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November 21, 2016

Jana Fussell, Program
Coordinator Certificate of Need
Program OHA-Public Health
Division 800 NE Oregon Street,
Suite 305 Portland, OR 97232

RE: Public comment in opposition to UHS/NEWCO Oregon, Inc. Certificate of Need Application (CN #675) to establish a psychiatric facility in Wilsonville, Washington County.

Dear Ms. Fussell,

On behalf of more than 65,000 workers represented by SEIU Locals 49 and 503, including more than 36,000 in healthcare professions, we write to oppose the Certificate of Need Application (CN #675) submitted by Universal Health Services, Inc. (UHS) and its subsidiary NEWCO Oregon, Inc., to establish a 100-bed psychiatric Hospital in Wilsonville, Oregon. SEIU represents the interests of healthcare workers and their families, as well as the patients our members serve in Oregon. Our members act as both direct healthcare providers and as consumers of healthcare services, including at existing mental health facilities. SEIU members represent one of the largest classes of healthcare consumers in the state and are impacted as purchasers, patients, and providers.

We are undergoing a pivotal moment in the transformation of our state's mental health system. The Oregon Health Authority (OHA) is embarking on a three-year performance plan stemming from an agreement with the US Department of Justice (DOJ) to improve mental health care services. The core elements of the plan are to avoid unnecessary institutionalization, improve community-based care to match individuals with the most integrated setting appropriate to their needs, and commit to quality and positive outcomes. In order to successfully implement this plan, as well as uphold the principles underlying this system transformation, we urge the OHA to be extra vigilant in selecting health providers to care for our state's mental health populations. It is essential that the healthcare providers who will be entrusted to provide vital psychiatric services to the community meet the highest standards of quality patient care, cost-containment, and legal compliance.

As dedicated caregivers, we have committed our professional lives to delivering healthcare in accordance with the highest quality standards and championing patient and worker safety. We expect UHS, the nation's largest provider of inpatient behavioral health services, to share in this mission. Unfortunately, UHS has a demonstrated record of failing to comply with basic patient health and safety requirements expected of all hospitals in communities across the U.S. In fact, many of

the troubling issues seen in UHS facilities across the country mirror those that sparked the 2006 DOJ investigation into Oregon's mental health system – which subsequently led to the current three year performance plan. These issues include: inadequate protection of patients from harm, high level of assault and self-harm incidents, failure to provide a safe living environment free from hazards, inadequate staffing, and inadequate remedies for such issues. Working in a psychiatric hospital is challenging enough as it is—and it is particularly challenging when workers do not have the ability to speak for and bargain for themselves to address workplaces safety and other issues that impact the quality of care provided to patients.

What's more, UHS has a questionable legal compliance record, most notably demonstrated by the fact that the company and twenty-five (25) of its behavioral health facilities in nine (9) states are currently facing federal investigations for potential fraud, including a criminal fraud investigation of the corporate parent.

In addition to the troubling developments mentioned above, UHS' proposed project also fails to meet a majority of the crucial Certificate of Need review criteria, as our comments demonstrate. This cover letter summarizes our concerns and the attached memorandum contains our analysis in greater detail:

- Bed need: UHS' own calculations from the statutorily-required bed need calculation methodology repeatedly concluded there is no need for its proposed inpatient facility. Rather than conceding there is no need for such a facility, UHS circumvents Oregon's CON regulatory regime by adopting its own methodology to justify need in the proposed service area. However, even using this methodology, there are bed need inconsistencies. In one UHS calculation from January 2016, bed need fails to emerge until the year 2025while a revised UHS calculation from March 2016 subsequently concluded there was no need.

- Quality of care: UHS fails to provide reasonable assurances that its proposed facility will provide "quality psychiatric inpatient care," due to its record of failing to meet state licensure and certification requirements, and Medicare program standards. Also, while UHS touts Joint Accreditation as a marker of quality care, many of its Joint Commission-accredited facilities have had serious quality of care breakdowns, some of which even involved patient deaths.

- Access to care: UHS' record as an operator- especially its record with regard to fulfilling charity care requirements, denying behavioral healthcare to those in need, and shuttering of facilities in low income areas-highlights serious concerns about "potential problems of [care] accessibility."

- Availability of resources: UHS does not meet the sub-criteria listed under the "Availability of Resources and Alternative Uses of Those Resources" criteria:
    - *Most effective and least costly alternative*: Given that UHS is facing federal investigations for potential criminal and civil billing fraud, as well as UHS' record of high utilization of local, public law enforcement and emergency medical service (EMS) resources, we have concerns that its proposed facility will not be the "most effective and least costly alternative."

    - *Sufficient qualified personnel:* UHS has a poor record on appropriate staffing, as evidenced by low staffing ratios, repeated cuts in staffing costs, difficulties in recruiting staff, and its practice of employing unqualified and untrained staff. All of these factors raise significant doubts about UHS' ability, and willingness, to provide sufficient, qualified personnel to meet patient needs and ensure safety.

- *Relationship to its service area*: UHS' failure to discuss how its proposed facility will impact existing providers raises concerns about UHS' willingness to work with other providers to coordinate care and control costs. Also, UHS' representations that it will rely on the "established relationships" of its Cedar Hills Hospital, coupled with Cedar Hills' deficiencies in establishing and maintaining appropriate support and ancillary services, raises concerns about the proposed facility's relationship to its service area.

- *Physical plant standards:* UHS has a troubling record regarding physical plant standards, as evidenced by incidents tied to tragic patient outcomes, capital spending on existing facilities, and unsafe patient boarding. All of which raises concerns about UHS' ability to satisfy physical plant standards to ensure patient and worker safety and wellbeing.

- Economic Evaluation: UHS' record of having high costs of care, as evidenced by high charge-to-cost ratios and payment-to-cost ratios at its facilities in the Pacific Northwest (including its Cedar Hills Hospital in Oregon) raises concerns that the proposed facility will likely continue this trend of imposing an "unacceptable impact upon the cost of healthcare."

For these reasons, UHS does not meet the high standard of care that our communities deserve. Therefore, we urge the Oregon Health Authority to deny UHS/NewCo's Certificate of Need application (CN #675). Thank you for your consideration.

Sincerely,

Meg Niemi
President, SEIU Local 49

Brian Rudiger
Executive Director, SEIU Local 503

UHS' CON proposal fails to demonstrate bed need under the State of Oregon's need criteria.

Bed Need Criteria (333-580): Does the service area population need the proposed project?

UHS' proposed facility fails to meet the State of Oregon's bed need criteria for several key reasons. The most evident of which is that UHS' own calculations from the statutorily-required, multi-step bed need calculation methodology, as specified in the Oregon Administrative Rules (OAR) 333-590-0050 (hereinafter "OAR 590"), showed there is no need for its proposed facility. Secondly, after UHS failed to demonstrate bed need using the regulatory regime specified in OAR 590, UHS adopted its own methodology in order to justify need for its proposed facility. Thirdly, UHS fails to meet the bed need criteria specified in the Oregon Administrative Rules (OAR) 333-615-0000 (hereinafter "OAR 615"). Oregon's certificate of need (CON) administrative rules specify that the "Burden of proof for justifying need and viability of a proposal rests with the applicant,"[1] but UHS repeatedly fails to meet this burden of proof. For these reasons, UHS' CON application should be denied.

I. UHS' own calculations from the methodology specified in the Oregon Administrative Rules (OAR) 333-590-0050 repeatedly fail to demonstrate need for its proposed facility.

According to several CON application document submissions from UHS, the company's calculations from the bed need methodology specified in OAR 590 have repeatedly failed to demonstrate need for the proposed facility in Clackamas, Multnomah, and Washington Counties.[2]

UHS' CON application submission from January 5, 2016, concluded that its proposal fails to meet the CON review criteria specified in OAR 590 by showing a bed surplus in the proposed service area. UHS' application notes that there would be overcapacity in the service area until 2030, nearly 15 years from now. UHS *states "If the peak census methodology is utilized, then without the project there is a surplus of beds (38) in the Service Area by 2030*." Additionally, UHS' own projections also showed a projected surplus of 562 beds in year 2020, before NewCo beds are even added.[3]

UHS' CON document submissions from March 11, 2016 also show that the company's proposed facility does not satisfy the need criteria in OAR 590. Following the submission of its January 2016 CON application, the Oregon Health Authority's (OHA) CON office asked UHS to revise its bed need calculations to include utilization data from its Cedar Hills facility.[4] Even after UHS revised its bed need model, the company again failed to demonstrate bed need for its proposed facility noting that *"…the acute model in Step 11 [of OAR 590] does not demonstrate need for general acute care inpatient beds…"*[5]

UHS is proposing a hospital that will serve all adolescent and adult populations; UHS should therefore be able to demonstrate need for all of the populations it intends to serve. Oregon's CON administrative rules specify that the "Burden of proof for justifying need and viability of a proposal rests with the applicant."[6] Yet, UHS' calculations, from the bed need methodology set forth in OAR 590, clearly show that UHS has not met the burden of proof establishing bed need for its proposed 100-bed inpatient facility.

II. UHS' CON proposal fails to meet Oregon's bed need criteria, as specified in OAR 333-590-0050, due to UHS' use of an alternate bed need calculation methodology rife with inconsistencies.

After UHS failed to demonstrate bed need using the regulatory regime methodology specified in OAR 590, UHS adopted its own methodology that deviates from, and in effect, bypasses, the state methodology specified in OAR 333-590-0050. UHS states in its CON application, "*We follow OAR 333-590-0050, but in our opinion, the better methodology is one that focuses on demand and supply of inpatient psychiatric care…"*[7]

But even after UHS was questioned about this method by the state CON office, UHS stated, *"it is our opinion [that] the analysis in OAR 333-590…will generate incorrect conclusions… we believe the superior methodology to establish whether there is projected net need for inpatient psychiatric beds is to specifically analyze the demand and supply of inpatient psychiatric services within the Service Area*."[8] It is highly suspicious that UHS could only conclude that there was a demonstrated need by utilizing its own adopted methodology. Even still, UHS' bed need methodology contains many inconsistencies and misrepresentations. This raises serious doubts as to whether UHS' calculations accurately reflect the bed need in the proposed service area.

1) **The reliability of UHS' alternative methodology is questionable because it inappropriately applies outdated elements from a bed need calculation method used in 2008.**

UHS' alternative methodology utilized the average daily census forecast and applied a 74.3 percent occupancy standard to the forecast, rather than using the peak daily census forecast for the service area. UHS justifies use of this method because it was the method used in 2008. However, while this methodology may have been appropriate in 2008, this may no longer be the case.

Since 2008, many events have occurred that contradict UHS' statement that *"the current application's service area is identical to Cedar Hill Hospital's"* and that *"it is assumed that the alternate methodology [used in Cedar Hills' case] can be applied to the current application."* Since 2008 several major changes have reshaped the healthcare landscape, including the passage of the Patient Protection and Affordable Care Act and related Medicaid expansion in Oregon, as well as the Mental Health Parity and Addiction Equity Act of 2008, resulting in more people receiving coverage for psychiatric services provided in less restrictive therapeutic environments. For example, more people now have mental healthcare coverage and access to preventative services such as depression and alcohol misuse screenings for adults and adolescents, as well as behavioral assessments and autism screenings for children.[9] These early detection services can provide effective treatment before mental health issues manifest into more serious conditions,[10] thereby diminishing the need for intensive services in more restrictive environments like inpatient care and hospitalizations.[11]

In fact, UHS could only conclude that there was a demonstrated need by utilizing its own methodology. UHS states in its January 5, 2016 CON application submission that, "*If the peak Census methodology is utilized (the state method), then without the project there is a surplus of 38 beds in the service are by 2030.*" UHS further states, "*if the alternate methodology* is *used, with* a 74.3 percent *occupancy standard, then there* is *demonstrated need for* 425 *beds, without the project, and* 325 *beds after the proposed 100 bed project is added to supply" by the year 2030.*[12] UHS' decision to ignore a well-defined regulatory regime and substitute with their own methodology, led to a bed need swing of nearly 500 beds.

2) **Perhaps one of the biggest problems with UHS' alternative bed need calculation methodology is that it fails to demonstrate future need for acute care inpatient beds.**

UHS' own calculations from its alternative methodology, as illustrated in its January 5, 2016 CON submission, showed that there's no immediate need for its proposed facility. UHS claims that there's a supposed need for 61 beds in year nine, or 2024. It is not until the following year, in 2025, that there's a need for 132 beds in the service area.[13] Given that there is not an immediate need for beds by UHS' own admission, there are serious doubts about UHS' claims – particularly the claim that "*there are significant current (2015) shortages of inpatient psychiatric beds, well in excess of our request."*[14]

Service Area, Net Acute Care, Inpatient Bed Need, 2015 – 2030 (Continued).

	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Year 14	Year 15
	2023	2024	2025	2026	2027	2028	2029	2030
Service Area Peak ADC	2,989	3,044	3,105	3,153	3,201	3,251	3,301	3,356
Total Service Area Bed Supply	3,394	3,394	3,394	3,394	3,394	3,394	3,394	3,394
Net Bed Need (Surplus) - Before Project	**-405**	**-350**	**-289**	**-241**	**-193**	**-143**	**-93**	**-38**
Proposed Newco Beds	100	100	100	100	100	100	100	100
Net Bed Need (Surplus) - After Project	**-505**	**-450**	**-389**	**-341**	**-293**	**-243**	**-193**	**-138**
Alternative Methodology (Using Non-Peak ADC With 74.3% Occupancy Standard)								
Service Area ADC	2,519	2,567	2,620	2,661	2,703	2,746	2,790	2,838
Gross Bed Demand (ADC Divided by Occupancy Standard)	3,390	3,455	3,526	3,582	3,638	3,696	3,755	3,819
Total Service Area Bed Supply	3,394	3,394	3,394	3,394	3,394	3,394	3,394	3,394
Net Bed Need (Surplus) - Before Project	**-4**	**61**	**132**	**188**	**244**	**302**	**361**	**425**
Proposed Newco Beds	100	100	100	100	100	100	100	100
Net Bed Need (Surplus) - After Project	**-104**	**-39**	**32**	**88**	**144**	**202**	**261**	**325**

Source: CON app packet pdf 116

UHS' claims about dire shortages of inpatient psychiatric beds are also questionable, in light of UHS' revised bed need model from March 11, 2016. UHS' revised, 15-year forecast calculation failed to demonstrate any bed need in the proposed service area using its alternative need methodology.

Table 56. Service Area, Net Acute Care, Inpatient Bed Need, 2015 – 2030.

	Base Year	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7
	2015	2016	2017	2018	2019	2020	2021	2022
Service Area Peak ADC	2,717	2,768	2,821	2,876	2,933	2,998	3,050	3,103
Total Service Area Bed Supply	4,298	4,318	4,318	4,318	4,318	4,318	4,318	4,318
Net Bed Need (Surplus) - Before Project	**-1,581**	**-1,550**	**-1,497**	**-1,442**	**-1,385**	**-1,320**	**-1,268**	**-1,215**
Proposed Newco Beds			100	100	100	100	100	100
Net Bed Need (Surplus) - After Project			**-1,597**	**-1,542**	**-1,485**	**-1,420**	**-1,368**	**-1,315**
Alternative Methodology (Using Non-Peak ADC With 74.3% Occupancy Standard)								
Service Area ADC	2,272	2,316	2,362	2,410	2,460	2,516	2,561	2,608
Gross Bed Demand (ADC Divided by Occupancy Standard)	3,057	3,117	3,179	3,243	3,310	3,387	3,447	3,510
Total Service Area Bed Supply	4,298	4,318	4,318	4,318	4,318	4,318	4,318	4,318
Net Bed Need (Surplus) - Before Project	**-1,241**	**-1,201**	**-1,139**	**-1,075**	**-1,008**	**-931**	**-871**	**-808**
Proposed Newco Beds			100	100	100	100	100	100
Net Bed Need (Surplus) - After Project			**-1,239**	**-1,175**	**-1,108**	**-1,031**	**-971**	**-908**

Service Area, Net Acute Care, Inpatient Bed Need, 2015 – 2030 (Continued).

	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Year 14	Year 15
	2023	2024	2025	2026	2027	2028	2029	2030
Service Area Peak ADC	3,158	3,214	3,276	3,325	3,374	3,425	3,476	3,532
Total Service Area Bed Supply	4,318	4,318	4,318	4,318	4,318	4,318	4,318	4,318
Net Bed Need (Surplus) - Before Project	**-1,160**	**-1,104**	**-1,042**	**-993**	**-944**	**-893**	**-842**	**-786**
Proposed Newco Beds	100	100	100	100	100	100	100	100
Net Bed Need (Surplus) - After Project	**-1,260**	**-1,204**	**-1,142**	**-1,093**	**-1,044**	**-993**	**-942**	**-886**
Alternative Methodology (Using Non-Peak ADC With 74.3% Occupancy Standard)								
Service Area ADC	2,655	2,704	2,759	2,801	2,844	2,888	2,932	2,981
Gross Bed Demand (ADC Divided by Occupancy Standard)	3,574	3,640	3,713	3,769	3,827	3,886	3,947	4,012
Total Service Area Bed Supply	4,318	4,318	4,318	4,318	4,318	4,318	4,318	4,318
Net Bed Need (Surplus) - Before Project	**-744**	**-678**	**-605**	**-549**	**-491**	**-432**	**-371**	**-306**
Proposed Newco Beds	100	100	100	100	100	100	100	100
Net Bed Need (Surplus) - After Project	**-844**	**-778**	**-705**	**-649**	**-591**	**-532**	**-471**	**-406**

Source: UHS responses to OHA questions, 3/11/16, p.77

By adopting its own alternative bed need calculation methodology, UHS decided to substitute its own judgment for 'need' while ignoring the state's carefully crafted statutory and regulatory regime. Not only does UHS bypass the state-required methodology, but the methodology they substituted, as discussed above, fails to adequately demonstrate need in order to justify the approval of its proposed facility.

III. UHS fails to satisfy a majority of the bed need criteria specified in OAR 615.

UHS fails to satisfy the review criteria specified in OAR 615 because firstly, the need for its proposed facility is not justified by OAR 590. Secondly, UHS' explanations of "suppressed demand," for the purpose of demonstrating bed need, are highly problematic. Thirdly, after failing to meet the state of Oregon's statutorily-mandated bed need methodology, UHS inappropriately applies an out-of-state bed need methodology in an attempt to illustrate need for its proposed facility.

1) UHS fails to meet the bed need demonstration criteria, as specified in OAR 333-615, because it failed to meet the bed need threshold specified in OAR 590.

Oregon Administrative Rule 333-615-000 specify that a proposal for new psychiatric beds cannot be approved unless it also meets the bed need demonstration criteria specified in OAR 590. Specifically,

> "As with hospital inpatient beds in general and in other specialties, new psychiatric beds, whether general or subspecialty, except under unusual circumstances with respect to non-availability, access and less costly alternatives, shall not be approved if the net effect of the project would be additional licensed short-term acute inpatient capacity … in the psychiatric service area, unless additional acute hospital beds are justified in that area by the criteria for acute inpatient beds in division 590 of this Chapter."[15]

As discussed above, UHS failed to show that it meets the bed need demonstration criteria specified in OAR 590.

2) **UHS attributes its failure in demonstrating bed need, as specified in OAR 590, to "suppressed demand" – however, its justifications of "suppressed demand" are questionable.**

UHS states in its January 5, 2016 CON application submission that "*utilization rates have been decreasing both in the Service Area and across the entire State of Oregon"* and in particular, use rates for inpatient psychiatric care have been constant in recent years.[16] Yet, UHS argues that there is a need for its proposed facility by making blanket statements about how there is a significant "suppressed demand," which UHS speculates *"is likely the result of hospitals' capacity constraints, not reduced demand for inpatient psychiatric care."*[17] Despite requests by the OHA CON office for UHS to demonstrate "suppressed demand" for their proposed facility following its initial application submission,[18] UHS failed to provide any objective evidence illustrating a "suppressed demand" for geriatric and adolescents inpatient psychiatric beds in the service area or state.

UHS relies on two main studies to show there is a "suppressed demand" for psychiatric care and for its proposed facility in particular. However, these studies are rife with inconsistencies and limitations, making any conclusions or extrapolations drawn from them highly questionable and warranting close examination. For example, UHS uses a Substance Abuse and Mental Health Services Administration (SAMHSA) report from 2008 to justify the need for its proposed facility. This study is problematic because it does not discuss suppressed demand for the service area or for the state, with UHS even admitting that the report "is not Oregon-specific."[19] UHS also draws inappropriate conclusions from the 2008 SAMHSA report. UHS claims that "this report states that just over half of those with a serious mental illness received treatment for a mental health program." Therefore, UHS concludes that utilization data will not reflect actual need for psychiatric care. However, UHS fails to mention that the study was released in 2008 and was based on data from 2004-2008.[20] Since 2008, there have been several changes in the healthcare system, including the passage of the Patient Protection and Affordable Care Act (ACA) and Mental Health Parity laws that have increased access to care.[21]

New, innovative models of treatment may impact the provision of mental healthcare.

Academics have noted that most proposed solutions for increasing psychiatric care have focused solely on increasing available inpatient psychiatric hospital beds, [22] rather than emergency care alternatives that could provide prompt access to treatment and reduce the need for many hospitalizations.[23] 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.[24]

The treatment model at the Unity Center in Portland, Oregon, which is set to open in early 2017,[25] is based on a proven successful model that aims to avoid psychiatric hospitalization altogether by focusing on immediate treatment at the outpatient level of care.[26] The Unity Center follows the "Alameda Model," a behavioral health initiative implemented at five community hospitals in Alameda County, California.[27] A study conducted on the Alameda Model found that psychiatric emergency services provide assessment and treatment that may stabilize over 75 percent of the crisis mental health population at this level of care, resulting in reduced demand for inpatient psychiatric beds[28] – the exact type of beds UHS proposes with its new facility.

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.

3) After finding that the methodology specified in OAR 590 did not show a need for its proposed facility, UHS attempts to circumvent Oregon State's CON regulatory regime by employing a methodology used in Washington State.

Oregon Administrative Rule (OAR) 333-615-000 specifies that a proposal for new psychiatric beds cannot be approved unless it also meets the bed need demonstration criteria specified in OAR 590. Specifically,

> "As with hospital inpatient beds in general and in other specialties, new psychiatric beds…shall not be approved … unless additional acute hospital beds are justified in that area by the criteria for acute inpatient beds in division 590 of this Chapter.[29]

As discussed above on pages 4-7, UHS failed to show that it meets the bed need demonstration criteria specified in OAR 590. Only after UHS determined that the state mandated methodology specified in OAR 590 did not support the need for its proposed facility did UHS utilize an out-of-state methodology (from Washington) in an attempt to circumvent Oregon rules and cobble together a justification for its proposed facility.

According to UHS, the methodology employed by Washington is based upon four main steps: 1) Estimating the service area population; 2) using a "reasonable" bed-to–population ratio, multiplying the population from step one; 3) compiling the bed counts from existing providers for similar services; and 4) subtracting the supply from the estimated need calculations in step 2.[30]

UHS' application of Washington's bed need determination methodology to an application in Oregon is inappropriate and problematic. The Washington method is based upon a "bed-to-population" ratio that is very specific to Washington, which should be enough of a reason to reject the use of this ratio in a completely different service area. This ratio also takes into account "suppressed need" that may exist in Washington but may not exist in Oregon. Additionally, the projections of bed supply and bed need in the service area using the Washington methodology does not take into consideration the historical utilization of those beds at existing provider facilities, as laid out in the Oregon rules, and ignores occupancy rates of those beds.[31]

As stated earlier, in the face of failure of the proposal to meet the established rules in Oregon, UHS has chosen to completely ignore Oregon's regulatory regime. Rather, UHS has chosen to reference inapplicable rules from a different state in a vain attempt to justify the construction of its proposed facility in Oregon. UHS is applying for approval to establish a psychiatric facility in the state of Oregon, not Washington, and should therefore follow the regulatory regime used in Oregon. UHS concedes that their proposal fails to meet the Oregon rules on several levels and therefore the proposal should be denied.

IV. Given UHS' poor quality of care record, UHS fails to provide reasonable assurances that its proposed facility will provide "quality psychiatric inpatient care," and therefore fails to meet the criteria specified in OAR 615.

Quality of Care Criteria (333-615): *In evaluating the relationship of any proposed project to the existing health care system of the service area, the division shall address possible compromising of quality of care. The division shall consider the conformity to state safety and program standards of both the proposed project and existing, related health services now provided to the population of the service area…and the feasibility that the proposed project will be sufficiently efficient to maintain quality standards at reasonable cost…*

All proposed psychiatric beds must meet the licensure, certification and accreditation criteria of the Public Health Division, Medicare and the Joint Commission on Accreditation of Health-care Organizations, as appropriate…

Oregon regulations note that *"due to Oregon's population size and distribution, the need for subspecialty services is limited, and the need for local access to quality general psychiatric inpatient care is great. Therefore, the number of large, multispecialty, freestanding units feasible in Oregon is limited."*[32] The emphasis on whether UHS will provide quality care at the proposed facility is essential in reviewing its CON application.

UHS' application emphasizes the need for services, and states that "current psychiatric facilities are significantly overburdened and as such, cannot reasonably be expected to provide sufficient, essential services to current and new patients in a timely manner…and there is only one solution for inpatient bed shortages: add beds…"[33] However, UHS fails to provide any details on the quality of services it will provide to the populations who will fill these beds.

As the largest provider of inpatient behavioral health services, UHS sets the standard for quality patient care and that standard unfortunately, is unacceptably low. UHS has a disturbing record of failing to meet state licensure and certifications and Medicare program standards. What's more, its Joint Commission-accredited facilities have had serious quality of care breakdowns. UHS' breakdowns in care have been so troubling, that even other healthcare providers have taken notice and spoken out publicly about them.

1) **UHS facilities in communities across the country have a record of failing to comply with state safety and program standards and licensing requirements.**[34]

UHS states in its CON application that, *"Due to our experience…UHS is confident that we are capable of meeting patient needs in a timely, efficient, and cost-effective manner, and most importantly, delivering accessible, high quality care."*[35] However, a close examination of UHS' record of noncompliance with state safety requirements is troubling.

In a review of UHS operations across the country, it is clear that many UHS facilities have violated state licensing requirements related to safety and patient care, and have risked license revocations for noncompliance. Examples include:

- Virginia: UHS' Poplar Springs Hospital in Petersburg, VA, has had the highest number of licensing violations among all private, freestanding psychiatric hospitals in Virginia during the period of Jan 1, 2012 through March 15, 2016. In 2015 alone, the facility was repeatedly cited for violations related to: patient attempted suicides, failure to provide one-to-one observation when indicated, failure to provide routine 15 minute observations as suicide risk assessment indicated, failure to provide self-harm treatment plans, and failure to timely complete suicide risk assessment when patients presented positive for suicide ideation with a plan.[36]

- Texas: UHS' Timberlawn Mental Health System in Dallas, TX, is another notable example. In March 2016, the Texas Department of State Health Services moved to revoke the facility's license and impose a record $1 million fine. These rare, drastic enforcement actions were taken only after regulators worked with Timberlawn for years to give the facility multiple chances for improvement. State officials said safety problems at Timberlawn, including a suicide and violent fights among patients, left them little choice but to revoke its license. State officials went on to say *"The list of serious issues kept stacking up, and we had to draw the line…it's rare that we get to this point with a hospital. Safety has to be paramount."*[37] These patient safety issues included several failures in patient supervision that led to a suicide, outbreaks of violence, and an incident in which the hospital

lost track of six patients.[38] Failures in addressing these patient safety issues were serious enough to prompt the Centers for Medicare and Medicaid (CMS) to terminate Timberlawn's participation in the Medicare program in August 2015.[39] It is clear that providing a therapeutic environment and providing appropriate services can be difficult for this patient population, however health systems can do this without having incidents such as those at Timberlawn. For example, the nonprofit Johns Hopkins Hospital in Baltimore has admitted at least 100,000 patients over nearly four decades, but not one has committed suicide at the facility. This is because the hospital has invested millions of dollars over many years to boost staffing so that it can screen and constantly monitor patients deemed at high risk for suicide.[40] In contrast, UHS has repeatedly been the subject of news reports, lawsuits, and state and federal regulatory citations for failing to provide a safe care setting to prevent suicide incidents within their facilities.[41]

- North Carolina: Before UHS voluntarily closed Keys of Carolina residential treatment facility in Charlotte, NC, in February 2013, the facility was facing a list of violations from the North Carolina Department of Health and Human Services and a $6,000 administrative fine for violations of laws regarding the "protection from harm, abuse, neglect or exploitation" of patients. State officials said conditions in the facility were "found to be detrimental to the health and safety of the clients" and were in the process of revoking the facility's license.[42]

- Pennsylvania: UHS' Friends Hospital's inpatient program in Philadelphia, PA, located less than an hour from UHS corporate headquarters, is operating under a provisional license through September 2016 due to deficiencies under regulations governing adequate treatment and treatment plans, upholding patient rights to a "humane physical and psychological environment," and staff training and background checks.[43] Provisional licenses, which are valid for a period of no more than six months, are issued when there are numerous deficiencies or a serious specific deficiency in compliance with applicable statutes, ordinances or regulations.[44] A provisional license cannot be renewed more than three times.[45] If a healthcare provider receives three consecutive provisional licenses and noncompliance continues thereafter, the state can initiate a licensure revocation action for failing to meet the conditions set forth in the provisional licenses.[46]

  Other UHS facilities in UHS' home state of Pennsylvania have also had a history repeated licensure issues. Fairmount Behavioral in Philadelphia, PA, was issued a third consecutive provisional license in November 2014 after an unsupervised patient eloped.[47] Previously in December 2013 the facility was issued a provisional license for patient rights and treatment plans and care violations,[48] while in June 2014, Fairmount was issued another provisional license for repeat deficiencies related to adequate treatment, treatment plans, and patient rights.[49]

Given these examples of license compliance issues, UHS' ability and willingness to comply with all state laws and regulations designed to ensure quality patient care and patient and worker safety are highly questionable. The sheer number of times regulators had to expend time and resources via site inspections and corrective action planning to ensure UHS followed basic health and safety standards is troubling.

UHS also cannot provide reasonable assurances that, in the event of breakdowns in care that compromise patient and worker health and safety, UHS will immediately and adequately address the issue. For example, UHS' responses to the Oregon Health Authority's (OHA) inquiries about "dangerously poor care and unsafe conditions at Universal Health Services (UHS) facilities around the country" are very telling. When the OHA asked UHS to address a *Dallas Morning News* report, "Danger in the Psych Ward" which profiled breakdowns in care at UHS-operated facilities nationwide, some involving patient deaths, UHS denied and downplayed the seriousness and shocking nature of the problems profiled. UHS stated, *"The reporter took isolated matters at a small, minority of facilities and attempted to aggregate such data to form a conclusion which is*

not accurate nor supported by an objective view of all the data relating to UHS…"[50] UHS went on to say *"…irregular and unpredictable events occasionally occur including instances of alleged non-compliance with regulatory requirements. Due to the large number of UHS facilities, we are subject to hundreds of surveys per year by regulatory agencies…"*[51]

Dr. Peter Breggin, a New York-based psychiatrist who has consulted for the National Institute of Mental Health and the commission that accredits hospitals, disagrees and commented about UHS: "*The large number of investigations aimed at misconduct within this hospital system is appalling.''* He added that, "*It is especially frightening that these deviations are occurring in the largest network of psychiatric hospitals in the country.''*[52]

Given these findings, there is reason to believe that UHS will continue this troubling pattern of conduct at its proposed facility in Oregon, thus, giving rise to serious doubt whether UHS' proposed facility will deliver healthcare in accordance with all applicable state requirements to ensure safe and effective care to the public.

2) UHS facilities in communities across the country have a record of failing to comply with the conditions of Medicare program participation.

UHS states in its CON application that "*Cedar Hills Hospital has CMS (Center for Medicare and Medicaid Services) and state accreditation"* which are *"important for measuring standardized care delivery and quality of care."*[53] However, a close examination of UHS' record shows a disturbing pattern of serious noncompliance with Medicare and Medicaid program standards at UHS facilities across the country. This noncompliance is disturbing, given that these are basic safety standards expected of all hospitals receiving federal funds to care for society's most vulnerable populations, including the poor, the elderly, and disabled. Most disturbing of all is that UHS has shown that, despite being given multiple chances for improvement, UHS management has been unable and/or unwilling, to remedy identified patient care or regulatory deficiencies at its troubled facilities.

In response to quality of care concerns raised by Congressmen Davis (D-IL) and Kennedy (D-MA), CMS revealed that in the past four years, 44 UHS facilities were cited by government inspectors for dangerously poor care or unsafe conditions.[54] *"Since January 2012, CMS has identified 50 Condition-level findings of non-compliance and eight (8) findings of … immediate jeopardy in 44 UHS Medicare-certified hospitals. The findings were identified during [state agency] reviews in response to complaints received from the public about the quality of care provided in a particular facility.*[55] Condition-level findings mean that serious deficiencies in quality of care and/or safety were identified, while immediate jeopardy findings involved situations in which the provider's non-compliance has caused, or is likely to cause, serious injury, harm, impairment or death.[56] According to an analysis by *The Dallas Morning News*, these 44 facilities, spanning 23 states, represented more than a quarter of the 154 UHS hospitals receiving taxpayer money to treat the poor and elderly.[57] Some notable examples have been described below.

- Texas: On August 14, 2015, the Centers for Medicare & Medicaid Services (CMS) terminated UHS' Timberlawn Mental Health System, a facility owned by UHS since 1996 located in Dallas, TX, from the Medicare program for "chronically unsafe conditions that posed "an immediate jeopardy to patient health and safety."[58] David Wright, CMS administrator for Region 6 which oversees Texas, stated, "We have an obligation to not continue to fund a facility that fails to meet the basic obligations for safety."[59] Wright further stated that it is "very, very rare" for a healthcare provider to be terminated from the Medicare program…Probably over 99 percent of the facilities that we issue notice of termination come back into compliance."[60] Yet in Timberlawn's case, despite multiple chances for improvement, CMS continued to find violations at Timberlawn, including inadequate supervision of suicidal patients,[61] failures in removing ligature risks (which resulted in a patient death),[62] unsafe

boarding of patients,[63] understaffing,[64] and patient-on-patient assaults.[65] The Texas Department of State Health Services also took serious issue with Timberlawn's chronic safety and patient care issues and in March 2016, moved to revoke the facility's license and impose a record $1 million fine.[66]

- Texas: UHS' Texoma Medical Center, a facility owned by UHS since 2007 located in Denison, TX, narrowly avoided termination from the Medicare and Medicaid program[67] by entering into a "Systems Improvement Agreement" (SIA) with CMS in early 2015.[68] An SIA is a type of stopgap measure for avoiding Medicare termination and loss of federal funding, in which the healthcare provider agrees to make improvements within a specified time period using independent safety monitors.[69] Texoma's agreement aimed to address serious deficiencies identified during a January CMS inspection, which found that Texoma's patient care and discharge procedures posed an "immediate jeopardy" to patient health and safety. The deficiencies refer to an unsafe discharge of a patient, who during his hospitalization at Texoma had expressed a plan of jumping off a bridge. Despite this, upon release the patient was directed by UHS to take a 200-mile bus ride home to Longview, Texas. According to a CMS report, the patient was found deceased under a bridge in Dallas after falling or jumping off within 24 hours of discharge.[70,71]

- Missouri: In April 2011, CMS notified UHS' Two Rivers Psychiatric Hospital, a facility owned by UHS since the 1990's located in Kansas City, MO, that the facility would be terminated from the Medicare program due to identified deficiencies of such a serious nature that placed patients' health and safety at risk.[72] The termination stemmed from a patient suicide incident, in which CMS faulted the facility for failing to monitor a suicidal patient, failures in providing life-saving interventions, and failures in safeguarding patients from potentially hazardous items and devices.[73] Two Rivers was able to abate the termination through court proceedings and by agreeing to a second "systems improvement agreement" (SIA) in just three years. Problems at this facility stemmed back to 2008, when Two Rivers first faced termination following an army soldier's suicide. Two Rivers fought the first termination decision in court, received an SIA as part of the settlement, but failed to achieve compliance under the first SIA.[74]

Despite the alarming number and range of safety and patient care failures at UHS facilities across the country,[75] a sampling of which have been highlighted above, UHS refuses to acknowledge the seriousness of its breakdowns in care and characterizes them as "highly isolated" incidents. UHS states that its patient safety and care issues are "ill-supported by documented evidence,"[76] even though numerous incident and deficiency reports have been issued to its facilities for serious violations of state and federal patient care and safety rules and regulations.[77] Furthermore, UHS states that such regulatory actions and incidents are not unique to UHS facilities.[78] According to an independent analysis by *The Dallas Morning News*, however, federal data suggests that UHS has a higher-than-average rate of problems. For example, federal inspectors investigating complaints found serious problems and violations at 8.4 percent of UHS facilities in 2014,[79] which is nearly three times the national average of 3 percent.[80]

3) UHS' Joint Commission-accredited facilities have had serious breakdowns in patient care, with some incidents even involving patient deaths.

UHS states in its CON application that NewCo will voluntarily apply for and maintain Joint Commission accreditation, which requires the accredited hospital to maintain policies and procedures assuring coordination of care and treatment and discharge planning to assure patients receive the least restrictive and appropriate level of care, based on their needs.[81] However, serious breakdowns in care at UHS' Joint Commission-accredited facilities raise serious concerns about whether UHS' proposed facility will ensure safe and adequate care to the public.

For example, UHS' NDA Behavioral Health System (FKA the National Deaf Academy in Mount Dora, FL) closed in the spring of 2016, following several civil lawsuits alleging negligence and abuse of children at the facility, and investigations by the U.S. Dept. of Health and Human Services Office of the Inspector General (OIG), U.S. Dept. of Justice (DOJ), and the Federal Bureau of Investigation (FBI).[82] Three NDA patients died between 2009 and 2014 in allegedly negligent circumstances, and one former NDA employee told reporters she called an abuse hotline a dozen times in just one six-week period. Another former employee told reporters about a severely disabled boy so desperate to communicate what was happening at the facility that he wrote, "Mom, please help" in a card he sent home for Mother's Day.[83] However, despite these highly disturbing developments, this facility was accredited by The Joint Commission in 2013 and remained accredited until its closure earlier this year.

UHS also touts its "respected" quality of care record by asserting that a number of UHS facilities have achieved "Top Performer status" from the Joint Commission.[84] This status recognizes accredited hospitals that "attain excellence on accountability measure performance" on a small set of clinical processes.[85] However, we note that the Joint Commission itself advises consumers that "Top Performer status" is not "a reflection of the overall care at an organization" and does not ensure patient outcomes.[86] In fact, since January 2012, CMS has identified fifty (50) Condition-level findings of non-compliance and eight (8) findings of immediate jeopardy in 44 UHS Medicare-certified hospitals. The findings were identified during Survey Agency reviews in response to complaints received from the public about the quality of care provided in a particular facility.[87] Condition-level findings mean that serious deficiencies in quality of care and/or safety were identified, while immediate jeopardy findings involved situations in which the provider's non-compliance has caused, or is likely to cause, serious injury, harm, impairment or death.[88] Of those 44 UHS facilities, more than half (or 25 facilities) have been given "Top Performer status" at one point or another since 2012.[89] We only have to look to two "Top Performer" UHS facilities in Texas to see that "Top Performer" status does not ensure high quality care for patients.

UHS' Timberlawn Mental Health System, which has been discussed above, received Joint Commission Top Performer status in 2013[90] and 2014[91] but was terminated from Medicare due to patient safety issues on August 14, 2015. The *Dallas Morning News* reported that the facility had "chronically unsafe conditions that have led to one woman's death and other patients' assaults," despite multiple chances to pass inspections between December 2014 and July 2015.[92,93]

Texoma Medical Center (TMC) also achieved Joint Commission Top Performer status in 2013.[94] It even received a UHS Quality Award for "Overall top performance in core measures and patient satisfaction."[95] However, as discussed above, the facility was under a Systems Improvement Agreement with CMS in lieu of being terminated from the Medicare program,[96] which was only lifted in July 2016.[97] In addition to the patient who was discharged with a 200-mile bus ticket and was found less than 24-hours later dead under a bridge, CMS also cited TMC Behavioral Health Center for deficiencies related to two suicide attempts in the facility in September and July of 2014.[98] A CMS representative said that in order to avoid termination, TMC Behavioral Health Center was required to *"make sustainable improvements in complex quality, cultural, policy and procedural deficiencies."*[99]

Many of UHS' facilities designated as Joint Commission "Top Performers" on quality are also currently facing a coordinated federal fraud investigation by the U.S. Department of Health and Human Services and the U.S. Department of Justice. This investigation includes both a civil and criminal component, and in February of 2015, UHS disclosed that the civil aspect of the coordinated probe is a False Claims Act investigation focused on billings submitted to the government.[100] In 2015, a total of 38 UHS behavioral facilities were given a Joint Commission "Top Performer designation." Of those 38, nearly 20 percent (7 facilities) are involved in ongoing fraud investigations. The facilities under investigation include: Wekiva Springs in Florida; Hartgrove

Hospital, Riveredge Hospital, and Streamwood Hospitals in Illinois; Friends Hospital, Roxbury Treatment Center, and Meadows Psychiatric Center facilities in Pennsylvania.[101]

UHS' patient care and safety record at its Joint Commission-accredited facilities is troubling, since the company often touts Joint Commission-accreditation as a marker of quality care. Equally troubling is the fact that UHS fails to address care breakdowns at its Joint Commission-accredited facilities, all the while using the veil of Joint Commission-accreditation or Joint Commission "Top Performer" designation to justify its "compassionate" and "high" quality of care. For example, in June 2016 UHS stated *"Over the past four years, 83 UHS facilities (both acute and psychiatric) have been designated Top Performers in Key Quality Measure by the Joint Commission. This list included 19 UHS facilities in Texas…"*[102] Yet, in recent cases involving UHS' facilities in Texas, UHS failed to correct cited deficiencies identified by regulators until the facilities were faced with revocation of state and federal funding for failing to meet basic health and safety requirements.[103, 104] For these reasons, we remain unconvinced that UHS and its proposed facility will take the appropriate actions necessary to immediately and effectively remedy any quality of care issues that should occur at its proposed facility, regardless of whether the facility will be Joint Commission-accredited.

4) Other Healthcare Providers have raised serious concerns about UHS as an operator.

Even other healthcare providers have raised concerns about UHS' quality of care record. For example, UHS recently sought CON approval from Washington to establish a 100-bed psychiatric facility in Spokane, Washington. During that CON review process, experienced behavioral health organizations raised serious concerns about UHS' patient care and legal compliance record. Signature Healthcare, for example, raised the issue of UHS' "failure to disclose [an] adverse history of poor quality of care."[105] Signature stated, "UHS describes their operation as having an 'impressive record of achievement.' However,

> "[T]here were required disclosures by Fairfax Behavioral Health of CMS actions resulting in suspension of Medicare and Medicaid funding, probation for several hospitals and notice that Universal Health Services is the subject of ongoing civil and criminal investigations involving approximately 20 hospitals by the Department of Justice. Attachment 20 provides examples of actions that should have been reported by Providence Health System-Fairfax Behavioral Health. Certificate of Need rules require that applicants disclose such activities as well as providing an action plan on how such deficiencies can be avoided in proposed projects." [106]

Another behavioral health organization, Springstone, LLC, also raised similar concerns. Springstone stated,

> "[UHS'] NEWCO neglected to inform the Department about federal sanctions and settlements [that] have been imposed on or entered into for each of its members. Failure to disclose means that the Department cannot at this time ask questions to clarify, and more importantly means that the Department cannot find that the project meets applicable quality standards."[107]

UHS' record of failing to meet state licensure and certifications and Medicare program standards, as well as the troubling quality of care breakdowns at its Joint Commission-accredited facilities, coupled with its history of failing to disclose these issues to state authorities when seeking Certificates of Need (CON), is highly disturbing. As noted above, these violations of safety rules and standards often have devastating effects on the patients entrusted in UHS' care. These repeated breakdowns in care raise further doubt about whether UHS and its proposed facility will be equipped to deliver healthcare in accordance with all applicable state and federal requirements designed to ensure the safety and well-being of patients, workers, and surrounding communities.

Given UHS' operating record, the UHS CON proposal will not result in an improvement in patients' reasonable access to care.

<u>Access to Care Criterion (333-580)</u>: Will the proposed project result in an improvement in patients' reasonable access to services? The applicant will 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… [108]

UHS claims in its CON application that approval of their proposal "will improve access for psychiatric patients in the Service Area and will also act to relieve capacity constraints now being observed [at existing providers." [109] However, UHS' record as an operator, especially with regard to fulfilling charity care requirements,[110] denying behavioral healthcare to those in need,[111] and shuttering of facilities[112] in low income areas, highlights concerns about "potential problems of accessibility" at the proposed facility.

I. UHS' CON application fails to adequately explain how the facility will treat indigent, uninsured, and public-pay patients.

UHS fails to address how its proposed facility intends to treat patients who cannot pay or have difficulties paying for care. The issue of facility accessibility becomes even more salient in light of UHS' vague responses when pressed by the OHA about how it would address providing care to lower income patients such as Medicaid or indigent populations. The most notable example of this was when UHS stated that it "fully intend[s] for [their] proposed facility to operate in the same manner as Cedar Hills,"[113] but provided scant discussion about what this actually means for care accessibility for all populations regardless of their ability to pay.

In fact, UHS fails to adequately disclose Cedar Hills Hospital's operational record in providing care to low income populations. For example, UHS states that the majority of Cedar Hills Hospital's patient population is comprised of adults aged 18-64 years.[114] Given that this patient population has historically been precluded from being covered by Medicaid, due to the Federal IMD ("Institution for Mental Diseases") exclusion,[115] the care provided to this population should therefore either be covered by private insurers or by UHS through charity care. However, UHS' CON application submissions fail to provide any data, or any objective evidence, showing Cedar Hills Hospital's historical payor mix, or the amount of charity care it has provided for its patient populations, compared to its peers. UHS' failure to disclose this data, or provide any substantive discussion addressing these topics, raises serious concerns that Cedar Hills' payer mix may be dominated by insured patients, or those with coverage from payers such as private insurers or Medicare. We have serious concerns that Cedar Hills Hospital caters primarily to insured patients, who likely have greater access to care by simply being insured.

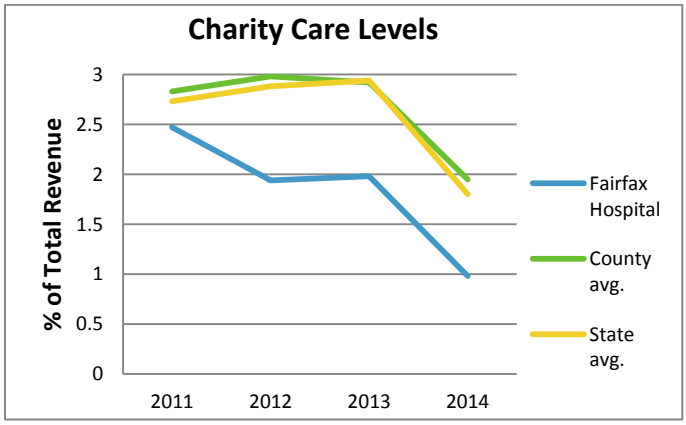
Additionally, throughout its CON application UHS makes vague blanket statements that its proposed facility will alleviate capacity constraints experienced by existing providers,[116] all while providing great detail about how the proposed facility will actually benefit the current operations of its own facility, Cedar Hills Hospital. UHS states in its CON application that *"Cedar Hills…has a 93 percent occupancy…at these occupancy levels not all patients needing access receive it. The new hospital would improve this…and…will have no adverse financial impact on Cedar Hills."*[117] This statement suggests that the purpose of this new facility is to capture the overflow of patients from Cedar Hills.

In light of UHS' statements about how the new facility will alleviate Cedar Hills' high occupancy,[118] coupled with the vicinity of the proposed facility to Cedar Hills,[119] as well as our concerns regarding Cedar Hills Hospital's patient and payer mix, we have reason to believe that UHS will likely funnel patients from its Cedar Hills facility to the new facility. As a result, we are concerned that the proposed facility will enable UHS to continue serving those patients who can pay for services, while neglecting all others. Thus, UHS will avoid providing its fair share of indigent care for service area populations. Despite UHS representations in its CON application submissions, its proposed facility will do little to provide care to those populations who do not have access to care but need it the most, including indigent and homeless populations in the service area.

II. UHS provides less charity care than their CON application and policies suggest, raising doubt about its willingness to care for indigent patients.

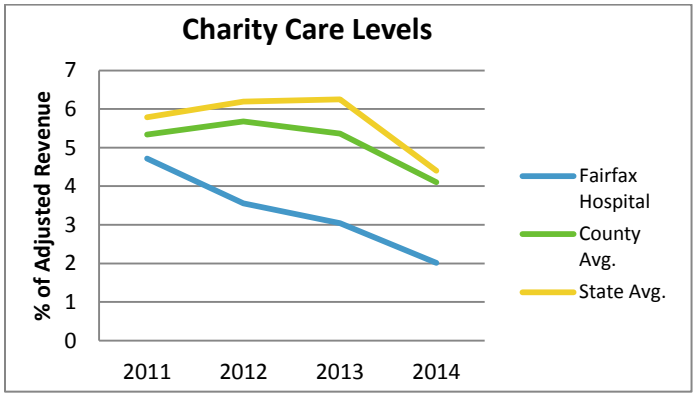
UHS states in its CON application that the proposed facility's charity care policy will mirror that of its Fairfax facility in Kirkland, Washington, noting that "NewCo's charity care policy will follow the same form and include similar content."[120] However, a closer examination of Fairfax's provision of charity care suggests that the facility has not been adequately fulfilling its charity care requirements. In fact, UHS facilities have a record of providing little charity care, and refusing to take responsibility for indigent patients.

While UHS has previously claimed that its Fairfax Hospital provided charity care – defined by Washington regulations as the percentage of total revenue[121] and the percentage of adjusted revenue[122] – above its regional averages for the last several years,[123] a closer examination suggests otherwise. Despite citing Washington Department of Health Charity Care Report data to support their charity care claims, UHS actually omits charity care data from Harborview Hospital, a public hospital, in order to arrive at their conclusion. When the charity care figures from Harborview Hospital are included, the level of charity care provided by Fairfax Hospital between 2011 and 2014[124] is actually well below its County and State averages. As you can see in the figure below, Fairfax's level of charity care, as a percentage of its adjusted revenue, is notably lower than its County and State averages.[125]



Year	Fairfax Charity Care % of Total Rev.	County Charity Care % of Total Rev.	State Charity Care % of Total Rev.
2011	2.47%	2.83%	2.73%
2012	1.94%	2.98%	2.88%
2013	1.98%	2.92%	2.94%
2014	.98%	1.95%	1.8%

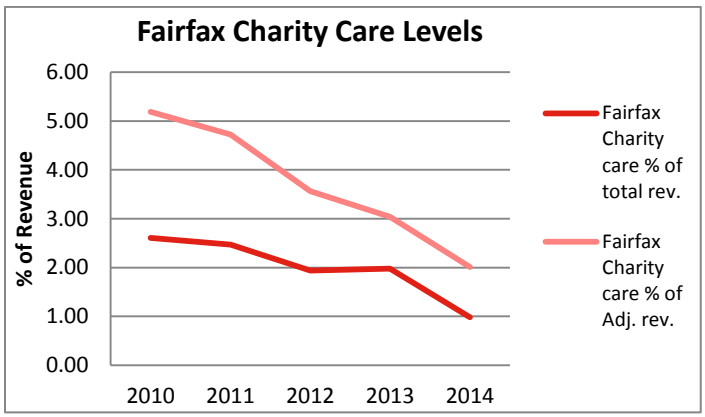
Note: There was a notable drop in 2014 charity care levels for the state as a whole, which the state of Washington attributes to ACA implementation. Despite the downward trend, Fairfax's charity levels were again well below the county and state averages.



Year	Fairfax Charity Care % of Adj. Rev.	County Charity Care % of Adj. Rev.	State Charity Care % of Adj. Rev.
2011	4.72%	5.34%	5.79%
2012	3.56%	5.68%	6.19%
2013	3.04%	5.36%	6.25%
2014	2.01%	4.1%	4.4%

Source: WA Department of Health's Charity Care Report data from 2011-2014

Further examination of the Washington Department of Health's Charity Care Report data also shows that since UHS' takeover of Fairfax Hospital's operations in November 2010, the level of charity care provided by Fairfax has been declining.



Year	Fairfax Charity care % total rev.	Fairfax Charity care % Adj. rev.
2010	2.61%	5.19%
2011	2.47%	4.72%
2012	1.94%	3.56%
2013	1.98%	3.04%
2014	.98%	2.01%

Source: WA Department of Health's Charity Care data from 2010-2014

It is surprising that UHS' charity care expenditures are so small, especially since the company has more than enough financial capacity to exceed state and local average levels of charity care at its facilities across the country. UHS' behavioral healthcare business line is highly profitable. In 2015 alone, UHS reported $9.0 billion in revenue and more than $680 million in net profit.[126] For every dollar that the behavioral health business line generates in revenue, UHS takes nearly a quarter of that in profit.[127] UHS has the financial ability to support, and even exceed, levels of charity care in the communities in which its facilities are located. Yet, it has chosen not to do so.

This pattern of behavior, coupled with UHS' statements that the proposed facility's charity care policy will mirror that of its Fairfax facility in Kirkland, Washington, is troubling. These concerns raise serious questions as to whether the proposed facility will provide adequate amounts of charity care to our community's indigent populations.

III. UHS facilities have been at the center of troubling regulatory citations for turning away patients in need of care from its facilities.

In order to determine whether residents would have adequate access to the proposed services, the department will review the applicant's charity care policies. These policies present the proposed facility's guiding principles around accepting patients for admission, and aim to provide assurances regarding access to treatment. Yet, UHS' policies raise serious concerns whether all persons in need of medically necessary care will have access to it regardless of ability to pay.

The State CON office even questioned UHS' policies. Specifically, the wait-listing policy currently utilized at Cedar Hills raises concerns. The CON office stated,

> "Basically patients are sent away with a signed "Crisis/Safety" form and told to come back for an appointment the next day. It contains the following provision: "if it appears that there will not be a bed available within 48 hours, or the patient is in need of immediate services, the Assessment Counselor will work with him/her to find an alternative placement." If adopted by the proposed hospital, it appears that this would not fulfill its duties under EMTALA."[128]

The state's questioning of these policies is reflective of UHS' general failures in fulfilling its obligations under EMTALA.

In fact, in the last few years, federal regulators have cited several UHS facilities in communities across the country for violating provisions of the federal Emergency Medical Treatment and Labor Act (EMTALA), which is federal law that aims to ensure that all hospital providers receiving federal funds provide emergency or stabilizing treatment to patients regardless of their ability to pay.[129] CMS issued these citations after finding that UHS denied or delayed behavioral health care to patients in need of those services. This is deeply concerning since many of the policies and practices governing the day-to-day operations of the proposed facility are modeled after existing UHS facilities. Examples include:

- Florida: In May 2016, UHS' Sun Coast Behavioral Health in Bradenton, FL, was issued a $1,000 state fine from the Agency for Healthcare Administration for turning away a patient in need of care. The fine was issued in relation to an incident in which the "facility failed to ensure emergency services and care was provided to patients presenting to the hospital…" The facility's Risk Manager and Administrator were interviewed and confirmed that the facility failed to provide assessment and treatment of the patient.[130]

- Texas: In May 2013, CMS cited UHS' Cypress Creek Hospital in Houston, TX, for EMTALA violations after the facility turned away four patients by informing them they did not have any open beds. Three of the four patients had even notified staff of their suicidal ideations upon presenting to the facility. CMS found that the facility failed to assess the patients to determine whether they had emergency medical conditions.[131]

- Georgia: In October 2012, CMS cited UHS' Peachford Behavioral Health System in Atlanta, GA, for delaying a patient's examination or treatment in order to seek additional information on the patient's insurance/payor source, and refusing to accept the patient even when the facility had the specialized capabilities and capacity to treat his/her emergent psychiatric condition.[132]

- Texas: In May 2011, CMS cited UHS' West Oaks Hospital in Houston, TX, for failing to abide by EMTALA provisions when it failed to conduct a medical screening exam for a patient (who had overdosed, fallen on his head, and started foaming at the mouth) after he arrived in the hospital's parking lot. Hospital personnel went outside to assess the patient, but despite the patient's emergent conditions, CMS found that *"[t]here was no attempt to escort the patient inside the hospital for a medical exam nor was there any attempt to get a physician to come out to the SUV to assess the patient. Instead, they depended on 911*." CMS also cited the facility after finding that the facility failed to certify the risks and benefits of the patient's transfer and failed to ensure that the receiving hospital would accept the patient.

- Florida: In April 2011, CMS cited UHS' Fort Lauderdale Hospital in Fort Lauderdale, FL, for noncompliance with EMTALA regulations requiring hospitals to perform emergency medical screenings and treatments regardless of patients' insurance status or ability to pay. CMS found that an autistic child exhibiting aggressive behaviors was denied an emergency medical exam and stabilizing treatment because the child's insurance provider did not contract with the hospital. The hospital also did not provide the child with an appropriate transfer to an alternate facility for care.[133]

In the examples above, UHS facilities were cited by regulators for violating various provisions of EMTALA, which aims to ensure that all hospital providers receiving federal funds provide emergency or stabilizing treatment to patients regardless of their ability to pay.[134] These regulatory violations and deficiencies in providing this vital treatment do not give the community reasonable assurance that UHS will provide

adequate access to treatment, and thus, raise concerns about the suitability of UHS as a provider to fulfill the psychiatric bed need of the proposed service area of Multnomah, Clackamas, and Washington.

IV. UHS' record of shuttering behavioral health facilities raises concerns about its commitment to maintaining services and providing healthcare access for medically needy communities.

UHS has a record of shutting down facilities after regulators have identified patient safety or other care breakdowns.[135] Some of these facilities are located in low income areas, with high percentages of "public-paid patients."

UHS' record of choosing to close, or threatening to close, its behavioral health facilities after regulators uncover serious patient care problems is highly troubling. Between 2011 and 2015 alone, UHS closed or sold (at least) 23 of its behavioral health facilities,[136] many of which abruptly ceased operations after state or federal regulators found patient care or other regulatory compliance issues.[137] Over the same 5-year period, UHS' behavioral health facilities generated an average annual income before taxes (or profit) of $886 million,[138] which suggests UHS had the resources to address its cited deficiencies.

Troubling still, is that some of these shuttered facilities were often located in communities with vulnerable patients, large numbers of uninsured, and high levels of poverty. These practices raise significant questions about whether UHS will be an appropriate provider to provide additional psychiatric services in Multnomah, Clackamas, and Washington counties. Previous examples include:

- Texas: On August 14, 2015, the Centers for Medicare and Medicaid Services (CMS) terminated Timberlawn Mental Health System in Dallas, TX, from the Medicare program due to "deficiencies that represented an immediate jeopardy to patient health and safety"[139] and repeated failures in remedying safety risks.[140] Shortly thereafter, Timberlawn filed a letter under the Federal Worker Adjustment and Retraining Notification Act, or WARN, disclosing it could close its operating units and all affiliated programs and permanently lay off 160 employees.[141] CMS argued that Timberlawn could bear the expense of keeping the facility in operation following termination from Medicare due to its parent company's, or UHS' remarkable profitability. In fact, in 2015 alone, the UHS reported over $9 billion in revenue and more than $680 million in net profit.[142] Yet Timberlawn officials said "it does not matter…that the parent company can afford to fund the hospital, if it will not…"[143] This potential closure would have had a dramatic impact upon the community it serves. *The Dallas Morning News* reported "it is one of the few psychiatric hospitals in Dallas that accepts the poor and uninsured, and has been one of three city institutions where police have routinely sent people for mental-health evaluations."[144] Dallas also has significantly higher levels of poverty and uninsured populations than the state averages,[145] with a poverty level of 24.1 percent, compared to the state average of 17.2 percent, and an uninsured rate of 32.1 percent, compared to the state average of 21.3 percent.[146]

- Illinois: UHS' Rock River Academy in Rockford, IL, closed in April 2015 following a December 2014 *Chicago Tribune* investigation, which described the facility as "violent, chaotic and under-resourced."[147] The *Tribune* found that many residents were fleeing the facility and some were being drawn into prostitution. State officials suspended new admissions to Rock River in December 2014 and ordered its administrators to take corrective action, but UHS decided to close the facility instead.[148] This facility served low-income and disadvantage youth, including state wards placed by the Illinois Dept. of Children and Family Services.[149] The facility was also located in an area with high levels of poverty and uninsured and disabled populations. Rockford, IL has a poverty rate of 25.4 percent compared to state average of 14.4 percent,[150] an uninsured rate of 15.9 percent compared

to state average of 11.1 percent, and disability rate of 10.5 percent compared with state average of 7 percent.[151]

- Virginia: When UHS' Marion Youth Center in Marion, VA, closed in early 2012, UHS claimed it was shutting down because the facility had lost its lease.[152] But two-and-a-half months later, UHS reached a $6.85 million deal with the U.S. Department of Justice to settle charges that the center did not provide the therapeutic level of care it claimed. Upon settling the suit, Daniel R. Levinson, inspector general of the Department of Health and Human services, said, "Any organization providing substandard health services then sending inflated bills to taxpayers, as UHS is alleged to have done, can expect intense scrutiny by government investigators."[153] This facility was also located in an area with high levels of poverty and uninsured and disabled populations. Marion, VA, has a poverty level of 23.2 percent compared with the state average of 11.8 percent,[154] an uninsured population rate of 19.4 percent compared to state average of 12.5 percent, and a disability rate of 17.8 percent compared to state average of 7.6 percent.[155]

With an average annual income before taxes (or profit) of $886 million during the years in which the above violations occurred,[156] UHS has the resources at its disposal to address any regulatory and quality of care deficiencies. However, the examples above suggest that UHS would prefer to close facilities, rather than spend the resources needed to correct problems at troubled facilities and continue providing care in medically needy communities. Taken together, these practices raise concerns about UHS' claims in its CON application that it "will provide all necessary working capital to ensure the [proposed] facility can continue to provide quality psychiatric healthcare to its patients."[157]

UHS' proposal fails to meet the state's "Availability of Resources and Alternative Uses of Those Resources" CON Review Criteria.

UHS' proposal does not meet the sub-criteria under the "Availability of Resources and Alternative Uses of Those Resources" CON Review Criteria due to a host of factors. Firstly, UHS' proposal is not "the most effective and least costly alternative," given that UHS is facing investigations for potential criminal and civil billing fraud, and the company's record of high utilization of public law enforcement and EMS services at its facilities. Secondly, the company has a poor record on properly staffing its facilities, as evidenced by low staffing ratios, cuts in staffing costs, difficulties in recruiting staff, and its practice of employing unqualified and untrained staff, which raises serious doubt that the proposed facility will have "sufficient qualified personnel… available to develop and support the proposed project." Additionally, we have reason to believe that the UHS proposal will not "have an appropriate relationship its service area," given the proposal's impact on community-based providers, as well as the facility's deficiencies with establishing and maintaining appropriate support and ancillary services. Lastly, the proposed facility will not "conform to relevant state physical plant standards," due to the company's poor record on physical plant maintenance, as well as its history of unsafe patient boarding. For these reasons, the proposal does not meet the "Availability of Resources and Alternative Uses of those Resources" CON review Criteria; therefore UHS' request for CON application approval should be denied.

"Most Effective and least Costly" Criterion (333-580)- Does the proposed project represent the most effective and least costly alternative, considering all appropriate and adequate ways of meeting the identified needs?

UHS' proposed facility does not represent the most effective and least costly alternative for fulfilling psychiatric bed need in the proposed service area of Multnomah, Clackamas, and Washington counties, given its troubling record around the delivery of therapeutic care and federal investigations for potential criminal

and civil fraud,[158] and track record of posing a burden on local resources due to its high utilization of public law enforcement and EMS services.[159, 160]

l. UHS' troubling legal compliance record and current federal investigations for potential fraud raises serious concerns about whether UHS will provide cost-effective, efficient care.

UHS' proposed project does not represent the most effective and least costly alternative, given UHS' troubling legal compliance record around the delivery of therapeutic care.

Regulator documents and media reports show that UHS facilities have a record of failing to provide patients with necessary levels of care and treatment.[161,162] In the past few years, UHS has paid millions of dollars to settle charges by the U.S. Department of Justice that the company did not provide the therapeutic level of care it claimed.[163] Specifically, UHS reached a $6.85 million deal with the U.S. Department of Justice to settle charges that Marion Youth Center (Marion, VA), which closed in early 2012,[164] allegedly provided "substandard health services" and then sent "inflated bills to taxpayers."[165] Despite the regulatory enforcement, the issue of failing to provide appropriate levels of therapeutic care appears to be ongoing at UHS facilities in Virginia. For example, Harbor Point Behavioral Health Center (FKA The Pines Residential Treatment Center) in Portsmouth, VA, has had nearly 600 reports of abuse incidents and nearly 400 reports of serious injuries since 2014.[166]

What's even more troubling is that Harbor Point, along with UHS and several of its behavioral facilities are being investigated by federal authorities for potential civil and criminal fraud. UHS has disclosed that the nature of ongoing federal investigations focuses on potential false claims for services. The UHS corporate entity and twenty-three (23) of its facilities across the country are the focus of an ever-widening federal investigation that includes the Department of Justice Criminal Frauds Section and the U.S. Health and Human Services Office of the Inspector General.[167] In addition to these 23 facilities under a coordinated investigation, it appears that UHS is facing at least two separate federal investigations at facilities in Texas. According to UHS disclosures, El Paso Behavioral Health has been subpoenaed for issues related to potential Stark Law violations and South Texas Health System has been subpoenaed related to potential False Claims Action violations concerning physician contracts. In addition to these investigations, at least two other UHS facilities (Friends Hospital in Philadelphia, PA, and Riveredge Hospital in Chicago, IL,) have received federal subpoenas for unknown reasons. Since February 2013, UHS has disclosed expansion of the federal investigation, including additional subpoenas, payment suspensions and criminal fraud investigation.[168] All of which suggests federal law enforcement continues to identify potential issues.

UHS has disclosed that the civil aspect of the coordinated probe is a False Claims Act investigation focused on billings submitted to the government.[169] UHS' corporate office is the subject of a related criminal fraud investigation by the U.S. Department of Justice. UHS' River Point Behavioral Health facility (Jacksonville, FL), has also had its payments suspended by Medicare and Medicaid pursuant to the investigations.[170] Several of those investigations began more than two years ago and UHS executives have said that the investigation is "not necessarily in its end stages [and] may go on for a while."[171]

The underlying conduct that may have sparked these ongoing civil and criminal fraud investigations involving the corporate parent and twenty-three (23) of its behavioral health facilities should raise doubts about whether UHS is the type of provider that Oregonians can trust to provide cost-effective care, as well as safe and adequate care to the public in accordance with applicable federal and state laws, rules, and regulations.

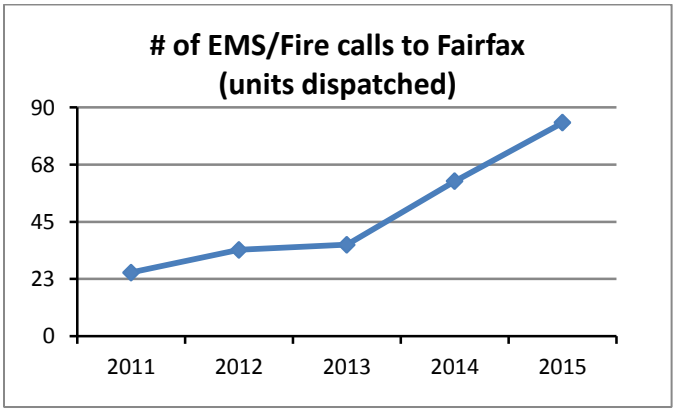
II. UHS' proposed project does not represent the most effective and least costly alternative, given the demonstrated pattern of high utilization of local law enforcement and emergency medical resources by UHS facilities in Washington and across the country.

We are concerned that UHS' proposed facility would impose a burden on the levels of public services maintained by local law enforcement and emergency medical services, given the safety and security issues at its facilities in Washington as well as the high utilization of these public services by UHS facilities in communities across the U.S.

1) The high utilization of public law enforcement services, and volume of facility violence incidents, indicates UHS is ill-equipped to provide proper security at its facilities.

A review of law enforcement records involving UHS' Fairfax Hospital (Kirkland, WA), the policies and operational standards of which UHS says the proposed facility will mirror,[172] shows that UHS facilities are disproportionately reliant on local law enforcement services for security and safety-related issues.

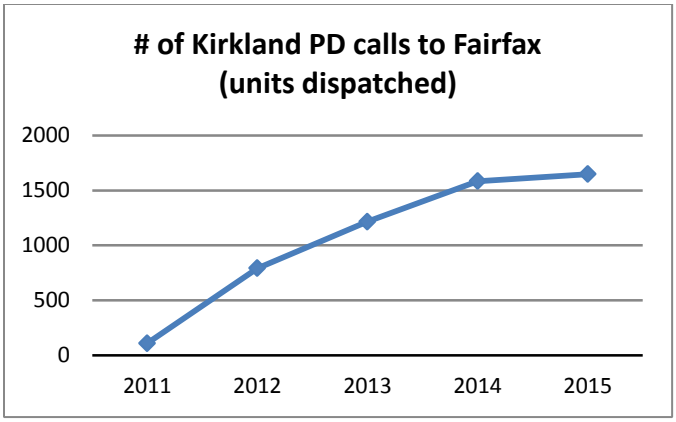
UHS acquired Fairfax in November 2010 and since 2011, the first full year of UHS ownership, the number of units dispatched to Fairfax Hospital for emergency medical/fire services has steadily increased. In 2011, 25 EMS/fire units were dispatched to the facility; this number increased to 84 in 2015.[173]



Year	# EMS Calls (w units dispatched)
2011	25
2012	34
2013	36
2014	61
2015	84
Total	***240***

Source: NORCOM Records.
Note: These figures depict the raw # of EMS/Fire Dept. units dispatched to Fairfax Hospital, not the number of incident reports resulting from the calls for service.

The volume of law enforcement, or Kirkland Police Department, units dispatched to Fairfax Hospital resulting from calls for service has also followed this upward trend, with 109 units dispatched in 2011 and jumping to 1,648 units dispatched in 2015. This figure amounts to nearly 5 police unit dispatches per day to Fairfax Hospital in 2015 alone.[174]



Year	# of Police Calls (with units dispatched)
2011	109
2012	791
2013	1,215
2014	1,584
2015	1,648
Total	***5,347***

Source: NORCOM Records
Note: These figures depict the raw # of Kirkland PD units dispatched to Fairfax Hospital, not the number of incident reports resulting from the calls for service.

Furthermore, when looking at law enforcement records from just the last two years,[175] the types of incidents for which law enforcement officers were dispatched to Fairfax Hospital are highly troubling. For example, during 2013-2015 there were approximately 110 incident reports associated with calls for service/assistance from the Kirkland Police Department. More than half of those 110 reports involved incidents of assault within the facility, either between patients or staff members and patients.

# Kirkland PD Calls for Service at Fairfax Hospital, 2013-2015		
Incident Type	**# of Calls (w/ units dispatched)**	**percent of Total**
Assault	59	53.6 percent
Suicide	15	13.6 percent
Disturbance	13	11.8 percent
Escape	11	10.0 percent
Missing adult	5	4.5 percent
Missing juvenile	4	3.6 percent
Rape	2	1.8 percent
Sex Offense	1	0.9 percent
Grand Total	***110***	***100 percent***

Source: NORCOM Records

The following assault incidents give a glimpse of the seriousness of patient and worker safety issues at UHS' Fairfax Hospital:

- On 8/25/2015, the Kirkland PD responded to disturbance call at Fairfax Hospital, in which a patient began destroying her room and the staff station, threw a chair through the glass window, and struck another patient in the head. Staff had to evacuate the unit as a result. The patient was subsequently subdued and taken into custody because she caused several thousand dollars of damage to property and office equipment.[176]
- On 3/19/2014, the Kirkland PD responded to a call for service at Fairfax Hospital after a patient struck and injured a staff member. The patient then started damaging several items in the dayroom, hallway, and nurses' station and caused the section of the hospital to stop operations for over an hour.[177]

- On 10/22/2014, the Kirkland PD responded to a call for service at Fairfax Hospital when a patient punched a peer, who was instantly knocked unconscious and suffered a skull fracture when hitting the ground. The victim was transported to a local hospital, while the attacker was kept in a locked psychiatric unit with 1:1 supervision. He/she was arrested for 2nd degree assault.[178]

Since the beginning of 2016, Fairfax Hospital has been in the local Kirkland Reporter police blotter nearly once a month for incidents in which staff were physically assaulted. [179, 180, 181] This suggests that the facility has continued to have serious safety issues, especially for workers.

2) UHS has a pattern of high reliance on local law enforcement in other markets.

Given other communities' experiences with UHS facilities, there is serious cause for concern that UHS' proposed facility will repeat this pattern of disproportionately relying on the resources of local public safety agencies to address security and safety-related issues.

In Massachusetts, for example, where UHS runs the largest private behavioral health system in the state under the name of Arbour Health System,[182] one community has expressed frustration over the local UHS facility's impact on its community. In Westwood, Massachusetts, community members have expressed concerns about the "long, distressing history'' of security lapses at UHS' Westwood lodge facility, while local officials said these *"steady stream of issues have caused 'an inordinate drain' on the resources of public safety agencies not only in Westwood but also in surrounding communities and the state."*[183]

In Florida, one of UHS' largest markets with nearly 20 facilities,[184] UHS-operated facilities also have a pattern of high utilization of law enforcement and emergency medical services. Examples include:

- In Pinellas County (FL), UHS' Windmoor Healthcare of Clearwater is the top user of the County's EMS services. In 2013 alone, Windmoor Healthcare had the most calls for service in the county with 968 calls, which is significantly higher than the Pinellas County Jail, the second highest user of EMS services with 576 calls.[185]

- In Marion County (FL), the Ocala Police Department reported receiving 772 calls for service at UHS' Vines Hospital since Jan. 1, 2011. Of these calls, 57 were related to criminal activity including battery, assault, and attempted homicide and homicide, among others.[186]

- In Lake County (FL), police have regularly responded to the National Deaf Academy (AKA NDA Behavioral Health) over the years for calls including reported sex crimes, fights, abuse and suicide attempts, before the facility closed during March/April 2016.[187] Mount Dora Police reportedly received 506 "calls for service" from UHS' NDA Behavioral Health facility (AKA the National Deaf Academy) between 2008 and 2013. These calls reportedly included everything from staffers reporting runaways to patients alleging abuse. While a list of 54 investigations between 2008 and 2014 provided by Mt. Dora police noted that 15 involved alleged battery, 10 involved alleged abuse, and three involved alleged sexual abuse.[188] In the past two years, Mount Dora police were dispatched to the academy 162 times, records show. Twenty-three calls were for child abuse and seven were for sex crimes, records show.[189]

- In Okaloosa County (FL), law enforcement had to respond to a riot at UHS' Gulf Coast Youth Academy in 2013, a detention center for youth, in which 30 teenagers were reportedly "throwing chairs and flipping tables over, causing property damage and assaulting staff members."[190]

The troubling security and safety records of some of UHS' existing facilities, especially those located in markets where UHS has a large market presence including Massachusetts and Florida, raises serious doubts

about UHS' ability to effectively address the issue of high utilization of law enforcement and emergency medical services by its facilities.

Currently, UHS does not have a large footprint in Oregon, operating only one facility in the state. If UHS is permitted to expand, we have reason to believe that UHS will become increasingly reliant on the resources of local public safety agencies to handle security and safety-related issues, or other incidents related to breakdowns in care. This is of particular concern, because UHS' Cedar Hills Hospital is already reliant on these public services. For example, between 2013-2016 the Washington County Sheriff's Office has responded to calls for service at UHS' Cedar Hills Hospital (Beaverton, OR) related to rape, assault, attempted suicide, missing persons, and even a death investigation.[191]

For these reasons, we have serious concerns that if UHS is permitted to expand its market presence in Oregon with its proposed 100-bed psychiatric facility, it will have the unfortunate consequence of imposing a burden on local and municipal public services and resources.

3) **OSHA violations and other safety issues at UHS facilities demonstrate that UHS management decisions lead to safety problems at facilities, requiring more intervention by local first responders.**

When UHS was asked by the OHA CON office to describe how its proposed facility would ensure patient, staff, and public safety, given the recent troubling safety breakdowns at UHS-operated facilities across the country, UHS provided an inadequate response. UHS stated that they employ "clinical oversight at the corporate level" as well as "best practice methods" in order to "ensure that [they] have the safest facilities possible."[192] These claims are highly suspect, given that UHS facilities have repeatedly been under regulatory scrutiny for their lax safety measures. We understand that UHS provides services to a difficult patient population, which is precisely why regulatory agencies such as OSHA and other state and federal regulators require safety measures. In many UHS hospitals, the dangerous mix of inadequate safety protocols, inadequate staffing and high occupancy, has had predictably terrible results, as discussed below. These examples clearly raise doubts about the UHS claims that "patient and staff safety are foundational elements at UHS."[193]

- Oregon: On several occasions, state regulators have found inadequacies with Cedar Hill's security and safety plans, which the facility is required to submit annually pursuant to CON Order Condition #7 for UBH of Oregon LLC dba Cedar Hills Hospital. In 2012, state regulators found that there was an absence of a secure area for triage and admission screening of potential patients (including involuntary hold patients), as well as an absence of any agreements outlining medical transfers to other hospitals in the case of emergencies, among other deficiencies.[194] Additionally, state regulators found issue with Cedar Hills Hospital's most recent safety plan from 2015, which lacked an "annual plan for monitoring and evaluating services" addressing among other things, "the care of patients served" and "accidents, injuries, safety of patients, and safety hazards…"[195] In fact, Cedar Hills has continued to have safety and security issues, most recently as of the first half of 2016. In March and May of 2016, the facility had two separate incidents of patient elopements. In the March incident, an involuntary patient was able to break through two sets of magnetically locked doors and escape. In the May incident, a voluntary patient eloped from the facility during a monitored outdoor break due to inadequate staffing.[196]

- California: UHS-owned Fremont Hospital in California was cited for failing to provide an effective communication system to summon help during incidents of patient violence, as required under state law.[197] Fremont Hospital spent more than three years fighting this violation, along with the $560 fine, first in front of the California OSHA Appeals Board[198] and then in California Superior Court.[199]

The case was decided in favor of the OSHA Appeals Board[200] and the OSHA case was closed on April 25, 2016.[201]

- Massachusetts: One of the most telling cases of UHS refusing to adequately address its safety problems, with often tragic results for patients and workers, involves recent events at UHS' Pembroke Hospital in Massachusetts. The *Patriot Ledger*, a local newspaper, reported on March 2, 2016 that *"Pembroke Hospital has ignored several requests from the Occupational Safety and Health Administration since October to respond to the agency's hazard alert letter that flagged the number of workers injured by violent patients and called for improved staffing and safety measures [such as panic buttons for staff caring for violent patients] at the 120-bed psychiatric hospital."*[202] According to OSHA, inspectors noted that Pembroke Hospital had recorded 13 injuries to workers from aggressive patients in the first five months of 2015. In 2014 there were 24 injuries of hospital workers from violent attacks, a 41 percent increase over 2013.[203] The weekend after that March 2, 2016 *Patriot Ledger* article was published, police officers responded to another savage attack on March 5, 2016, during which "a patient nearly tore off a nurse's ear and attempted to gouge out her eye."[204] Despite all of this,[205] Pembroke Hospital's CEO has refused to provide personal panic alarms to employees – as suggested by OSHA – relying instead on walkie-talkies carried by two employees per unit.[206]

  Another former worker also spoke to local press about her experiences with workplace violence at Pembroke Hospital, stating, "I had bruises all over me. He dropkicked me on my new knee, and he ripped a handful of hair out of my head…I don't think I can go back there… I have nightmares..." At the time of the incident, she says she and only two other workers had been covering 20 patients, some of them very violent and that the "staff-to-patient ratio at the 120-bed hospital is dangerous." She further stated, "Somebody's going to get killed there…In that situation, it was me and them two trying to save me." [207]

- Texas: One of the most tragic cases of workplace violence occurred at Timberlawn Mental Health System, a UHS-operated facility in Dallas, TX. In June 2016, a physician died after being attacked by a patient. The patient "violently tackled" the psychiatrist, who struck her head, lost consciousness and died two days later.[208] The facility is also under regulatory scrutiny for serious safety violations, with the Centers for Medicare & Medicaid Services terminating the hospital's participation in Medicare and state regulators moving to revoke its facility license and imposing a $1 million fine.[209]

In effect, UHS' use of local law enforcement to respond to assaults and other incidents at some of their facility campuses, as well as its refusal to respond to regulator recommendations for safety improvements, as in the case with Pembroke Hospital, demonstrates UHS does not have the capability to manage its patient population and protect its workforce. Taken together, these factors raise serious concerns about whether UHS has enough security staff, or takes any protective measures to ensure a safe environment for its patients and staff. Given UHS' track record on the use of these public services, coupled with its record on security, we have reason to believe that the proposed facility would impose an unnecessary burden on the levels of service maintained by local law enforcement and emergency service agencies.

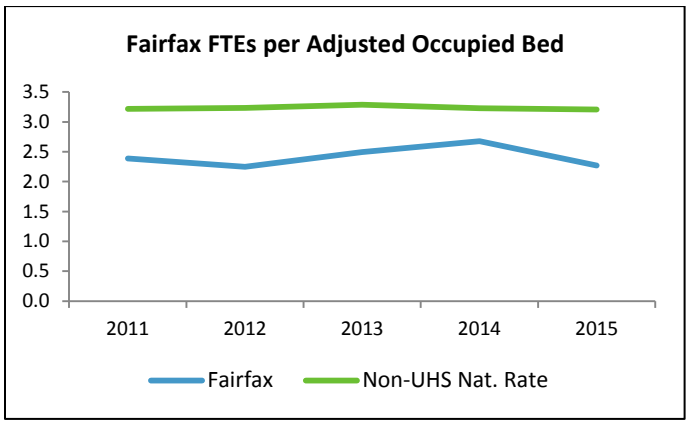
<u>Staffing Criterion (333-580)</u>: Will sufficient qualified personnel…be available to develop and support the proposed project? The applicant must demonstrate that there are, or will be sufficient physicians in the area to support the proposal; sufficient nurses available to support the proposal; sufficient technicians available to support the proposal.

UHS fails to adequately demonstrate in its CON application submissions, that it will provide sufficient, qualified personnel to support its proposed facility.

In fact, UHS fails to disclose that UHS-operated facilities often present lower staffing ratios than their peers. UHS has cut staffing costs in its behavioral health business division while keeping occupancy high. Additionally, the company has a track record of employing unqualified and untrained staff, and has admitted to having difficulties in recruiting sufficient numbers of qualified mental health staff.

I. UHS facilities often present low staffing levels.

UHS' Fairfax Hospital in Kirkland, Washington, is a notable example of UHS facilities presenting low staffing levels. The prevalence of safety and security and workplace violence issues at Fairfax Hospital discussed above on pages 23-24, suggests that UHS' staffing of the facility is not adequate to prevent repeated occurrences. Medicare Cost Report data shows that, since UHS began operating the facility in November 2010, the staffing ratios (defined as full time equivalents, or FTEs, per adjusted occupied bed) for the facility have been lower than the state and national averages for freestanding inpatient psychiatric facilities.[210] In 2015, Fairfax Hospital's FTE rate was 29 percent lower than the national non-UHS average, meaning the facility had nine (9) fewer FTEs available for every ten (10) patients. Fairfax Hospital's FTE rates between 2011-2015 are as follows:

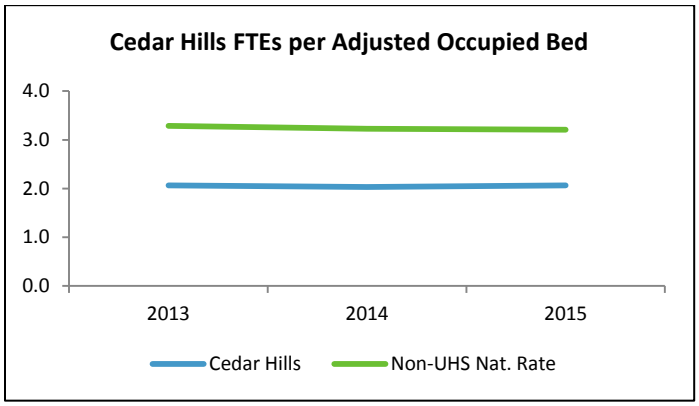


Year	Fairfax FTE Rate	Non-UHS Nat. FTE Rate
2011	2.4	3.2
2012	2.3	3.2
2013	2.5	3.3
2014	2.7	3.2
2015	2.3	3.2

Source: Medicare Cost Reports

These low staffing ratios suggest that Fairfax Hospital does not have the adequate staffing resources to provide adequate care and security for the populations in their care. As a result, adverse incidents, including incidents of assault discussed above, may be occurring at a much higher rate than would be expected from well-staffed facilities.

What's also troubling is that UHS states in its CON application that the staffing at its proposed facility will be reflective of its current Oregon facility, Cedar Hills Hospital. UHS states "UHS operates Cedar Hills, a facility that is virtually the same in terms of staffing as that planned for NewCo, with the exception that NewCo will provide care for adolescent patients.[211] This statement is highly concerning because Cedar Hills Hospital also presents lower staffing ratios than" its peers. Medicare Cost Report data shows that the staffing ratios for Cedar Hills Hospital have also been consistently lower than national non-UHS averages between 2013 and 2015.

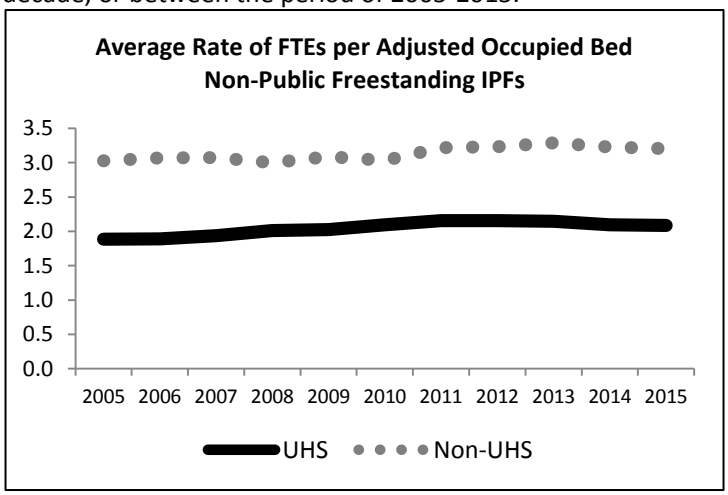


Year	Cedar Hills FTE Rate	Non-UHS Nat. FTE Rate
2013	2.1	3.3
2014	2.0	3.2
2015	2.1	3.2

Source: Medicare Cost Reports

UHS also states in its CON application that, "Once it is fully operational, our proposed facility will have approximately 188 full-time employees"[212] for its 100-bed facility. Assuming a 100 percent occupancy rate, this amounts to just 1.88 FTEs per bed. This ratio is far below the national non-UHS average FTE rate of 3.2 for 2015.

This pattern of low staffing ratios is not isolated to Fairfax Hospital and Cedar Hills Hospital. In fact, Medicare Cost Report data shows that the staffing ratios for UHS' behavioral health system as a whole, have been consistently below the averages for non-UHS[213] freestanding inpatient psychiatric facilities (IPFs) for over a decade, or between the period of 2005-2015.



Year	UHS' FTE Rate	Non-UHS FTE Rate
2005	1.9	3.0
2006	1.9	3.1
2007	1.9	3.1
2008	2.0	3.0
2009	2.0	3.1
2010	2.1	3.0
2011	2.2	3.2
2012	2.2	3.2
2013	2.1	3.3
2014	2.1	3.2
2015	2.1	3.2

Note: The overall number of IPFs included in any given year is around 300; by 2015, UHS-operated facilities account for approximately 30% of these facilities. For this reason, the "Non-UHS" rate is used (as opposed to the national average) because the national average would be heavily influenced by UHS' facilities.

Low staffing ratios suggest that UHS facilities have less staff to provide care for the vulnerable populations (who often have complex medical needs) entrusted in their care. It also suggests that inadequate staffing, especially security staff, can create an unsafe environment for patients and facility staff.

II. High occupancy and low staffing maintain the company's profitability, but have implications for patient care.

Low staffing ratios are especially disturbing, given that UHS executives have told investors that keeping occupancy rates high and cutting staffing costs helps the company stay profitable.[214] UHS Chief Financial Officer Steve Filton has acknowledged that the company sees full facilities as profitable ones, saying, *"We operate this business at fairly high occupancy rates and operating margins. I think those two things are tied together.*[215]

Filton also had this to say about staffing costs:

> "The bottom line… is when you look at the behavioral business model and you look at our financial statements, you will see that at least 50 percent of our expenses are salary and wages and salary-related, and probably the next biggest functional expense line is maybe 5 percent of expenses…" [To make up the] "gap in our margins, a good chunk of that has to come from a more efficient use of people, headcount, people in the right positions, etc., and frankly, that's a big part of our focus going into it."[216]

In practice, UHS cut staffing costs in its behavioral health division in 2014 to their lowest level in the last decade, with just 48.6 percent of revenue going to salaries, wages, and benefits (SWB).[217] Yet, for every dollar that UHS' behavioral business generates in revenue, a quarter goes into profits rather than patient care.[218]

Repeated cuts to staffing costs, as well as low staffing ratios, may be taking a toll on patient care and can be dangerous for patients, workers, and communities, as evidenced by repeated regulatory citations related to unsafe staffing at UHS facilities.[219]

UHS' University Behavioral Center in Florida is a telling example of how unsafe staffing levels place patients and staff at risk. When state agency officials visited the facility in 2012, they found that the facility had failed not only to provide front line staff with effective communication equipment but also to employ enough staff to care for its young patients. One nurse described a "near riot" among boys in the facility during a period of understaffing. The facility's CEO reported receiving calls about staff needing help but said he was frustrated a nurse called him rather than a weekend supervisor.[220]

UHS facilities' demonstrated pattern of understaffing is particularly concerning because psychiatric staffing levels must take into account patients' risk of violence and suicide as well as their medical needs, which tend to be higher than the general population. While UHS claims that it will "optimize capital and operating expenses" to allow for "lower priced services" within the Planning Area,[221] we have serious concerns that, since UHS has repeatedly failed to provide the adequate staffing resources, the proposed facility will be ill-equipped to adequately address patient needs, and to ensure sufficient safety and security for patients, workers, and surrounding communities.

III. UHS often employs unqualified and untrained staff at its facilities, with often troubling, and even tragic, outcomes.

UHS touts in its CON application that the company "can leverage [its] experience to successfully recruit, train, and employ staff for its NewCo operations."[222] UHS also states that it would plan to "utilize only Board-eligible or "Board-certified" psychiatrists to treat its patient populations[223] Yet, again and again administrative agencies charged with overseeing UHS facilities have found many staffing violations in recent years, including in the areas of licensing and other job qualifications, training and supervision, and unsafe staffing levels. Inspectors have found such violations at UHS facilities in (at least) California, Connecticut, Florida, Georgia, Kentucky, Missouri, North Carolina, Ohio, Louisiana, Pennsylvania, Texas, Virginia, and Washington since 2009.[224]

One of the most notable cases of UHS' failures in the area of unlicensed and unsupervised staff was heard before the Supreme Court of the United States on April 19, 2016 in *Universal Health Services, Inc. v. United*

States ex rel. Escobar. The family in the case sought to hold UHS accountable under the False Claims Act (FCA) for claiming Medicaid payments even though UHS' care failed to meet minimum licensure and supervision requirements for mental health services. The family's teenage daughter tragically passed away while under the care of unlicensed and unsupervised staff at Arbour Lawrence, a UHS provider in Massachusetts. Yarushka Rivera was a 17-year-old girl living with a psychiatric disability who sought care at a UHS facility. The teen was treated by unlicensed and inadequately supervised staff. UHS' staff prescribed a medication for Ms. Rivera that allegedly led her to develop seizures and she died a few months later of a seizure. UHS then billed the Massachusetts Medicaid program for the girl's care. Upon investigation of these events, the state's Department of Public Health and Division of Licensure (DPH) confirmed that care was provided by unsupervised staff in violation of state law.[225] The Clinical Director of the UHS provider even admitted to the DPH that he was "unaware that supervision was required to be provided on a regular and ongoing basis."[226]

UHS facilities nationwide have also been subject to inspection report citations for breakdowns in care due to untrained staff.[227] In Ohio, for example, inspectors in 2014 twice found inadequately trained staff providing care at UHS' Foundations for Living facility. Even after warning Foundations that untrained staff could not physically restrain patients, inspectors returned to find that an untrained staff member had pushed a patient against a wall and bent his arm behind his back.[228]

IV. UHS discloses difficulties in recruiting staff, which raises further doubt about UHS' ability to provide adequate staffing resources at its proposed facility to meet patient needs.

UHS also states in its CON application that it "…can leverage that experience to successfully recruit, train and employ staff for its NewCo operations."[229] UHS goes on to say that "UHS has a dedicated corporate recruitment office that employs national searches for physicians and nurse practitioners."[230]

What UHS fails to disclose in its CON application and additional submission materials is that the company has had trouble recruiting staff. In fact, UHS executives disclosed to investors, but not the Oregon CON office, issues the company is having with staffing shortages. UHS CFO Steve Filton stated, *"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 psychiatrists, nurses, other clinical personnel that we need."*[231] Filton goes on to say that, *"the nursing shortage, I think, on the behavioral side is a little bit more problematic. First of all, physically, we don't have as many options to replace nurses. We physically need nurses at the bedside…"*[232] As a result, *"in some markets, that's causing us to not be able to treat all the patients who present themselves for admission."*[233]

This raises serious concerns about UHS' ability to recruit and employ sufficient numbers of staff to provide care for the vulnerable populations, who often have complex medical needs, that will be entrusted in their care at the proposed facility.

Appropriate relationship to its service area: Impact on other providers Criterion (333-580)-Will the proposed project have an appropriate relationship to its service area, including limiting any unnecessary duplication of services and any negative financial impact on other providers?

UHS failure in discussing how its proposed facility will impact existing hospital providers raises concerns about UHS' willingness to work with providers to coordinate care and control costs.

UHS states in their application that its proposed facility "will not impact existing providers, with the exception of alleviating the burden of a growing population desperately needing quality inpatient psychiatric health services."[234] However, its application fails to provide any additional details, or explanations, about the impact

of its proposed facility on existing providers. Rather, UHS only discusses how the proposed facility is expected to benefit its own operations, and specifically the UHS-owned Cedar Hills Hospital:

> "Cedar Hills has opened 52 additional beds over the past four years and yet has maintained occupancy rates over 85 percent, and currently, has a 93 percent occupancy. At these occupancy levels, not all patients needing access to care receive it. The new hospital would improve this lack of access and, from UHS' perspective as the largest current provider of psychiatric care in the Service Area, NewCo will have no adverse financial impact on Cedar Hills."[235]

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. As a for-profit, standalone hospital, its main priority will be to employ strategies to achieve its projected margins of 30 percent.[236] This raises serious concerns about UHS' willingness to work with other providers in order to coordinate care and control costs, given that it will have very little incentive to do so.

Yet coordinating and integrating care is crucial because the prevalence and interacting effects of comorbid mental illness, substance use disorders, and physical health conditions are well documented, as is the high cost of care for individuals with comorbid physical and behavioral health conditions.[237] According to Arpan Waghray, Swedish Health Services System's medical director for behavioral health, "*When people have chronic medical illnesses, they tend to have co-occurring behavioral health conditions…When there is a combination of medical illness and behavioral health concern, we know that there are poor outcomes on both sides. We know there's increased functional disability in our patients, and we know there is increased inappropriate utilization of healthcare resources."*[238]

The State of Oregon's guiding principles for interpreting its CON review criteria even note that standalone inpatient psychiatric hospitals are the state's least desirable method for fulfilling bed need.[239] It states, "*The methods of meeting acute psychiatric bed need, in order of preference, shall be: (a) Conversion of existing licensed space to purposes of psychiatric treatment; (b) A project resulting in the smallest feasible net increase in acute licensed capacity within an existing general hospital or specialty hospital license; and (c) A separately licensed new psychiatric hospital, not part of a general hospital."*[240]

In light of these findings, we have serious concerns that UHS' proposed standalone facility will perpetuate the care delivery model in which physical and behavioral health care systems operate independently. Inadequate coordination and integration between these two systems can result in gaps in care, inappropriate care, and increased costs.[241]

Appropriate relationship with its service area: Necessary Support Service Criterion (333-580) - The applicant must 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.

UHS claims in its CON application that it has the necessary support services for its proposed facility, because these relationships have already been established through the *operation of its Cedar Hills facility*. UHS states, it "*has established relationships with other healthcare providers in the planning area, including hospitals…We would expect to utilize those same relationships at the outset…"* However, a closer examination reveals serious inadequacies in these "established relationships," as well as its proposed plan to "utilize those same relationships at the outset."

In fact, state regulators have continued to find issue with Cedar Hills Hospital and its failure to establish the necessary arrangements with acute care hospitals for timely ED transfers. For example, in 2012, state regulators found deficiencies with Cedar Hills Hospital's safety plan that the facility is required to submit annually as a condition of its CON approval, because the annual safety plan lacked an agreement outlining medical transfers to other hospitals in the case of emergencies—specifically hospitals that are close in proximity to Cedar Hills.[242] As of April 2016, Cedar Hills still does not have such a medical transfer agreement with nearby hospitals.[243]

UHS goes on to say that it currently has an ED transfer agreement with Tuality Hospital and that its proposed facility, NewCo, "would develop the same type of agreements with the same or similar providers."[244] The fact that UHS anticipates using Tuality Hospital in ED transfers for its proposed NewCo facility is highly concerning, given that these facilities are located more than 20 miles (and up to an hour away depending on traffic) away from one another. UHS also states that it is in talks with Providence St. Vincent's for possible new transfer agreements,[245] but again this facility is located nearly 20 miles from the proposed facility site—raising questions as to where UHS would send patients in the event of an emergency situation.

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 populations. Given that UHS has clearly failed to demonstrate that it has the necessary services in place that are crucial to supporting its operations, UHS does not meet this review criterion.

<u>Physical plant Criterion(333-580)</u>-Does the proposed project conform to relevant state physical plant standards, and will it represent any improvement in regard to conformity to such standards, compared to other similar services in the area?

I. UHS has an abysmal record on physical plant maintenance.

UHS claims in its CON application that it *"has a long, successful history of building and operating freestanding psychiatric facilities throughout the country. UHS is familiar with state licensing, architectural and fire code standards based on its extensive experience in the healthcare industry. To ensure compliance with all necessary state building standards, UHS has engaged state-certified architects and engineers."*[246] In truth, UHS has a record of failing to ensure a safe environment for its patients, as evidenced by lawsuits and health inspection report citations at UHS facilities across the country.[247] Regulators have cited tragic cases of patient deaths for failure to remove suicide hazards, or other physical plant violations and deficiencies that have placed patients' safety at risk.[248]

UHS' failure to follow state and federal safety regulations can have tragic consequences for patients, as demonstrated by the following examples:

- West Virginia: In 2012 UHS' River Park Hospital was cited by CMS for physical plant safety risks that violated state licensure rules and CMS conditions of participation. The facility moved its forensic inpatients into an area of the hospital which had previously been used as an adolescent outpatient program in the 1990's and then as the facility's billing office. River Park renovated this area before moving the patients, but did not submit its plans to the Office of Health Facility Licensure and Certification (OHFLAC) for approval. In its response, the facility wrote that it had considered the conversion to be "face-lifting" a unit to re-open it, which did not require approval from OHFLAC. However, CMS found that the construction done in the conversion did not meet the minimum standards for health care facilities. The unit contained door hinges, door knobs and faucet handles that should have been replaced because they were not safe for suicidal patients. CMS found that

looping and ligature suicide hazards were not limited to just this unit, but were present in all eight patient care units of the hospital.[249]

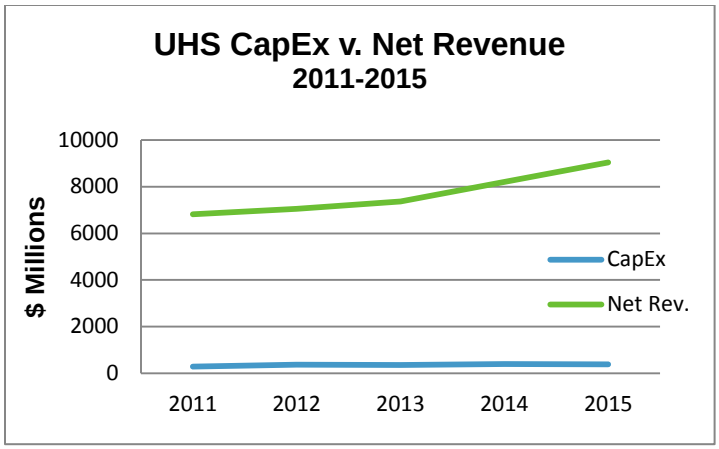
- Illinois: In 2013, CMS found that UHS' Riveredge Hospital in Chicago violated the Medicare condition of participation of patient rights and placed a patient in "immediate jeopardy" by failing to ensure that suicide hazards were removed from its patient units. A suicidal patient was placed in a room with an accessible ceiling vent cover, which she used to hang herself. CMS found that these vent covers were present in other units, which posed potential risks to 40 patients in the facility.[250] A wrongful death suit was also filed by the decedent's husband as a result, alleging the patient was placed on "routine" 15-minute observation when admitted, the lowest observation level possible, despite showing several risk factors for suicide. The suit also alleged that the State had identified the air vents as dangerous, and had mandated they be modified, five years prior to the decedent being admitted to the facility. [251]

- Texas: In December 2014, a patient seeking treatment at UHS-owned Timberlawn Mental Health System in Dallas committed suicide by hanging herself from a doorknob in the trauma unit. Despite the facility's knowledge of the patient's history of attempted suicides and the patient's placement on assault/suicide precautions and 15-minute observation, this event occurred due to the hospital's failures in correcting its "hospital plant anomalies." CMS inspectors found an internal facility document titled "Hospital Plant Anomalies" from May 2014 (7 months prior to the patient suicide) which identified, "*Trauma unit…patient door handles and closet door handles could be a ligature risk…"* A CMS interview with a staff member further revealed that no action was taken to remove the risks until after the suicide event, and that patients continued to be admitted to the rooms with the existing doorknobs even after the patient suicide event. Two months following the patient suicide, a CMS facility inspection was again conducted, *which "Revealed the continued presence of unsafe items accessible to psychiatric patients for potential harm which included, plastic liners in trash cans, electrical cords and phone cords."*[252] Despite the tragic death and CMS' findings mentioned above, Timberlawn's CEO at the time Shelah Adams told *the Dallas Morning News* in June 2015, that "the doorknobs in question did not violate any regulations."[253]

The disturbing cases discussed above are the tragic result of UHS' focus on profits over patient care. Even after a patient died within its care, as in the case of Timberlawn, UHS still failed to take any meaningful actions to prevent the accessibility of unsafe items to the psychiatric patients entrusted in their care.

In fact, with the exception of a slight bump in capital expenditures following its acquisition of PSI, Inc. in 2011, capital expenditures by UHS have remained flat since 2012, while revenues have grown substantially.[254]

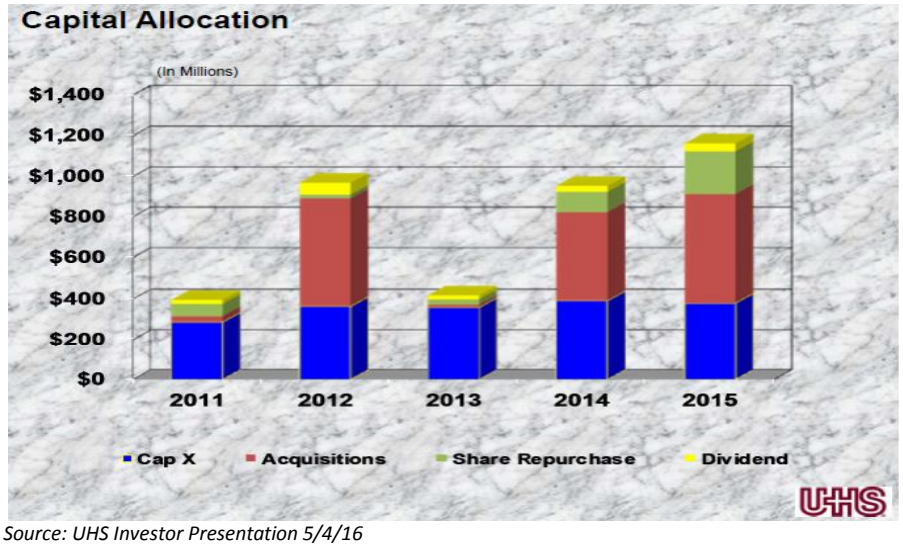
UHS has had remarkable annual growth in net revenues; yet, capital expenditures as a percentage of net revenues have been in steady decline each year since 2012. Between the 5-year period of 2011-2015, UHS only spent an annual average of $355.4 million on capital expenditures (for all facilities operated by the company), while during the same period, UHS took in average annual net revenues of $7.7 billion. In fact, just to give a sense as to how profitable UHS has been, UHS' behavioral health facilities alone generated an average annual income before taxes (or profit) of $886 million between 2011-2015.[255]



Year	CapEx ($ millions)	Net Revenue ($ millions)	% of Net Revenue
2011	286	6,812	4.20%
2012	363	7,054	5.15%
2013	358	7,370	4.86%
2014	391	8,210	4.76%
2015	379	9,040	4.19%

Source: UHS10K Filing for year ending 12/31/15, pg36

What's more, UHS' own investor presentation materials show that while the company's investment in capital expenditures remained flat between 2011 and 2015, its capital allocation towards acquisitions and share repurchases have followed a generally upward trend.



Source: UHS Investor Presentation 5/4/16

This information leads one to conclude that rather than spending profit on fixing up dilapidated facilities and known safety risks, management has decided to prop up the share price for investors and buy more facilities. UHS' deployment of cash runs counter to what is expected of healthcare facilities. Healthcare facilities require significant investments in brick and mortar, equipment, and human capital to operate.[256] Due to UHS' remarkable profitability year after year, one would expect that the company would allocate more resources to continually update their existing plants and bring them up to state and federal standards.[257] Unfortunately, UHS' failure to do so has been tied to tragic patient outcomes, as discussed above.

Given UHS' demonstrated pattern of failing to adequately adhere to state and federal physical plant standards, coupled with its failure to prioritize capital spending on its existing facilities, we question UHS' ability to abide by relevant physical plant standards in order to ensure the safety and well-being of patients and staff.

II. History of unsafe patient boarding, or co-mingling of distinct patient populations without regard to their specific needs, raises doubts about UHS' conformance with physical plant regulations.

UHS also states in its application how its proposed hospital *"will be built to involuntary patient safety and restraint licensure standards, and the number of voluntary/involuntary patient bed spaces will be flexible to meet patient needs, which are expected to vary over time."*[258] Yet, after the OHA CON office raised concerns with this, and noted that state administrative rules (OAR 333-5335-0061(8)(d)) require that *"child and adolescent care units are physically and visually separate from each other and from adult units,"* UHS backtracked and gave completely contradictory response stating, "*As a matter of clinical practice …we never co-mingle adult and children and adolescent patients."*[259] UHS' conflicting responses to the OHA CON office, coupled with its record on unsafe patient boarding at its facilities nationwide, raises serious safety concerns. Examples include:

- Texas: In April 2015, the CMS conducted an unannounced, facility inspection at Timberlawn Mental Health System and found that the facility failed to secure proper unit placements for patients. CMS found that the facility's adolescent unit serves the dual role of housing mentally ill patients, while also providing care to individuals apprehended by police officers without a warrant (APOWW), some of whom may be adults. Most of the adolescent APOWWs may not require hospitalization and staff estimated that about half are sent out of the facility after an initial evaluation. CMS found that "[t]hroughout the day seriously mentally ill persons may be sharing meals, groups, etc. with persons not seen as mentally ill. The potential for harm to the acutely ill patients is therefore quite high." CMS also noted that: "There may also occur APOWW persons who are adults. Administrator estimates that 10 percent to 20 percent of these persons are assessed as not requiring acute care hospitalization yet are present throughout their stay with acutely mentally ill patients. There is a likelihood that other patients may be victimized by these persons who are not patients."[260]

- Florida: In March 2014, River Point Behavioral Health was cited by the Florida Agency for Health Care Administration (AHCA) after the facility failed to have an organized and separate unit for their adult substance abuse patients, even though state regulations require that "the beds assigned to the program must be physically separate from and not commingled with beds not included in the unit." AHCA found that instead of separating its substance abuse patients from its psychiatric patients, River Point Behavioral used rubberized mattresses on the floor of patient rooms for "overflow patients" without regard to whether they were substance abuse or psychiatric patients. Rather than directly addressing its cited deficiencies by designating separate units for its substance abuse and psychiatric disorder patients, River Point ceased the admission of substance abuse patients.[261]

- Texas: In December 2010, Hickory Trail Hospital was cited by CMS after the facility failed to ensure that children under 12 were provided safe, secure sleeping quarters separate from adolescents. It was found that a 10 year old male resided in a 4-patient bedroom with 12, 14, and 16 year old males. CMS wrote, "Failure to provide separate sleeping quarters for child and adolescent patients potentially compromises the younger child's safety and is incongruent with the growth and developmental needs of both children and adolescents."[262]

- Pennsylvania: In December 2010, the Department of Health also found violations of cross-boarding regulations at UHS Meadows Psychiatric Center. One staff member reported feeling uncomfortable with cross-boarding, in part, because of a specific incident in which younger children slept in the adolescent unit which the staff member believed had housed two "known pedophiles." The staff member felt that the administration was not responsive to employees' concerns.[263]

UHS' proposal fails to meet the "Economic Evaluation" Criteria (OAR 333-580-0060) due to its record on having high costs of care.

<u>Impact on health care costs criterion:</u> Will the impact of the proposal on the cost of health care be acceptable? (a) 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: 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…

UHS claims in its CON application that the "proposal for a new 100-bed psychiatric facility will alleviate the burden on existing facilities and provide necessary access to psychiatric services. This will result in a lower cost of healthcare delivery."[264] UHS also states that since "there is no history for NewCo,"[265] the expected "financial model is driven off Cedar Hills' actuals for the most recent period available" but UHS acknowledged that "there is no public data available in Oregon that we are aware of that allows comparison to other providers' charges and expenses on a per statistic basis."[266]

When asked by the OHA CON office to provide specific information to support UHS' claims about the cost of care at its current Cedar Hills Hospital, UHS fails to do so and says it cannot reproduce that information because it is proprietary. Rather, UHS makes blanket statements that it is "the lowest cost provider of psychiatric care when compared with other inpatient psychiatric unit providers" in Oregon without any objective evidence to back up its claims.[267] If the proposed facility's "proposed charges for services offered at the Wilsonville facility are based on actual charges at [the] Cedar Hills facility,"[268] then we must take a closer look at UHS Cedar Hills facility.

According to Medicare data[269] in 2013 and 2014, or since UHS began operating Cedar Hills Hospital in October 2012, Cedar Hills has had the highest charge-to-cost ratios and payment-to-cost ratios compared to its Oregon peers. In 2014 for example, Cedar Hills had the highest charge-to-cost ratio of 377 percent, compared to the second highest of 239 percent. To put this figure into context, Cedar Hills' charge-to-cost ratio was not only significantly higher than its peers, but also higher than the Freestanding IPF national average of 262 percent. Cedar Hills' payment-to-cost ratios also follow similar trends. Cedar Hills' payment-to-cost ratio for 2014 was 125 percent, compared to the second highest which was 78 percent.[270] Once again, Cedar Hills' payment-to-cost ratio was higher than the Freestanding IPF national average of 118 percent in FY 2014.

Given these high charges at Cedar Hills, and the fact that UHS states that their "proposed charges for services offered at the Wilsonville facility are based on actual charges at [the] Cedar Hills facility,"[271] it is no wonder that UHS' projected profit margins for the proposed facility are astoundingly high. UHS states, "NewCo is projected to…become profitable thereafter, as volumes are realized and resources are more efficiently utilized…From year three thereafter, operating margin is forecast to rise above 30 percent and stabilize at 36 percent (year four).[272]

These high charges are not isolated to Cedar Hills. In fact, similar healthcare cost trends can also be found at its Fairfax Hospital in Kirkland, Washington. In 2014, Fairfax Hospital had the highest charge-to-cost ratios, and the second highest payment-to-cost ratios compared to its peers in Washington. In 2013, Fairfax Hospital had the highest charge-to-cost ratios, and the highest payment-to-cost ratios compared to its peers.

These high charges are due, in part, to the fact that UHS is a for-profit provider. According to a recent *Health Affairs* study co-authored by Gerard Anderson, a professor of health policy and management at Johns Hopkins University, for-profit hospitals generally had higher surpluses per adjusted discharge than other

types of hospitals and that a large majority of hospitals with high charge-to-cost ratios and high profitability were for-profit facilities.[273] All of these factors raise serious concerns that UHS' proposed facility will have an unacceptable impact upon the cost of healthcare due to its focus on profits rather than patient care. Thus, the UHS proposal to establish a for-profit behavioral health facility in Wilsonville, Oregon, should be denied.

Conclusion

It is essential that the healthcare providers who will be entrusted to provide vital psychiatric services to our communities meet the highest standards of quality patient care, cost-containment, and legal compliance. Only then, will we be able to achieve our state's goals of improving mental health services for our communities. However, as discussed above, UHS' troubling operational record shows that UHS-operated facilities have repeatedly failed to meet basic standards of quality care, patient and worker safety, and legal and regulatory compliance.[274] What's more, UHS' proposal fails to meet a majority of the state's CON review criteria regarding bed need, quality of care, access to care, availability of resources, and economic evaluation. For these reasons, we urge the Oregon Health Authority to reject UHS' proposal to build a 100-bed psychiatric Hospital in Wilsonville, Oregon.

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[3] UHS/NewCo initial CON application submission pack Jan 5, 2016 pdf 116-117
[4] UHS responses to OHA questions dated March 11, 2016, pdf 24
[5] UHS responses to OHA questions dated March 11, 2016, pdf 25, 78
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[14] UHS/NewCo initial CON application submission pack Jan 5, 2016 pdf 1
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