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COURT OF APPEALS,  
DIVISION I  
OF THE STATE OF WASHINGTON

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OVERLAKE HOSPITAL ASSOCIATION and OVERLAKE HOSPITAL  
MEDICAL CENTER, Washington nonprofit corporations; and KING  
COUNTY PUBLIC HOSPITAL DISTRICT NO. 2 d/b/a EVERGREEN  
HEALTHCARE, a Washington Public Hospital District,

Appellants,

v.

DEPARTMENT OF HEALTH OF THE STATE OF WASHINGTON,

Respondent.

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REPLY BRIEF  
OF APPELLANTS OVERLAKE HOSPITAL ASSOCIATION AND  
OVERLAKE HOSPITAL MEDICAL CENTER; AND KING COUNTY  
PUBLIC HOSPITAL DISTRICT NO. 2 d/b/a EVERGREEN  
HEALTHCARE

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A. INTRODUCTION

The Ambulatory Surgery Facility need methodology (the “Methodology”) requires including Exempt Surgical Facilities on both sides of the need/capacity equation. The Department of Health (the “Department”), however, is undisputedly and inexplicably interpreting the same terms differently in WAC 246-310-270(9), which is not in accordance with the well-established rules of statutory construction and operates to automatically and unrealistically inflate the forecasted need for additional operating rooms in the planning area. The record from the public hearing demonstrates that there is significant idle operating room capacity already in East King County. For example, both Evergreen and Overlake have operating rooms that are currently unused.

A primary purpose of the Certificate of Need (“CN”) laws is to make reasonable forecasts of future demand for health services so that facilities (i.e., outpatient operating rooms) can be added in a rational manner to fulfill the present and future needs of the community. The Department cannot apply different meanings to the same terms within the methodology – which is exactly what it is doing. The approach improperly inflates the projected need for operating rooms in the health

planning area to unexplainable and unsustainable levels, which is exactly contrary to the purpose of the CN laws.

In short, the Department must include the Exempt Surgical Facilities in the methodology. It cannot include them in one portion of the methodology and then exclude them in other portions of the methodology. That approach is irrational and not sensible health planning.

Operating rooms in Exempt Surgical Facilities should be counted (with those in hospitals and Ambulatory Surgical Facilities) when measuring the capacity of operating rooms in a planning area. Likewise, surgeries performed in Exempt Surgical Facilities (with those performed in hospitals and Ambulatory Surgical Facilities) should be used as the basis for projecting the need for future surgeries. Both sides of the need/capacity equation simply must use consistent sets of data for the equation to be in balance. When data from inconsistent sets is used on either side of the equation, the Methodology *cannot* be an accurate predictor of future need for outpatient operating rooms.

Of critical importance, the Department and Swedish Health Services (“Swedish”) acknowledge that their approach is imbalanced, internally inconsistent, and contrary to the plain language of the Methodology. They then contend, however, that this imbalanced approach

is somehow justified. Their attempts to justify the skewed approach fail, as is explained below.

**B. ARGUMENT**

1. The Department Acknowledges its Imbalanced Approach is Contrary to the Plain Language of the Methodology.

It is important to recognize that the Department's and Swedish's position is that:

(1) the plain language of the Methodology requires including Exempt Surgical Facilities in the projection of future capacity under WAC 246-310-270(9)(b)(i) (the *need* side of the equation);

(2) the plain language of the *capacity* side of the equation also “appears to be all inclusive [of Exempt Surgical Facilities]” under WAC 246-310-270(9)(a)(iii); but

(3) a plain language reading of the *capacity* side of the equation under WAC 246-310-270(9)(a)(iii) should be abandoned for the capacity side of the equation.<sup>1</sup>

In other words, the Department and Swedish contend that despite an accurate textual reading of the Methodology that includes Exempt Surgical Facilities in calculation of needed surgeries, this accurate plain-

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<sup>1</sup> CP 28-29 (also AR 506-07), Paragraphs 2.7 through 2.9 (the Final Order is also attached hereto as Appendix A-3 to Overlake's and Evergreen's Opening Brief). As Overlake and Evergreen point out in their Opening Brief, the Health Law Judge inverted this argument (probably mistakenly), but this was the result he clearly believed he was reaching, and this is the position of the Department and Swedish on appeal.

language approach should be abandoned when interpreting other sections of the same Methodology.

Significantly, both the Department and Swedish acknowledge this unbalanced approach. Swedish points to the plain language when discussing the future need side of the equation under WAC 246-310-270(9)(b)(i) (Section C of Swedish's brief), but then abandons looking at the language of the agency rule when applying the existing capacity side of the equation (Section B of Swedish's brief). This is a tacit acknowledgment that Swedish is applying the same terms of the Methodology differently depending on what section of the agency rule is being applied. This violates all applicable canons of statutory construction.

Swedish also attempts to quote just part of the text of the agency rule in an apparent attempt to mislead. Swedish Brief at 18-19 (claiming that the distinguishing factor is "the existing capacity side subsection counts 'operating rooms'; the future need subsection projects 'surgeries.'"). This disregards the complete, plain language of the Methodology. Both WAC 246-310-270(9)(a)(iii) for existing capacity and WAC 246-310-270(9)(b)(i) for future capacity use the terms "operating rooms" and "surgeries" in the text. Swedish's attempts to misdirect this Court by only citing to part of the agency rule should be rejected.

The Department correctly relies on the word "within" in WAC 246-310-270(9)(b)(i), stating that this word is all inclusive and therefore

Exempt Surgical Facilities should be included on the future forecasting side of the equation. Department Brief at 8-9. The Department, however, fails to explain how WAC 246-310-270(9)(b)(i) is more inclusive than the language in WAC 246-310-270(9)(a)(iii). If the language in the former is all inclusive, then so is the latter. The Department, like Swedish, entirely abandons discussing the plain language of the agency rule when it comes to the existing capacity side of the equation under WAC 246-310-270(9)(a)(iii). Once again this violates the applicable canons of statutory construction and leads to arbitrary inflation of the forecast of future demand in the community.

Swedish and the Department attempt to justify their wrong approach by arguing that the Department has “always” done it this way, the Department is entitled to deference in its legally wrong application, and that misguided policy arguments justify skewing the Methodology in this way.

2. The Department is Not Entitled to Deference Because it is Legally Wrong and No Expertise is Needed to Correctly Read the Methodology.

The Department is not entitled to deference in interpreting the Methodology when it is legally wrong and when there is no reason to defer to the Department’s expertise. *Mader v. Health Care Auth.*, 149 Wn.2d 458, 473, 70 P.3d 931 (2003); *Children’s Hosp. and Med. Ctr. v.*

*Dep't of Health*, 95 Wn. App. 858, 873, 975 P.2d 567 (1999).<sup>2</sup> Here, no deference to the Department is required because the Methodology is a series of mathematical calculations, which is described by a series of terms that can and should be used consistently throughout the Methodology, without any specialized knowledge of health planning.<sup>3</sup> The Court should reject the contention that illogical and unsupportable assumptions and speculation by the Department regarding the nature of ambulatory surgery are “agency expertise” that somehow require deference.

The Department and Swedish also overstate the deference that a reviewing court must give to an agency’s interpretation of its own rule. Although a court may defer to an agency’s interpretation, such deference is not automatic, absolute, or unlimited. A court retains the ultimate authority to interpret an agency rule to ensure that it is being interpreted and applied in accordance with the law. *Children’s Hospital*, 95 Wn. App. 864-65.

Swedish unsuccessfully attempts to distinguish *Children’s Hospital* from the present case. Swedish puts significance on the fact that the language interpreted in *Children’s Hospital* was partly defined both by statute and rule rather than only by rule. This distinction makes no difference in the present case. In fact, the *Children’s Hospital* court

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<sup>2</sup> The doctrine of agency deference was never intended to be an excuse to avoid the well-established principles of statutory construction and particularly when, as here, the Department and Swedish are inappropriately using it as a shield to divert attention from their mathematical nonsensical application of the methodology.

explicitly recognized that the rules of statutory construction apply equally to statutes and administrative rules, and that both “require a rational, sensible construction.” *Children’s Hospital*, 95 Wn. App. at 864 (quoting *State v. McGinty*, 80 Wn. App. 157, 160, 906 P.2d 1006 (1995)).

Swedish cites to a case from 1976 for the proposition that an agency’s interpretation of administrative rules is somehow accorded more deference than those of a statute. *Hayes v. Yount*, 87 Wn.2d 280, 289, 552 P.2d 1038 (1976). Swedish, however, misses the point. *Hayes* was based on a finding of the agency’s special expertise regarding fill material and how water would percolate through a landfill. *Hayes*, 87 Wn.2d at 289. The present case involves no such level of detailed knowledge or expertise. The only expertise that is required is the legal expertise of this Court to resolve whether an agency rule should be read consistently throughout, or whether, as the Department and Swedish contend, that the Department has the unbridled discretion to interpret the same terms within the same agency rule differently.

Swedish also cites *Providence Hosp. of Everett v. Dep’t of Social & Health Services* for the principle that “a reviewing court accords ‘substantial deference to the agency’s interpretation, particularly in regard to the law involving the agency’s special knowledge and expertise’.” (Brief of Respondent Swedish Health Services (“Swedish Brief”), pg. 10.) Swedish conveniently omits the portion of the quote from the case immediately preceding the quoted portion which reads: “[t]he error of law

standard permits this court to substitute its interpretation of the law for that of the agency....” *Providence Hosp. of Everett v. Dep’t of Social & Health Services*, 112 Wn.2d 353, 356, 770 P.2d 1040 (1989).

Contrary to Swedish’s claim, the issue here is not whether special knowledge and expertise of the Department is required in determining how outpatient operating room need is most accurately projected within a planning area. Rather, the issue is simply whether the same terms throughout the Methodology should be applied consistently. The answer, clearly, is yes.

3. The Department’s “Longstanding” Misapplication and Erroneous Interpretation does not Justify a Continued Misapplication of the Rule.

The Department’s past erroneous interpretation of the Methodology does not mean it may or is required to continue to misconstrue the Methodology. The argument is equivalent to saying that because the Department has misapplied the CN laws for a period of time, the Department has the right to continue misapplying the CN laws regardless of whether it is correct or whether the intent of the CN laws are satisfied. The Department certainly can and should correct itself, and courts have the authority to require a correction.

In fact, in a previous CN case regarding the correct application of a need methodology for open-heart surgery facilities (to which Petitioners

and Swedish were all parties), the Department changed course on its own.

The Health Law Judge ruled that:

**[t]he method of calculating current capacity is a question of law rather than an issue of fact, and the [Department] is not estopped from correcting its calculations consistent with the regulatory language even though it consistently calculated current capacity using a different interpretation of the same regulatory language.**

*Overlake Hospital Medical Center and Evergreen Healthcare, Dept. of Health Docket No. 03-06-C-2005CN, Findings of Fact, Conclusions of Law and Order of Remand, p. 2 (attached hereto as Appendix A) (emphasis added).*

The issue in the present case is similar to this prior decision: whether the Department is estopped from correcting its interpretation of an unambiguous regulation relating to a calculation required in a need forecast methodology, even though the Department consistently performed the calculation using a different interpretation of the same regulatory language.

While this prior CN decision is not binding on this Court, it illustrates that the Department has recognized that it must correct itself when its longstanding practices have been wrong according to the plain language of the regulation. Unfortunately, the Department has not done so here, and, therefore, Overlake and Evergreen petition this Court to correct

the Department's wrong interpretation of the need calculation for Ambulatory Surgical Facilities. As such, Swedish's argument that the Department would have acted arbitrarily had it interpreted the calculation of capacity to include CN exempt operating rooms is wrong.

4. Swedish's Unsupported Assertion of "Need" in the Planning Area Does Not Justify Skewing the Methodology to Justify that "Need".

Swedish's unsupported assertions of a need for additional ambulatory operating rooms in the East King planning area are self-serving statements without a basis in fact. Likewise Swedish's citation to national trends in outpatient surgery has no bearing on the correct application of the Methodology. Swedish's argument that intentionally skewing the Methodology to find a need, because a "need" exists, turns the Methodology on its head. Whether a need exists can only be determined if the need Methodology is correctly applied by balancing the need/capacity equation with data from the same sets of operating rooms on both sides of the equation.

Swedish's claim that there is a shortage of operating rooms in East King County and that the methodology is "conservative" based upon the use rate is unsubstantiated. Swedish's only real factual claim that there is a shortage in East King County is based upon the Methodology itself, which is the issue before this Court.

Swedish also accuses Evergreen and Overlake of wanting to prevent competition (Swedish Brief p. 1), which is a red herring. The real issue is the significant idle bed capacity in the East King County planning area. Swedish wants to divert the attention away from the real issue in this case, which is the proper interpretation and application of the Methodology.

5. The Department May Not Skew the Methodology Based on Misunderstandings and Unsubstantiated Assumptions about the “Availability” of Operating Rooms to the Public.

This Court should decide this case based on the textual analysis set forth in Overlake’s and Evergreen’s Opening Brief and need not examine whether the Department’s policy justifications are valid or even internally consistent. However, the Department’s justifications for its unbalanced reading of the Methodology and skewing the Methodology toward inevitably finding a need are illogical and fall apart upon review. These arguments are largely based on speculation and assumptions without any factual support in the record. Without factual support, they are arbitrary and capricious. *Netversant Wireless Sys. v. Wash. State Dept. of Labor & Indus.*, 133 Wn. App. 813, 822, 138 P.3 d 161 (2006). *See also, Motor Vehicle Mfrs. Ass’n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983) (agency must articulate a rational connection between the facts and the decision it makes). Far from being entitled to deference, these poor rationales lack both logic and common sense.

The Department holds the illogical opinion that CN-regulated Ambulatory Surgical Facilities should be able to accommodate not only all surgeries currently performed in CN-regulated Ambulatory Surgical Facilities, but also all surgeries performed in CN-Exempt Surgical Facilities. It is logical to assume that most surgeries performed in Exempt Surgical Facilities now will continue to be performed in Exempt Surgical Facilities in the future. The Department and Swedish, however, apparently believe that the Department should plan as if Exempt Surgical Facilities will somehow suddenly disappear in the future.

There is no indication in the record that there is or will be a lack of Exempt Surgical Facilities to accommodate the surgeries that are currently performed therein. In fact, the data shows exactly the opposite. The number of Exempt Surgical Facilities is growing, not shrinking. There is no data to suggest that this trend will reverse or that Exempt Surgical Facilities are not going to suddenly disappear. Thus, it is irrational for the Department to assume that it must provide enough operating capacity for the remote possibility that all of the Exempt Surgical Facilities would suddenly disappear. This line of thinking results in an unnecessary over-supply of operating rooms in the community. Such an outcome necessarily harms existing CN-approved facilities.

The Department and Swedish attempt to justify their assumption by asserting that most Exempt Surgical Facilities are specialized and are located in dental offices or cosmetic plastic surgery centers. Swedish and

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the Department contend that operating rooms in these facilities should, therefore, not be counted in the general supply. Yet, this rationale would logically lead to also excluding the procedures performed in those operating rooms from the surgeries that are counted as a basis for calculating future need for surgeries.<sup>4</sup>

Moreover, if, for some reason, dentists and plastic surgeons with private operating rooms left the planning area, their patients would simply travel to their providers' new locations or find other dentists or plastic surgeons in the planning area. Much plastic surgery, for example, is elective, and therefore a lack of private operating rooms in plastic surgeon's offices in the planning area may be an inconvenience, but it does not create an emergent need that justifies creating an oversupply of operating rooms in Ambulatory Surgical Facilities in the planning area. Of course, if the Department followed the consistently inclusive approach required by the Methodology, both the number of procedures in Exempt Surgical Facilities *and* the capacity of those Exempt Surgical Facilities themselves would be properly taken into account.

The Department and Swedish also wrongly argue that patients have greater "access" to operating rooms in Ambulatory Surgical Facilities than to operating rooms in Exempt Surgical Facilities in private

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<sup>4</sup> Although the Methodology requires a consistent *inclusive* approach, consistently using the same set of data on both sides of the need/capacity equation is the most important factor.

physician's offices. Patients, however, acquire access to all operating rooms (exempt or non-exempt) through their physicians, not on their own. Members of the public are not able to walk into either an Ambulatory Surgical Facility or an Exempt Surgical Facility and simply request a surgery.<sup>5</sup> Patients consult with physicians, who may recommend surgery, which is then performed in an available facility. Because surgeons are the gatekeepers, Ambulatory Surgical Facilities are just as inaccessible to patients as Exempt Surgical Facilities in private offices. In addition, most physicians who have Exempt Surgical Facilities in their private offices also have privileges at a hospital and Ambulatory Surgical Facilities, or both. Access to health care in the context of surgery means access to physicians, not to operating rooms. This argument, therefore does not justify deliberately misconstruing the Methodology to create an oversupply of operating rooms.

In sum, the Department's unsupported opinions on the nature of ambulatory surgery are not based on any facts in the administrative record and should not be accorded any deference, especially when used to flout the plain language of the Methodology. The Department must not be allowed to misread its own Methodology, especially when it results in oversupply in the planning area. In this instance, the Department's rationale appears to be based on misguided and unsupported beliefs

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<sup>5</sup> An exception to this may be cosmetic procedures, which, according the Swedish and the Department, are performed in private physician's offices (Exempt Surgical Facilities) anyway, as discussed above.  
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regarding the nature of ambulatory surgery. The input from the public hearing in this matter demonstrates that there is already significant idle operating room capacity in the health planning area. Hospitals and other facilities in the area have operating rooms that are currently “mothballed” while waiting for the demand to catch up with the supply. It does not make sense to add more facilities when the real data demonstrates that the community has ample supply already.

6. The 82/1000 Use Rate is not Being Challenged and is Thus not at Issue in This Case.

The Department mistakenly claims that Petitioners fail to show that the Department erred in applying an 82/1000 use rate in performing the need methodology calculation. Department Brief, pp. 7-11. Petitioners do not argue that the Department is misapplying the 82/1000 use rate. The use rate of 82/1000 used in the Department’s calculation is not at issue before this Court. See Petitioners Brief, pp. 10, 34. As previously noted, the significance of the use rate lies in the fact that in calculating this use rate, the Department accounted for surgeries performed in Exempt Surgical Facilities. In other words, the Department interpreted the methodology for calculating future need to be inclusive of all surgeries performed within a planning area. The Department’s error was in not adopting a similarly inclusive approach by counting all operating rooms when calculating available capacity for all surgeries.

When the Methodology is consistently applied, including all surgeries and all operating rooms in the East King planning area, the result is a finding of no need for additional dedicated outpatient operating rooms in the East King Planning Area. This is supported by the actual surplus of idle operating room capacity already in the health planning area.

C. **CONCLUSION**

The Department erred by failing to properly apply and/or interpret the need methodology found at WAC 246-310-270(9) according to the plain language of the agency rule. The Department has egregiously violated the well-settled rules of statutory construction. It correctly included surgeries performed in Exempt Surgical Facilities in the calculation of future surgical demand (WAC 246-310-270(9)(b)(i)), but erred by excluding those operating rooms in the same Exempt Surgical Facilities when calculating existing capacity (WAC 246-310-270(9)(a)(iii)). The approach is clearly mathematically flawed and inflates the demand for operating room facilities to proportions where need will always be found, regardless of the true fact that substantial idle operating room capacity exists in the planning area.

In doing so, the Department applied inconsistent interpretations to the same terms, i.e., “operating rooms” and “outpatient surgeries” within the same agency rule. Regardless of what Swedish says, the words “operating rooms” and “surgeries” are used on both sides of the equation and should be interpreted consistently. Both the Department and Swedish

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agree that they are not being applied in the same way, but attempt to justify the difference through unsupportable “policy” arguments. This is impermissible under the rules of statutory construction and not sensible or supportable.

The application of different interpretations of the same terms, absent any indication in the rule to do so, is simply not permitted. This Court need not defer to the Department’s erroneous interpretation of its rule because the plain language of the rule is clear and unambiguous, because interpreting the rule does not require specialized knowledge or expertise possessed only by the Department, because the Department’s interpretation conflicts with the underlying legislative intent to plan for *needed* health care facilities, and because of the Court’s authority to assure that the Department is acting in accordance with the law. Furthermore, from a purely mathematical standpoint, it makes no sense whatsoever to make existing capacity a function of one set of criteria and the forecast of future need a function of a completely separate set of criteria. The Administrative Law Judge was incorrect in trying to state that these are “separate concepts.” They are not “separate concepts” at all; rather, they are concepts that work in harmony to establish a reasonable forecast of future demand for operating rooms. The “separate concepts” approach for abandoning established principles of statutory construction does not pass muster.

Petitioners respectfully request that this Court find that no need exists for Swedish's proposed Ambulatory Surgical Facilities in the East King Planning Area when the need methodology is correctly applied using a consistent interpretation of the same terms in the rule. Alternatively, Petitioners ask for this matter to be remanded to the Department with instructions to correctly apply methodology according to the plain language as set out at WAC 246-310-270(9).

RESPECTFULLY SUBMITTED 18 day of Jan., 2008.

OGDEN MURPHY WALLACE, P.L.L.C.

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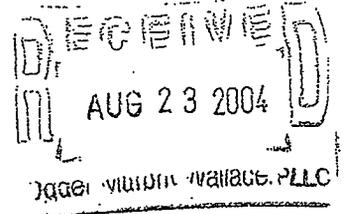
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# **APPENDIX A**

STATE OF WASHINGTON  
DEPARTMENT OF HEALTH  
ADJUDICATIVE SERVICE UNIT



In the Matter of: )  
)  
)  
OVERLAKE HOSPITAL MEDICAL )  
CENTER, a Washington non-profit )  
Corporation; and KING COUNTY )  
PUBLIC HOSPITAL DISTRICT NO. 2, )  
Dba EVERGREEN HEALTHCARE, )  
A Washington public hospital district, )  
)  
Petitioners. )  
)

Docket No. 03-06-C-2005CN

FINDINGS OF FACT,  
CONCLUSIONS OF LAW  
AND ORDER OF REMAND

APPEARANCES:

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Stephen I Pentz, Attorney at Law

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

PRESIDING OFFICER: John F. Kuntz, Health Law Judge

The Presiding Officer, through authority delegated to him by the Secretary of  
Health, conducted a hearing on January 8 and January 9, 2004, in Tumwater,  
Washington. On May 27, 2003, the Certificate of Need Program denied the joint open-

FINDINGS OF FACT,  
CONCLUSIONS OF LAW  
AND ORDER OF REMAND

heart surgery (OHS) and percutaneous transluminal coronary angioplasty (PTCA) application filed by Overlake Hospital Medical Center and Evergreen Healthcare.

Remanded.

### ISSUES

Did the Program correctly calculate "current capacity" in step one of the open-heart surgery need methodology when analyzing the Petitioners' open-heart surgery facility application?

If the Program did not correctly calculate current capacity, must the Program engage in the rule making process under the Administrative Procedure Act (chapter 34.05 RCW) before correcting its current capacity computation?

When it consistently followed a different interpretation of the current capacity definition when approving previous applications, is the Program estopped from computing the planning area's current capacity using the "correct" definition?

Would granting the Petitioners' application cause the reduction of an existing program below the 250 OHS minimum volume standard under WAC 246-310-261(3)(c), when the existing program's OHS surgery numbers were already below the minimum volume standard at the time of the application?

### SUMMARY OF DECISION

The Program did not correctly apply the need forecast methodology set forth in chapter 70.38 RCW and WAC 246-310-261 when analyzing the Petitioners' open-heart surgery application. The Program failed to calculate current capacity in a manner consistent with the regulatory definition set forth in WAC 246-310-261(5)(b) when calculating step one of the forecast need methodology.

The method of calculating current capacity is a question of law rather than an issue of fact, and the Program is not estopped from correcting its calculations consistent with the regulatory language even though it consistently calculated current capacity using a different interpretation of the same regulatory language. Given the regulation is unambiguous on its face, the Program is not required to engage in the APA rule-making process before interpreting the current capacity regulatory language to the Petitioners' joint application.

The language of WAC 246-310-261(3)(c) does not directly address the issue of the reduction of an existing OHS program that has not reached the 250 OHS minimum standard. Because it is ambiguous, statutory construction rules apply in interpreting the regulation. When read in context with other chapter 246-310 WAC provisions, and given that tertiary health services providers are required to reach sufficient patient volumes to optimize provider effectiveness and quality of services, any reduction of an existing providers volume, even for an existing provider that has not reached the minimum standard, appears contrary to the legislative intent of chapter 70.30 RCW and WAC 246-310-261(3)(c).

### PROCEDURAL HISTORY

On August 30, 2002, Overlake Hospital Medical Center and Evergreen Hospital Medical Center (the Petitioners) filed a joint application for a certificate of need to establish an open-heart surgery (OHS) and nonemergent percutaneous transluminal coronary angioplasty (PTCA) service program at the Evergreen Healthcare facility. The Program denied the joint application on May 27, 2003, and the Petitioners appealed the Program's denial decision on June 24, 2003. A three day hearing was scheduled for January 7 – 9, 2004. Swedish Health Services requested, and was granted, intervention on a limited basis under RCW 70.38.115(10) on August 29, 2003. Prehearing Order No. 1.

On November 12, 2003, the Intervenor moved to consolidate the Good Samaritan and Overlake/Evergreen proceeding, arguing the two proceedings involved similar factual and legal issues. The Program filed a memorandum in support of the Intervenor's motion on November 17, 2003. The consolidation motion was denied on the grounds that Good Samaritan and the Petitioners were not considered competing parties and the Intervenor (Swedish) had not intervened in the Good Samaritan matter. Prehearing Order No. 5.

On November 14, 2003, the Program moved to remand the decision on the Petitioners application to correct errors the Program contended it made in applying the OHS/PTCA methodology. The Program argued OHS figures from Harrison Hospital (a facility located in the same health service area that recently received an OHS/PTCA certificate of need) were not included in the WAC 246-310-261 calculations and figures relating to DRG 514 and 515 needed to be included under WAC 246-310-261(5)(e).

The Petitioners opposed the remand motion, arguing:

- (1) Neither the APA nor agency regulations permitted remand of an agency decision during an adjudicative proceeding to review agency errors;
- (2) A remand action would effectively continue the hearing date without showing any good cause existed to do so; and
- (3) The Petitioners disagree that any methodology errors exist in the present case.

The remand motion was denied on December 15, 2003. Prehearing Order No. 6.

On December 15, 2003, the Program moved for summary judgment, arguing:

- (1) The three changes made to the methodology were "correct";
- (2) The properly performed methodology mandates a denial of the application; and
- (3) The Program was not equitably estopped from correcting the methodology under Washington case law.

The Petitioners opposed the motion as untimely, as it was filed less than 28 days before the scheduled hearing date. See CR 56. Because it was unclear that the Program's most recent interpretation of WAC 246-310-261 was "correct", and given the

timing of the filing of the motion, the Presiding Officer denied the summary judgment motion on December 19, 2003. Prehearing Order No. 8.

The certificate of need application file was admitted as an exhibit at the prehearing conference. Prehearing Order No. 8. The hearing was conducted on January 8 and January 9, 2004. The parties agreed to incorporate the Good Samaritan hearing exhibits in the present hearing. OE RP at 9 – 10<sup>1</sup>. The Good Samaritan exhibits were:

- Exhibit 1: Certificate of Need application (Good Samaritan).
- Exhibit 2: OHS Current Capacity (1999 – 2001), prepared December 3, 2003 (new methodology differing from the one attached to the Program's denial decision).
- Exhibit 3: DRG 514 and 515 procedures by hospital/state for 2001.
- Exhibit 4: OHS Current Capacity (1999- 2001) prepared December 3, 2003 (variation of Exhibit 2, taking into account DRG codes 514 and 515).
- Exhibit 5: Calculation of Good Samaritan Hospital's proposed OHS Program on Tacoma General Hospital.
- Exhibit 6: Curriculum Vitae for Nayak L. Pollisar, Ph.D., dated September 22, 2003.
- Exhibit 7: Regression analysis charts (using data from 1997 to 2001).
- Exhibit 8: Charts regarding internal referral of cases; cumulative percentage of cases vs. average length of stay; and cumulative proportion of cases vs. DRG WT 2 for St. Joseph Medical Center and Tacoma General Hospital (re: acuity).

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<sup>1</sup> The parties agreed to incorporate portions of the Good Samaritan hearing transcript in the present hearing. For ease of reference the Good Samaritan report of proceedings is referred to as GS RP, and the Overlake/Evergreen report of proceedings as OE RP. Reference to the application record is identified by the abbreviation AR and the relevant page number. References to the hearing transcript will be identified by the abbreviation RP (report of proceeding), and referenced by the specific RP and relevant page number.

- Exhibit 9: Comparison of Tacoma General Hospital and St. Joseph Medical Center on case acuity (DRG WT 2).
- Exhibit 10: Second Declaration of Charles Frank (with attachments). Admitted on a limited basis.
- Exhibit 11: Department of Health analysis granting OHS/PTCA certificate of need to Harrison Memorial Hospital, dated November 2, 2001.

At the Overlake/Evergreen hearing the following additional exhibits were admitted (except where noted):

- Exhibit 13: Rick Ordos declaration in lieu of testimony, dated January 8, 2004.
- Exhibit 14: Petitioners' Designation of Testimony (with excerpts of testimony index and portions of Exhibits 15 – 19<sup>2</sup>), dated January 6, 2004.
- Exhibit 15: Randy Huyck deposition (Good Samaritan) (10/23/03).
- Exhibit 16: Randy Huyck deposition (Evergreen) (11/12/03).
- Exhibit 17: Karen Nidermayer deposition (Good Samaritan) (10/20/03 and 10/21/03).
- Exhibit 18: Karen Nidermayer deposition (Evergreen) (11/12/03).
- Exhibit 19: Janis Sigman deposition (Evergreen) (11/12/03).
- Exhibit 20: Attachment 20 – Open Heart Surgery Forecasts by HSA I Average Use Rates.
- Exhibit 21: OHSD Document prepared by Karen Nidermayer (revised) 6/30/98.
- Exhibit 22: Northwest Hospital – University of Washington certificate of need analysis, dated May 16, 1997.
- Exhibit 23: Appendix I – Open Heart Surgery Need Methodology per WAC.

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<sup>2</sup> This exhibit included an excerpt of Ms. Benedict's cross examination of Karen Nidermayer from the Good Samaritan proceeding, Docket No. 03-07-C-2002CN, on December 8, 2003. Given that the Good Samaritan record was made a part of this hearing record, this two-page document was not offered or marked as a separate exhibit.

- Exhibit 24: St Mary Medical Center certificate of need analysis, dated July 21, 1997.
- Exhibit 25: Central Washington Hospital certificate of need analysis, dated February 19, 1999.
- Exhibit 26: OHSD document prepared by Karen Nidermayer (revised) 9/28/92.
- Exhibit 27: Kadlec Medical Center – Kennewick General Hospital certificate of need analysis, dated February 6, 1998.
- Exhibit 28: Kadlec Medical Center – Kennewick General Hospital certificate of need settlement analysis, dated November 5, 1999.
- Exhibit 29: Open Heart Surgery Projections prepared by Karen Nidermayer, dated October 6, 1999.
- Exhibit 30: Mary Bridge Children's Hospital – Tacoma General Allenmore Hospital certificate of need application, dated March 13, 2000. Denied on grounds of relevance.
- Exhibit 31: Withdrawn.
- Exhibit 32: Open Heart Surgery Projections prepared by Karen Nidermayer (revised), dated 11/07/00.
- Exhibit 33: Karen Nidermayer email re: OHS data request sent December 23, 2003.
- Exhibit 34: OHSD document prepared by Karen Nidermayer, prepared 1/7/2004.
- Exhibit 35: Jody Carona Matrix of Certificate of Need Open Heart Surgery Decisions (Adult Only) 1993 –2003. Admitted on a Limited Basis.
- Exhibit 36: Overlake/Evergreen Certificate of Need Application file.
- Exhibit 37: CD-ROM disc containing open heart surgery analysis, created December 2003.
- Exhibit 38: Copy of Federal Register, Vol. 66, No. 148 (66 FR 39828).
- Exhibit 39: Copy of Department of Health Memorandum from Joe Campo to Open Heart Surgery Advisory Committee, dated August 7, 1991.

- Exhibit 40: Steps 5 and 6A per Karen Nidermayer's capacity method, prepared January 7, 2004.
- Exhibit 41: Adult Open Heart Surgery Discharges from Overlake Hospital Medical Center (CHARS) from 1994 through 2001.
- Exhibit 42: Kadlec Medical Center/Kennewick General Hospital Open-Heart Analysis (reconciliation of Step C per DOH Analysis to CHARS data provided by DOH 1996 email file).
- Exhibit 43: Harrison Memorial Hospital Open-Heart Analysis (reconciliation of Step C per DOH Analysis to CHARS data provided by DOH on CD-ROM).
- Exhibit 44: Recommended Standards and Forecasting Method for Certificate of Need Review of Open Heart Surgery Programs, Open Heart Surgery Advisory Committee, September 1991.
- Exhibit 45: Copy of Department of Health Memorandum from Joe Campo to Open Heart Surgery Advisory Committee, dated August 26, 1991.
- Exhibit 46: Summary and Analysis of Written Comments on Proposed Certificate of Need Rules on Open Heart Surgery and Nonemergent Interventional Cardiology Services, undated (ten pages).

The parties agreed to incorporate the Good Samaritan hearing record into the Overlake/Evergreen record to avoid having to repeat the testimony of witnesses presented at the prior hearing. OE RP at 6. The Petitioners reserved the right to object to portions of the Good Samaritan record, and agreed to file those objections no later than the date of filing their initial closing brief. OE RP at 7 – 8. The parties were granted permission to file briefs in lieu of closing argument. OE RP at 329 – 300; Posthearing Order No. 1. The hearing record was closed on May 3, 2004. Posthearing Order No. 2. The date for issuance of the final order was extended. Posthearing Order Nos. 3 & 4.

## HEARING

The Petitioners filed a joint application to develop and manage an open-heart surgery and elective intervention program located at Evergreen Hospital Medical Center (EHMC). AR at 1199. Overlake Hospital Medical Center (OHMC) began operating its own open-heart surgery and elective interventional program in November 1986. AR at 1210. EHMC would be the legal operator, but the Petitioners would establish a new entity, the Eastside Cardiac Care Alliance (ECCA), that would ultimately enter into an agreement with EHMC and OHMC and be responsible for the day-to-day operations of a single open-heart program operating at the two hospitals. The Petitioners anticipated joint management would include medical staffing, policies and procedures, quality assurance, professional education and community outreach. AR at 1211. To support this goal EHMC and OHMC entered into a Memorandum of Understanding. AR at 1219, 1230 – 1233.

Consistent with WAC 246-310-261(3)(d), the Petitioners initially provided that the OHMC cardiac surgeons would also staff the EHMC program, with a third surgeon to be recruited prior to the opening of the service. AR at 1246. The Petitioners did not anticipate any problems addressing the emergency needs of the service area population required under WAC 246-310-261(3)(e), and anticipated the higher risk patients would be referred to OHMC. AR 1246. In response to the Program's request for supplemental information, the Petitioners stated no contract existed but considered the employee-employer relationship of OHMC with its cardiac surgeons would ensure the availability of OHMC surgeons for emergency surgery on a 24/7 basis. AR 1451.

They set out those instances when they anticipated patient transfers, and provided a sample transfer agreement regarding emergency access. AR 1451, 1479 – 1482.

Open heart surgery (OHS) and percutaneous transluminal coronary angioplasty (PTCA) services are “tertiary health services”, which are specialized services that meet complicated medical needs of people and require sufficient patient volume to optimize provider effectiveness, quality of service and improved outcome of care.

RCW 70.38.025(14). An applicant seeking to establish a tertiary health service must apply for a certificate of need. RCW 70.38.105(4) (f); WAC 246-310-020(1)(d)(i)(E).

OHS is a specialized surgical procedure utilizing a heart-lung bypass machine.

WAC 246-310-261. OHS does not include organ transplantation. Nonemergent PTCA services are performed in institutions having an established on-site OHS program capable of performing emergency open heart surgery. WAC 246-310-262. An OHS/PTCA application must also meet the general certificate of need review criteria set forth in WAC 246-310-210 through 246-310-240. WAC 246-310-261(2).

To assist potential applicants, the Program creates an annual OHS need forecast using a seven-step methodology. WAC 246-310-261(4). The need forecast methodology calculates need using known open heart surgery volumes in the identified service area for a three year period prior to the application and calculates a current capacity figure based on that information. Relevant information is obtained from the Comprehensive Hospital Abstract Reporting System (CHARS), a database containing information on all surgeries reported by all hospitals within the state. GH RP at 21 – 22.

Open heart surgery codes or diagnostic related groupings (DRG 104 - 109<sup>3</sup>) identify the relevant OHS surgeries. GS RP at 22. The CHARS data from the relevant three-year period is used to forecast open-heart surgery service needs four years after the concurrent review process (for example, a 1992 review forecasts 1996 need).

WAC 246-310-261(4)(a) through (g); WAC 246-310-261(5)(c).

Karen Nidermayer, a Health Services Consultant 3 with the Certificate of Need Program, was the lead analyst for the OHS/PTCA joint application filed by the Petitioners and their application was filed during the same concurrent review cycle as the Good Samaritan application. OE RP at 61. Ms. Nidermayer analyzed the application using the WAC 246-310-261 methodology. OE RP at 62. In Appendix A to the analysis (calculated using the "highest year" approach) the need forecast was for an additional 529 open-heart surgeries. OE RP at 62. However, in the body of the analysis itself, Ms. Nidermayer projected a net need of 492 OHS surgeries for the 2006 forecast year (calculated using the "highest age" approach). AR at 2109. As the forecast need figure was greater than the 250 OHS minimum volume figure, Ms. Nidermayer did not deny the Petitioners' application on this basis.

At the hearing for both Good Samaritan and the Petitioners, Ms. Nidermayer sought to correct the OHS methodology by substituting the "highest hospital" for the "highest age" approach. OE RP at 62 – 63. By way of background, when Ms. Nidermayer began with the Certificate of Need Program she approached Joe

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<sup>3</sup> WAC 246-310-261(5)(e) specifies that only the diagnostic related surgery codes identified in DRG 104 – 108 are to be considered for open-heart surgery purposes. It is unclear from the testimony why the Program includes DRG 109.

Campo for guidance on how to calculate current capacity for purposes of completing a forecast methodology analysis. He advised her to ignore the "highest hospital" language in WAC 246-310-261(5)(b) and use a "highest age" calculation instead, as the highest age figures were more readily available from CHARS statistical data at that time. GS RP at 85 – 87. Ms. Nidermayer subsequently used this "highest age" figure to calculate current capacity when analyzing OHS application.<sup>4</sup>

In addition to correcting the forecast methodology from the "highest age" to the "highest hospital" approach, Ms. Nidermayer sought to include the 255 OHS procedures Harrison Memorial Hospital projected it would perform under its application. OE RP at 63; see Exhibit 12. These two corrections to the current capacity calculation methodology changed the projected need from an additional 492 OHS services in 2006 to a surplus of 130 OHS services for forecast year 2006. OE RP at 63; see Exhibit 2 (the actual forecast OHS surplus figure was 137). This surplus need figure shows there is no additional OHS need existed for HSA 1 and the Petitioners' application should be denied on that ground. OE RP at 64.

As previously noted, Ms. Nidermayer found sufficient need existed to support at least one new OHS program in her analysis, and lack of need was not the basis for her decision denying the Petitioners application. Her denial decision was based on the Petitioners failure to meet the WAC 246-310-261(3)(c) standard. Ms. Nidermayer determined approval of an OHS program at EHMC (one of the Petitioners) would act to

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<sup>4</sup> The Overlake/Evergreen expert, Jody Carona, asserted at hearing that the CHARS data system has consistently allowed the retrieval of "highest hospital" information during the relevant time period. GS RP at 494.

reduce OHMC's program below the minimum 250 OHS volume standard and would also prevent another OHS facility, Northwest Hospital, from reaching its 250 minimum standard. OE RP at 65; AR at 2110 – 2115. While Northwest Hospital's OHS case level for 2001 was already below the minimum 250 OHS standard, she decided that EHMC recapturing its eight verified OHS cases would act to further reduce Northwest Hospital's OHS figure from 154 to 146 OHS procedures. Ms. Nidermayer interpreted the WAC 246-310-261(3)(c) standard required an existing facility's OHS cases not be further reduced by a new OHS application, even though that facility was already below the 250 OHS minimum standard. OE RP at 71.

The Petitioners verified EHMC referred 278 OHS patients to seven of the twelve OHS facilities in HSA 1 and contended the establishment of the new OHS facility would not reduce any of the other facilities below the minimum standard. Their conclusion was based upon total volumes of HSA 1 hospitals and the number and percentages of these volumes generated by Eastside residents. AR 1244 – 1245; AR 2111 – 2115.

Ms. Nidermayer rejected the Petitioners approach. AR at 2113 – 2115. She rejected the approach, in part, because EHMC included out of state OHS cases in its calculation and the out of state case numbers were not predictable and should not be included in the calculations. After adjusting the figure by removing the nine out of state cases, EHMC's recapture of cases it referred to OHMC would reduce OHMC's volume to 244 cases or less than the 250 OHS minimum. Additionally, Ms. Nidermayer concluded EHMC would recapture OHS cases from Northwest Hospital, with the effect that it would reduce Northwest Hospital's volume (already below the 250 OHS

minimum) even further. Finally, Ms. Nidermayer concluded the Petitioners approach did not really show any impact on other facilities. It was irrelevant to EHMC's referral patterns, so it was not helpful in determining the impact on the existing providers. OE RP at 77.

In analyzing whether the Petitioners' application would reduce the OHS volumes for any of those seven facilities, Ms. Nidermayer found eighty-one percent of the EHMC referrals were made to two facilities, Swedish Medical Center and OHMC (its co-applicant). AR at 2111. Using a simple mathematical calculation, she determined that if EHMC recaptured 100% of its referrals to those two facilities then the Petitioners' application would cause OHMC to be reduced below the 250 OHS minimum procedures. Use of the 100% recapture rate was consistent with her approach in previous OHS application analyses, including her approach in the Good Samaritan application.

After denying the Petitioners' application for failing to comply with the WAC 246-310-261(3)(c) standard, Ms. Nidermayer applied a regression analysis to determine the projected number of OHS procedures to be performed for the health service area and the state. AR at 2114 – 2115. Neither the health service area nor the state regression analysis formed a part of her decision to deny the application, but Ms. Nidermayer chose to include them in the evaluation.<sup>5</sup>

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<sup>5</sup> It is unclear from the analysis why Ms. Nidermayer included material in her evaluation/analysis when it was not used in making the ultimate decision. If it was included to address an issue or concern raised in the application record, no specific reference to the record was identified in the analysis.

Ms. Nidermayer was unable to determine if the Petitioners' application complied with the WAC 246-310-261(3)(d) standard relating to the availability of board certified cardiac surgeons. She found no contract existed between EHMS and a cardiac entity to provide for cardiology services. AP 2115 – 2116. Ms. Nidermayer concluded the executed Memorandum of Understanding did not provide sufficient information for that purpose. AP at 2116. While the Petitioners did provide a sample transfer agreement, the Program concluded it did not contain sufficient information to allow a determination if the Petitioners' program would comply with WAC 246-310-261(3)(e).

Gary Bennett, the Program's director of facilities and services licensing, denied the Petitioners application based on Ms. Nidermayer's analysis. His normal practice is to rely on the expertise and determinations made by the analysis. OE RP at 24 – 25. Any review and analysis of an OHS application is based upon the relevant statutes and regulations. Staff and applicants may also refer to prior OHS written determinations, as there is no written policy manual on how to apply any specific methodology for calculation of need. OE RP at 23 – 24. The Program's goal is to ensure and maintain a consistent approach in reviewing applications. Mr. Bennett notes the Program would not continue to apply any methodology it knows to be incorrect simply to be consistent with its past decisions. OE RP at 36.

Following her employment with the Certificate of Need Program, Jody Carona created a consulting firm in 1981, Health Facilities Planning and Development, which has participated in five open-heart surgery applications since the 1992 rule change. This includes the OHS application by the Petitioners.

The open heart surgery rule was last amended in 1992, and Ms. Carona participated on a technical advisory subcommittee to develop a forecast methodology. OE RP at 225. One issue discussed by the subcommittee was how to calculate capacity. Four different approaches were considered. OE RP at 227 – 228. Three of the four approaches identified were the highest year (selecting the calendar year with the highest OHS volume from the three year calendar period), highest age (the total of the highest OHS age-specific use rate amounts from each of the three calendar years within the period) and highest hospital (the total of the highest OHS volumes from each of the facilities within the three year period). The subcommittee found none of the approaches was considered empirically superior to the other. OE RP at 228.

Ms. Carona described capacity as the maximum amount of throughput volume the existing provider could accommodate. OE RP at 229. From a policy standpoint, she believes using the highest hospital approach allows for a significant overstatement of capacity, as a one-year spike in a hospital's figures allows for the overstatement of capacity. OR RP at 234 – 235. According to statistician Nayak Pollisar, Ph.D., the highest hospital approach is a worst case interpretation, as it is unlikely that the maximum number across the board for each hospital will be achieved. GS RP at 236 – 237. Ms. Carona considers the highest year calculation as the most reasonable approach.

Nonemergent PTCA procedures and all other nonemergent interventional cardiology procedures shall be performed in institutions which have an established on-site OHS program capable of performing emergency open heart surgery.

WAC 246-310-262. Since its joint application was not consistent with the criteria in WAC 246-310-261, the Petitioners' application for PTCA services was denied. AR 2122.

Because the Petitioners' application was not consistent with the standards under WAC 246-310-261(3), the Program found it was not consistent with the requirements under the general certificate of need requirements under WAC 246-310-210 through 246-310-240. AR at 2123 – 2134. In deposition, and again at hearing, Ms. Nidermayer stated if the Petitioners met the WAC 246-310-261 requirements she would find the Petitioners met the general CON requirements. Exhibit 18; OE RP at 172 – 173.

#### LEGAL ANALYSIS

The Department of Health is authorized and directed to implement the certificate of need program. RCW 70.38.105. "The [Certificate of Need] program seeks to control costs by ensuring better utilization of existing institutional health services and major medical equipment. Those health care providers wishing to establish or expand facilities or acquire certain types of equipment are required to obtain a CN, which is a nonexclusive license." *St. Joseph Hospital and Health Care Center v. Department of Health*, 125 Wn.2d 733, 735 – 736 (1995). Reduced to its simplest terms, the Program controls health care costs by granting or denying of a certificate of need application. An OHS applicant must show it complies with the need methodology requirements under WAC 246-310-261(4), the standards under WAC 246-310-261(3) and the general need requirements under WAC 246-310-210 through 246-310-240.

The Program initially found additional OHS need existed in Health Service Area 1 in the 2006 forecast year and it did not deny the Petitioners' application for this reason. The Program denied the Petitioners' application because it failed to comply with three of the standards contained in WAC 246-310-261(3). First, granting the Petitioners' application for an OHS program at EHMC would act to reduce OHMC and Northwest Hospital's OHS volume below the minimum volume standard under subsection (3)(c).<sup>6</sup> Second, in its applications the Petitioners failed to demonstrate it would have at least two board certified cardiac surgeons as required under subsection (3)(d). Finally, the Program found the Petitioners did not have a sufficient plan for facilitating emergency access under subsection (3)(e). The Petitioners disagreed with the Program's analysis on these issues and appealed the decision.

In its remand motion, and at hearing, the Program sought to correct the methodology it used to calculate need in the analysis. It argued WAC 246-310-261(5)(b) required the calculation of current capacity using the highest hospital, rather than the highest age, approach. It also argued the clear language of WAC 246-310-261(4)(a) required the inclusion of 255 OHS assumed volume from Harrison Memorial Hospital in its calculations. If need was calculated using this approach it would reveal surplus OHS capacity existed in the forecast year and the Petitioners' application should be denied on those grounds. The Petitioners dispute the Program's current capacity calculations were a "mistake". They argue the Program

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<sup>6</sup> In its post hearing brief the Program conceded that using OHS surgeries on out of state patients could be used in the calculations, and no longer claimed that the Petitioners' proposed program would fail to comply with WAC 246-310-261(3)(c) by reducing OHMC surgeries below the minimum standard. Program Post Hearing Brief, at 12 – 13.

must use the highest age method, a method it has consistently used in reviewing previous OHS applications. The Petitioners argue by its consistent use of the highest age method, the Program is now estopped from using the highest hospital method absent the amendment of WAC 246-310-261(5)(b) following the required APA rule making process.

The same issues were recently addressed in the case *In re Good Samaritan Hospital*, Docket No. 03-07-C-2002CN (July 16, 2004) (*Good Samaritan*). In that decision the Presiding Officer held:

1. The plain language of WAC 246-310-261(5)(b) defines "current capacity" using the highest hospital approach rather than the highest age or highest year approaches.
2. The Harrison Memorial Hospital OHS program capacity must be included in any calculation of current capacity.
3. The Program is not estopped from using the correct current capacity approach even though it previously used an incorrect (highest age) approach in analyzing previous OHS applications.

*Good Samaritan*, at 26 – 29. Based on the reasoning of that decision, current capacity must be calculated using the highest hospital approach. As the adjudicative proceeding does not supplant the certificate review process, the matter should be remanded to address this issue.

The Petitioners argue granting its application will not reduce OHMC and Northwest Hospital's programs below the WAC 246-310-261(3)(c) minimum standard. The Program now agrees with the Petitioners that granting its application would not reduce the number of OHMC's open heart surgeries below the minimum standard. Program Post Hearing Brief, at 13.

FINDINGS OF FACT,  
CONCLUSIONS OF LAW  
AND ORDER OF REMAND

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The parties disagree whether reducing Northwest Hospital's open heart surgery numbers from 151 to 143 would cause the Petitioners' program to fail to comply with WAC 246-310-261(3)(c). The Program argues its interpretation is correct because the Petitioners proposed program undeniably would reduce the Northwest Hospital volume. Program Post Hearing Brief, at 13. The Program argues laws should be construed to effectuate statutory intent (i.e., preventing an OHS provider from reaching the 250 OHS minimum standard has the same effect as reducing it below the standard) and laws should be construed to avoid unlikely, absurd or strained consequences. Program Brief, at 13 (case citations omitted). The Program argues its interpretation (falling within its area of expertise) should be given substantial weight. *Id.*

The language of WAC 246-310-261(3)(c) provides "no new program shall be established which will reduce an existing program below the minimum volume standard." The minimum standard, pursuant to WAC 246-310-261(3)(a), is 250 OHS procedures. Since its application did not reduce Northwest Hospital below the minimum standard (as it was already approximately 99 to 107 surgeries below the OHS minimum standard), the Petitioners argue their application does comply with the language of the regulation. Petitioners' Initial Post Hearing Brief, at 12 – 14.

WAC 246-310-261(3)(c) states "no new program shall be established which will reduce an existing program below the minimum volume standard." The Petitioners argue the regulation is plain on its face and unambiguous, and therefore must be given its plain and obvious meaning. Petitioners' Initial Post Hearing Brief, at 12 (case citation omitted). The Program disagrees. In reviewing the WAC 246-310-261(3)(c), the

language of that subsection does not specifically address the issue in question, that is how to address an OHS facility which is already below the 250 OHS minimum standard.

A court interpreting a statute must first determine whether the statute's language is ambiguous, that is one whether the language is capable of more than one reasonable interpretation. *Gorman v. Garlock, Inc*, 121 Wn.App. 530, 541 (citations omitted). The question is whether WAC 246-310-261(3)(c) has more than one reasonable interpretation. Each party provides what it considers a reasonable interpretation.

In interpreting WAC 246-310-261(3)(c), the Program appears to distinguish between those situations where an existing program's surgical numbers are below the 250 OHS minimum standard and the new program does not recapture any OHS procedures from that existing program (see Exhibit 12) or where, as here, the new program does recapture OHS procedures from the existing program. The Petitioners contend WAC 246-310-261(3)(c) applies only in those situations where a new provider reduces an existing provider's OHS procedure level below the 250 OHS procedure level. In the event the existing provider is currently performing below the 250 OHS minimum level, the regulation does not apply (or reduce the existing program), even if the new program recaptures OHS procedures from that existing provider.<sup>7</sup> Were the Presiding Officer to read WAC 246-310-261(3)(c) independent of the remaining sections of chapter 246-310 WAC, the Petitioners argument would carry greater weight.

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<sup>7</sup> A review of chapters 70.38 RCW and 246-310 WAC does not reveal that the Program has any authority, once a certificate of need is awarded to a provider, to "close down" an OHS program that does not meet the 250 OHS minimum standard. It is unclear to the Presiding Officer why that authority does not exist, given that the 250 OHS procedure standard is deemed necessary to maintain OHS surgical competency levels.

The primary goal of the statutory construction is to carry out legislative intent. *Cockle v. Department of Labor & Industries*, 142 Wn.2d 801, 807 (2001). In determining legislative intent, a court must consider the entire sequence of all statutes related to the same subject matter. *Boise Cascade Corp. v. Washington Toxics Coalition*, 68 Wn.App. 447, 455 (1993). The legislative intent in chapter 70.38 RCW, in relevant part, is to develop health services in a planned, orderly fashion, consistent with identified priorities and *without necessary duplication* or fragmentation. RCW 70.38.015(2) (Emphasis added). It is necessary to give effect to all of the statutory language in construing a statute so that no portion is rendered meaningless or superfluous. *Davis v. Department of Licensing*, 137 Wn.2d 957, 963 (1999):

Open heart surgery programs are required to perform a minimum of 250 OHS procedures per year. WAC 246-310-261(3)(a). Open heart surgery, a tertiary health service, requires sufficient patient volume to optimize provider effectiveness, quality of service and improve outcomes of care. WAC 246-310-261-010. An OHS program shall meet the general standards in WAC 246-310-210 through 246-310-240 in addition to the specific open-heart surgery standards in order to receive a Certificate of Need. WAC 246-310-261(2). The population to be served must have a need for the services of the type proposed and the services are not or will not be sufficiently available or accessible to meet that need. WAC 246-310-210(1). The accessibility of such health services includes assessing the efficiency and appropriateness of the use of existing services and facilities similar to those proposed. WAC 246-310-210(1)(b).

The Program's practice of considering OHS program which are currently below the 250 OHS standard appears to include situations where (as here) a new provider recaptures OHS surgeries from an existing, but below standard, OHS provider. This reduces that existing provider's ability to maintain or achieve sufficient patient volumes and affects that provider's effectiveness. Where a new provider does not recapture any OHS surgeries from an existing, but below standard, OHS provider, that provider's ability to maintain or achieve sufficient patient volumes and effectiveness are not affected. Under that analysis, the Program's interpretation of WAC 246-310-261(3)(c) appears the more appropriate approach.

The Program determined it could not conclude whether the Petitioners complied with the WAC 246-310-261(3)(d) and (3)(e) standards. After reviewing the documentation contained in the Petitioners' application, the Presiding Officer agrees. On remand the Petitioners should be allowed additional time to provide documentation in support of these two requirements.

As stated in the Good Samaritan matter, the certificate of need adjudicative proceeding is not to supplant the certificate of need review process but to assure that the procedural and substantive rights of the parties have been observed and that the factual record supports the Program's analysis and decision. *See Ear, Nose, Throat and Plastic Surgery Associates*, Docket No. 00-09-C-1037CN (April 17, 2001), Prehearing Order No. 6, at page 8. For that reason the matter will be remanded so the Program can correct its analysis, and/or the Petitioners can supplement their application, consistent with this decision.

## I. FINDINGS OF FACT

1.1 The Petitioners submitted a joint application to establish OHS/PTCA services in Health Service Area I in August 2002. Analysis of this application was assigned to Program analyst Karen Nidermayer.

1.2 In Appendix A to the analysis, the 2006 projected need for additional OHS services was calculated to be 529 additional OHS procedures. Current capacity for this projection was calculated using the highest year approach and did not include the estimated OHS volumes for the Harrison Memorial Hospital application granted by the Program in November 2001.

1.3 In the body of the analysis Program analyst Karen Nidermayer used the highest age, rather than the highest year, approach when calculating current capacity. She projected a net need of 492 additional OHS surgeries in forecast year 2006. In calculating this net need figure she did not include the estimated OHS volume for the Harrison Memorial Hospital application granted by the Program in November 2001.

1.4 The Program made two mistakes in calculating "current capacity". It used the "highest age" rather than the "highest hospital" approach required under WAC 246-310-261(5)(b). The Program did not include the Harrison Memorial Hospital OHS assumed volume in calculating current capacity required under WAC 246-310-261(4)(a).

1.5 Utilizing the "highest hospital" approach, and calculating current capacity to include Harrison Memorial Hospital's assumed volume, results in a surplus OHS capacity of 137 surgeries for health service area 1 for the 2006 forecast year.

1.6 In the absence of need for additional OHS capacity, the Petitioners application failed to meet the PTCA requirements under WAC 246-310-262, and the general certificate of need requirements under WAC 246-310-210 through 246-310-240.

1.7 Granting an OHS application to EHMC reduces the minimum OHS volume for Northwest Hospital from 151 to 143 surgeries.

1.8 A review of the Petitioners' application does not provide sufficient information to determine whether they complied with the WAC 246-310-261(3)(d) and (3)(e) requirements.

## II. CONCLUSIONS OF LAW

2.1 The Department of Health is responsible for managing the certificate of need program under chapter 70.38 RCW. WAC 246-310-010. An applicant denied a certificate of need has the right to an adjudicative proceeding. WAC 246-310-610(1); RCW 34.05.413(2). A certificate applicant contesting a Department decision must file a written application for a proceeding within twenty-eight days of receipt of the department's decision or reconsideration. WAC 246-310-610(3). Chapters 34.05 RCW and WAC 246-10 govern the proceeding.<sup>8</sup>

2.2 The Petitioners filed a joint certificate of need application to establish OHS/PTCA services in health service area 1. The application was denied on May 27, 2003, and the Petitioners appealed the Program's decision denying their application on June 24, 2003. The Petitioners' request was timely.

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<sup>8</sup> WAC 246-310-610(3) provides chapter 246-08 WAC governs the proceeding. 246-10 WAC has replaced chapter 246-08. WAC 246-10-101(3).

2.3 The burden of proof in certificate of need cases is preponderance of the evidence. WAC 246-10-606. In all cases involving an application for licensure, the applicant shall establish it meets all applicable criteria. WAC 246-10-606. Evidence should be the kind upon which reasonably prudent persons are accustomed to rely in the conduct of their affairs. RCW 34.05.452(1); WAC 246-10-606.

2.4 To be granted a certificate of need, an open-heart surgery program shall meet the standards in [WAC 246-310-261] in addition to applicable review criteria in WAC 246-310-210 through WAC 246-310-240. WAC 246-310-261(2).

2.5 A planning area's current capacity for open-heart surgery equals the sum of the highest reported annual volume for each hospital within the planning area during the most recent available three years. WAC 246-310-261(5)(b). In those planning areas where a new program is being established, the assumed volume of that institution will be the greater of either the minimum volume standard or the estimated volume described in the approved application and adjusted by the department in the course of review and approval. WAC 246-310-261(4)(a).

2.6 WAC 246-310-261(5)(b), as written, requires current capacity as the highest reported annual volume for each hospital, and requires the use of the "highest hospital" method in calculating that number. *In re Good Samaritan Hospital*, 03-07-C-2002CN (July 16, 2004). That number is then used to calculate step one of the forecast need methodology under WAC 246-310-261(4). Because the Program did not use the "highest hospital" method to calculate current capacity, it failed to correctly calculate the OHS forecast need amount for the 2006 forecast year.

2.7 WAC 246-310-261(4)(a) requires the calculation of current capacity include the minimum or estimated volume of a new program where such program is being established. A new program (Harrison Memorial Hospital) was established in 2001 after the Petitioners application was filed and should have been used in calculating current capacity. The Program failed to do so and therefore did not correctly calculate current capacity in analyzing this application.

2.8 The language in WAC 246-310-261(5)(a) is unambiguous and requires calculation of current capacity using the "highest hospital" method. The language in WAC 246-310-261(4)(a) is unambiguous, and requires the calculation of current capacity using the 255 OHS assumed volume of Harrison Memorial Hospital. Because the regulation is unambiguous it is not subject to the rules of statutory interpretation, and must be applied by the Program as written. Because the issue raised on appeal speaks to a matter of law rather than an issue of fact, the Program is not estopped from correctly applying the language of the relevant regulation.

2.9 WAC 246-310-261(3)(c) provides no new OHS program shall be established which will reduce an existing program below the minimum volume standard. The regulation does not specifically address the situation where an existing program is currently performing below the 250 OHS minimum standard. The regulation is therefore ambiguous and subject to the rules of statutory interpretation.

2.10 Based on the legislative intent contained in RCW 70.38.015(2), and interpreting WAC 246-310-261(3)(c) in conjunction with the other regulatory sections contained in 246-310 WAC, an applicant can reduce the OHS volume of an existing

program, even though the existing program's OHS volume has not achieved the 250 OHS minimum standard. By reducing Northwest Hospital's OHS standard from 151 to 143, the Petitioners application fails to comply with the WAC 246-310-261(3)(c) standard.

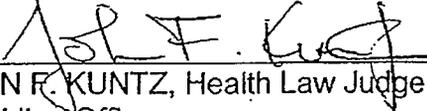
2.11 The language of WAC 246-310-261(3)(d) provides an OHS program shall have at least two board certified cardiac surgeons, at least one of whom is available for emergency surgery twenty-four hours a day. WAC 246-310-261(3)(e) provides that institutions with OHS program shall have plans for facilitating emergency access to open heart surgery services at all times for the population they serve.

2.12 Based on a review of their application, and supplements to that application, there is insufficient evidence to determine whether the Petitioners meet the standards contained in WAC 246-310-261(3)(d) and (3)(e).

### III. ORDER

Based on the foregoing Procedural History, Findings of Fact and Conclusions of Law, the Certificate of Need Program's determination denying the Petitioners' open-heart surgery application is REVERSED and the application REMANDED to the Program for processing consistent with the terms of this Order. The recalculation shall be filed with the Adjudicative Service Unit within 28 days of the date of service of this order.

Dated this 20<sup>th</sup> day of August, 2004.

  
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JOHN F. KUNTZ, Health Law Judge  
Presiding Officer

FINDINGS OF FACT,  
CONCLUSIONS OF LAW  
AND ORDER OF REMAND

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## NOTICE TO PARTIES

This is not a final order issued under RCW 34.05.461. A final order based upon these Findings of Fact shall be issued after receipt of the recalculation completed in accordance with this order.

The recalculation shall be filed with the Adjudicative Service Unit within 28 days of the date of service of this order. "Filing" means actual receipt of the document by the Adjudicative Service Unit. RCW 34.05.010(6). This Order was "served" upon you on the day it was deposited in the United States mail. RCW 34.05.010(19).