment of the applicant's response to its questions and to concerns raised about safety and billing issues at its other facilities.

The "Burden of proof for justifying need and viability of a proposal rests with the applicant." OAR 333-580-0000(8). In addition, "[a]pplicants must demonstrate to the Division that a proposal is approvable." OAR 333-580-0030(5). For the reasons explained above, the applicant has not met its burden to establish that the question posed in this criterion can be answered in the affirmative as required by OAR 333-580-0030(2).

3. Will the proposed project have an appropriate relationship to its service area, including limiting any unnecessary duplication of services and any negative impact on other providers?[30]

This section of the rule requires the applicant to identify the extent to which the proposal and its alternatives are currently being offered to the identified service area population, or in the case of acute inpatient beds, could be offered on the basis of an analysis under Division 590 of the CN administrative rules. The applicant is required to discuss to the best of its knowledge, any negative impact the proposal will have on those presently offering or reimbursing for similar or alternative services.
OAR 333-580-0050(3). Areas to be discussed are utilization, quality of care and cost of care. OAR 333-580-0050(3)(b). The applicant must demonstrate that jointly operated or shared services between the applicant and other providers have been considered and the extent to which they are feasible or not. OAR 333-580-0050(3)(c). The applicant must also demonstrate that all necessary support services and ancillary services for the proposal are available at acceptable levels to insure that patients will have the necessary continuity in their health care. OAR 333-580-0050(3)(d).

In determining whether this criterion can be answered in the affirmative the discussions that appear above in conjunction with OAR 333-580-0040(3) (Will the proposed project result in an improvement in patients' reasonable access to services?); OAR 333-580-0050(2) (Will sufficient qualified personnel, adequate land, and adequate financing be available to develop and support the proposed project?); and
OAR 333-580-0050(2) (Will sufficient qualified personnel, adequate land, and adequate financing be available to develop and support the proposed project?) are directly applicable and are incorporated herein by this reference.

As noted above, the applicant has not met its burden to establish that the proposed hospital will result in an improvement in patients' reasonable access to services. There are inpatient psychiatric beds available in the service area and concerted efforts underway to provide lower cost and more effective community based alternatives designed to prevent the need for hospitalization and to shorten lengths of stay. Institutional care is very expensive and prevention and crisis response services that avoid the need for hospitalization and shorten lengths of stay will save money for patients, families, payers such as insurance companies and government, and for the general public. Money spent on inpatient care diverts money from favored community based alternatives.

[30] OAR 333-580-0050(3).

A new, stand alone, 100-bed psychiatric hospital, located in the suburbs of Portland without adequate access to public transportation, lacking an emergency room and not resulting from a larger broad-based planning effort does not appear to have an appropriate relationship to its service area. The proposed facility would add unneeded beds resulting in an unnecessary duplication of services.

Since comprehensive medical care will not be available at the facility, patients who require emergency care beyond the scope of the facility's scope of services will not be able to access its services. These patients are often the individuals most acutely in need of services and are also often the most costly patients to treat and, if this facility were to be approved, the burden of caring for these patients will fall on existing community based hospital inpatient psychiatric units. This will have a negative impact on these providers. Additionally, lack of an emergency room in combination with its location would mean that the proposed hospital is less likely to serve individuals without health insurance or who are under-insured. This will also have a negative impact on the existing community based providers.

Insured patients using the proposed facility will be those who would otherwise be treated by existing community hospital inpatient psychiatric units thereby resulting in a diminished contribution from commercially insured patients thus negatively impacting existing providers.

As discussed previously, given the difficulty in recruiting qualified staff such as psychiatrists and psychiatric RNs, the proposed hospital may dilute this already scarce resource leading to fragmentation of care, higher costs and negative impacts on other providers.

The paucity of appropriate ED transfer agreements at Cedar Hills Hospital, the facility that NEWCO is modeling itself on, and the applicant's response to the Division's inquiry regarding ED transfer agreements at the proposed facility calls into question whether patients utilizing the proposed hospital would have the necessary continuity in their health care.

The "Burden of proof for justifying need and viability of a proposal rests with the applicant" and the applicant "must demonstrate to the Division that a proposal is approvable." OAR 333-580-0000(8) and 333-580-0030(5). For the reasons explained above, the applicant has not met its burden to establish that the proposed hospital will have an appropriate relationship to its service area, including limiting any unnecessary duplication of services and any negative impact on other providers.

4. Does the proposed project conform to relevant state physical plant standards, and will it represent any improvement in regard to conformity to such standard, compared to other similar services in the area?[31]

[31] OAR 333-580-0050(4).

Under this criterion, the proposed project must comply with state licensing, architectural and fire code standards. OAR 333-580-0050(4)(a). If the proposal is already being offered in the defined service area, the applicant must describe, to the best of his or her knowledge, to what degree the existing service complies with state licensing, architectural and fire code standards. OAR 333-580-0050(4)(b).

NEWCO has provided floor plans for the proposed facility and while an in-depth formal plan review was not completed since the project had not been approved by the CN program major elements were reviewed and comments provided to NEWCO. NEWCO's Architectural Firm (SRG Partnership, Inc.) provided responses to those comments and the following items are not compliant with the Oregon Health Authority Physical Environment (Division 535) Oregon Administrative Rules:

- No visual separation is provided between adolescent and geriatric cohorts as required by OAR 333-535-0061(8)(d);
- No visually functional windows are provided in patient rooms as required by OAR 333-535-0025(1)(c); and
- No age appropriate spaces are provided as required by OAR 333-535-0061 (8)(a) since some required spaces are shared between adolescent/geriatric cohorts and some between adolescent/adult/geriatric cohorts.

Additionally, SRG Partnership, Inc. has sent a set of questions via email as directed by FPS to help identify rule requirements/interpretations. In the emailed document SRG Partnership, Inc. references previously approved waivers for a similar facility type and has inquired if those waivers could be applied to NEWCO's facility. A reliance on the possibility of obtaining an approved waiver indicates that NEWCO does not intend to comply with the Oregon Health Authority Physical Environment (Division 535) Oregon Administrative Rules. Whether NEWCO would be able to obtain a waiver is unknown. However, it is clear from a review of the floor plans that the project, as presented, is not compliant with state physical plant standards.

C. Economic Evaluation: OAR 333-580-0060

In this portion of the analysis, the specific rule requirement will be set out and the analysis will follow.

1. Is the financial status of the applicant adequate to support the proposed project and will it continue to be adequate following the implementation of the project?[32]

a. Any financial forecasts which deviate significantly from the financial statements of the five-year historical period presented in the application must be fully explained and justified. OAR 333-580-0060(1)(a).

UHS is proposing a new subsidiary to be created, therefore there are no historical

[32] OAR 333-580-0060(1).

financial statements, however, UHS has a similar facility, CHH, in which financial information was utilized to project pro forma financial information.

b. An applicant must describe how it will cover expenses incurred by the proposal in the event the proposal fails to meet budgeted revenues in any forecasted year. OAR 333-580-0060(1)(b).

As discussed above, UHS believes it will be able to fund the operations from cash reserves of the proposed project if revenue and expenses are not in line with forecasted amounts, however, UHS is projecting the project will be self-sufficient in year three of operations where the proposed project will be making a profit. The bottom line ratio (excess revenue over expense pre tax divided by total operating income) is projected to be -132%, -6%, 16%, 24% and 25% based on year one of operations through year five of operations. Based on historical information for CHH, bottom line ratio for 2014-2016 is in the range of 32%–33% before intercompany expenses. After intercompany expenses CHH had a bottom line ratio of -5% to -6%. Operating margin for CHH for 2014-2016 is 34%–35% while the projected project is assuming it will be as high as 37% in year five of operations.

c. Applicants must discuss the results of ratio analysis required by Form CN-9 and OAR 333-580-0100(4), explaining strengths and weaknesses. The discussion should refer to each ratio as detailed in Table 1 of OAR 333-580-0100(4). Specifically:

i. Applicants must describe their debt capability in terms of the required ratio analysis. OAR 333-580-0060(1)(c)(A).

As discussed in the application, the proposed project will be a subsidiary of UHS and will not have standalone financial statements as all assets and liabilities will be held at the parent company, therefore the applicant did not comment on the debt capability as it is driven based on the proforma balance sheet. In addition, the project will be funded out of cash reserves of UHS, therefore no additional debt will be taken out. If the building and land is recorded on UHS' books there would be no depreciation and amortization expense recorded on a standalone basis for the proposed project, instead these expenses would be recorded on UHS' consolidated financial statements.

ii. The discussion of liquidity should include comments on the adequacy of cash, the collection period for patient accounts receivable, and the payment period for accounts payable. OAR 333-580- 0060(1)(c)(B).

Based on the December 31, 2015 10-K filed, UHS consolidated accounts receivable collection period was ~52 days (average accounts receivable $1,292,582,000/ ($9,043,451,000/365 days). UHS consolidated cash and cash equivalents as of December 31, 2015 were $61,228,000. See above for additional information.

iii. The profitability ratios required by OAR 333-580-0100(4) and Form CN-9 must be discussed. OAR 333-580-0060(1)(c)(C).

As noted above, the applicant does not believe a large portion of Form CN-9 ratios are applicable, as a standalone balance sheet will not be presented and no debt will be incurred as part of the proposed project.

d. Board designated assets: The intended uses of this fund are to be discussed in general terms. Alternative uses or contingent availability of these funds, such as to meet a cash requirement, also need to be addressed. Additionally, the proportion (percent) of depreciation that was or is to be funded is to be identified for each financial period presented. OAR 333- 580-0060(1)(d).

The applicant noted this was not applicable as UHS will use existing cash reserves to fund the project as noted above.

e. The applicant must discuss the availability of other sources of funding, including, but not limited to, donor restricted assets, assets of parent or subsidiary corporations, or a related foundation, which may be acquiring assets and/or producing income that is for the purpose of, or could be used for the purpose of, capital expenditure by the applicant. OAR 333-580-0060(1)(e).

UHS is the parent company for the proposed project and will fund the capital expenditures based on a letter of financial commitment from Senior Vice President and Chief Financial Officer on behalf of Universal Health Services, Inc. dated December 28, 2015.

f. Money market conditions must be discussed in terms of their impact on project financing, including interim financing, if applicable. Include the month and year in which financing is to be secured in this narrative:

i. The estimated rate of interest must be justified by the applicant. If debt financing is secured before or during the review process, the actual rate of interest obtained should be reported within 30 days of securing financing. OAR 333-580-0060(1)(f)(A).

As noted above, applicant will be funded from the parent company, therefore this is not applicable.

ii. When a bond rating report is issued before or during the review period in conjunction with a proposed bond issue to fund a certificate of need proposal, the applicant must submit a copy of the report to the Division within 30 days of its issuance. OAR 333-580-0060(1)(f)(B).

As noted above, applicant will be funded from the parent company, therefore this is not applicable.

iii. The financing term selected must be supported with evidence showing the benefits of its selection. OAR 333-580-0060(1)(f)(C).

As noted above, applicant will be funded from the parent company, therefore this is not applicable.

g. Patient days, admissions and other units of service used in forecasting projected expenses and revenues, both for the facility as a whole and for services affected by the proposed project, must be consistent with projections used to determine area need. All assumptions must be discussed. OAR 333-580-0060(1)(g).

Expected patient days forecasted is based on Cedar Hills and is therefore consistent.

In the review of patient days provided, we noted in a letter from an affected party that including an insurance payor such as Kaiser, which is seen as a closed system, may be misleading as those members would not be expected to contract with the applicant. Kaiser would represent approximately 18% of residents, and no additional information was provided by the applicant on how they will direct patients to its facilities.

h. An applicant must identify and explain all inflation assumptions and rates used in projecting future expenses and in completing the forms described in OAR 333-580-0100. It is important that the assumptions used by the applicant in preparing financial forecasts be carefully considered. All relevant factors pertaining to historical experience of the applicant, together with upcoming changes affecting the future, should be considered in forecasting the financial condition of the entity. Specifically:

i. Projected changes in wages and salaries should be based on historical increases or known contractual obligations and planned future personnel increases. Considerations should include expected full-time equivalent staffing levels, including increases resulting from the proposal. OAR 333-580-0060(1)(h)(A).

The proposal did not anticipate any increases in wages and salaries or other obligations, however, if increases were utilized, the proposed project would still be profitable in year three as initially projected.

ii. Projected deductions from revenues should be explained and justified. OAR 333-580-0060(1)(h)(B).

The proposed project utilized information from another operating entity, which is similar to arrive at deductions from revenue, which was consistent based on the application.

iii. Expected changes in the intensity and/or complexity of services provided must be considered in addition to the rate of inflation in arriving at an overall rate of increase in revenues or expenses.
OAR 333-580-0060(1)(h)(C)

The applicant does not believe any changes in the revenue per patient day would change at the new location compared to CHH location even with a change in the mix of patients.

With over 50% of payor mix in the Portland Metro area comprising of Medicaid for 18–64 year olds, it is unclear what the impact of this payor will have on this new facility. The Applicant noted the proposed project will be reimbursed by Oregon Medicaid for child/adolescent and geriatric patient as it is expected a majority of their inpatients will be eligible for Medicaid coverage, however, a break down by patient mix was not provided. According to the recent cost report provided by UHS for CHH for the year ended December 31, 2015, total discharges for Medicaid patients were 56 out of 2,845 or 1.97%. Medicare patients were 877 discharges of 2,845 or 30.82% for the year ended December 31, 2015.

The applicant projects the reimbursement rates on a global basis, which is estimated at $2,250 per Patient Day (Gross), but no anticipated payor mix was provided. It would be reasonable to anticipate that this optimal Revenue calculation would be based on a perceived payor mix, which was not identified in the Application.

iv. Projected gross revenue must reflect:

- Patient day increases/decreases
- Outpatient activity increase/decrease
- All debt service coverage requirements; and
- Other significant impacts the proposal will make on revenue projections.
- Each applicant must submit within 30 days, a copy of the financial feasibility report if the applicant arranges for such a report and it becomes available before or during the review period. OAR 333-580-0060(1)(h)(D).

The applicant has shifted its projection of patients to a 24% 5–17 years old, 52% 18–64 years old and 24% 65 years old and older patient mix based on the most recently submitted architectural analysis. No change in average gross revenue per day was adjusted. As discussed earlier, the Portland Metro area generally sees a payor mix within the 18–64 years olds that is at least 50% Medicaid.

The Length of Stay calculated mimics that of the CHH location. It was noted that the CHH population includes military personnel stationed outside the service area (Joint Base Lewis McCord). Typically, this population has a length of stay that is 2 to 3 days longer than the other patients seen at CHH. It is unclear that there would be a repeat of

this population at the new facility, and as such, it would seem reasonable that the patient length of stay would be shorter than CHH. Also a new facility in Lacey, Washington located 20 miles from Joint Base Lewis McChord may reduce the amount of outmigration from Washington to Oregon.

As the applicant has indicated, a decrease in length of stay would be offset with an increase in patients. This would be proven by a shortage of beds in the area which is not evident from the data from other facilities in the area that have average occupancy rates of 80.7% for adult and geropsychiatric (Table 23) and 69.7% for child and adolescent (Table 24). The occupancy data does not seem to have significantly changed in the past 6 years (Table 18 of Application). Table 21 of Application also demonstrates an average daily census of 141 to 145 over the 6-year analysis. Willamette Valley Medical Center, who is 28 miles away from the proposed project, noted they were only at 70% capacity. Based on this data, it is not clear whether a decrease in length of stay would be offset through an increase in patients.

As discussed above, the applicant's patient mix is expected to be 52% 18–64 years old, however, a provision referred to as the Institute for Mental Disease (IMD) Exclusion prevents federal Medicaid funds from being used by states to care for adults seeking inpatient care in freestanding psychiatric hospitals with more than 16 beds, which could raise concerns about the ability and intent to meet the needs of Oregon's large and growing Medicaid population. It is unclear at this time on the impact of IMD and this proposed facility.[33]

2. Will the impact of the proposal on the cost of health care be acceptable?[34]

The applicant has not demonstrated that the proposed facility is needed or the most effect and least costly alternative considering all appropriate and adequate way of meeting the population's need for services. For the reasons previously discussed, the proposed facility would add unneeded inpatient hospital beds to the service area. Hospital care is the most expensive level of care in the mental health system. As explored in this order, less costly and more effective alternatives to the building of more resource intensive inpatient psychiatric beds are preferable. Consequently, the impact of this proposal on the cost of health care is not acceptable.

a. <u>The applicant must discuss the impact of the proposal both on overall patient charges at the institution and on charges for services affected by the project</u>

   i. <u>An applicant must show what the proposal's impact will be on the gross revenues and expenses per inpatient day and per adjusted patient day. OAR 333-580-0060(2)(a)(A).</u>

Based on the application, gross revenues and operating expenses per patient day

[33] See Exhibit #8, attached for financial considerations regarding the applicant's proforma statements.
[34] OAR 333-580-0060(2).

and per adjusted patient day would remain relatively constant, as the forecast does not include any assumed price inflations. As explained above, the payor mix was not identified by the applicant; therefore it is not possible to project the impact on other similar facilities populations. If the Medicaid portion as a percentage of total discharges mimicked the 2% of CHH, this would be far below the 50%+ seen across the geographic area, which could result in a shift in payor mix seen at other facilities in the area.

ii. An applicant must show what the proposal's impact will be on the gross revenues and expenses per inpatient day and per adjusted patient day. OAR 333-580-0060(2)(a)(B).

See response above.

b. The applicant must discuss both the proposed or actual charges for the proposed service and the profitability of the proposed service, compared to other similar services in the state (if any). OAR 333-580-0060(2)(b).

Based on the application, the proposed charges, deductions, and expenses are based on actual charges from the CHH location.

c. The applicant must discuss the projected expenses for the proposed service, and demonstrate the reasonableness of these expense forecasts. OAR 333-580-0060(2)(c).

As discussed above, expenses projected were based on actual CHH's expenses.[35]

d. If the proposed service is currently not being provided in the area, the applicant should identify potential travel cost savings by:

i. Establishing what the existing travel costs are to patients. OAR 333-580-0060(2)(d)(A).

CHH is within 13 miles of the proposed project however, CHH does not accept children/adolescents. The applicant believes "these costs are unknown but very likely significant, given the substantial psychiatric bed shortage."

There are other facilities that provide similar services proposed by UHS. As Portland has the most beds of any area in the state of Oregon, there is no evidence of significant outmigration of patients to other service areas; therefore travel cost savings are not seen as significant.

[35] See Exhibit #8 for additional information regarding expenses.

ii. Establishing what the travel costs will be to patients after implementation of the proposal. OAR 333-580-0060(2)(d)(B).

See above for discussion of travel costs.

iii. Showing what the difference is between the figures in OAR 333-580-0060(2)(d)(A) and (B). OAR 333-580-0060(2)(d)(C).

See above for discussion of travel costs.

e. The applicant must discuss the architectural costs of the proposal:

i. An applicant must demonstrate that the existing structure will last long enough to derive full benefits from any new construction or remodeling. OAR 333-580-0060(2)(e)(A).

Since the building is only proposed, there is no "existing structure" in place. The applicant did not provide the building construction type so it is not possible to estimate with accuracy the lifespan of the building.

ii. General construction costs must be within reasonable limits (within high/low range as described in the most current issue of the Dodge Research Report adjusted for location). OAR 333-580-0060(2)(e)(B).

Using the information provided on the applicant's Form CN-3 it is shown that total project cost is $35,834,324 and construction cost is $27,716,081. This calculates out to $574.52/SF and $444.36/SF respectively. Using online construction cost estimating software (www.buildingJournal.com) the projected low cost of construction is $325.17/SF and the projected high cost of construction is $502.77/SF. Since the provided cost of construction by the applicant ($444.36/SF) falls between these projected estimates the price per square foot appears reasonable.