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No. 82728-1

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(Court of Appeals No. 60554-2-1) HALO R. CARPENTER

SUPREME COURT OF THE STATE
OF WASHINGTON

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OVERLAKE HOSPITAL ASSOCIATION and
OVERLAKE HOSPITAL MEDICAL CENTER

and

KING COUNTY PUBLIC HOSPITAL DISTRICT NO. 2,
d/b/a EVERGREEN HEALTHCARE,

Respondents,

vs.

DEPARTMENT OF HEALTH OF THE STATE
OF WASHINGTON

and

SWEDISH HEALTH SERVICES,

Petitioners

**SUPPLEMENTAL BRIEF OF
SWEDISH HEALTH SERVICES**

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I. INTRODUCTION

Outpatient surgery is an increasingly important part of Washington's healthcare system. As a result of technological advances, such as lasers, advanced anesthetic agents, and laparoscopic procedures, more surgeries now can be performed on an outpatient basis than ever before. Providing outpatient surgery at ambulatory surgery centers ("ASCs"), rather than in hospitals, is good for patients, because they are able to obtain surgery in a more convenient location, closer to home. It is also good for healthcare providers and the healthcare system as a whole, because procedures can be performed more efficiently, and thus at a lower cost.

East King County has more than 500,000 residents and only three Certificate-of-Need-approved ASCs: Evergreen Healthcare's ASC, approved in 1981; Overlake Hospital's ASC, approved in 1999; and the Northwest Nasal Sinus Center ASC, approved in 2002. The Eastside simply does not have enough operating rooms ("ORs"), whether in its hospitals or ASCs, to meet the outpatient-surgery needs of its large and growing population. Indeed, thousands of Eastside residents travel to Seattle facilities every year for outpatient surgery, including more than 4,000 surgeries at Swedish's hospitals alone. The Department of Health's "conservative" estimate is that the Eastside has a shortage of five

outpatient ORs; Swedish estimates the actual shortage to be at least eleven outpatient ORs.

The Department of Health (the "Department") approved Swedish's application for a Certificate of Need to establish a 5-OR ambulatory surgery center in Bellevue. This new facility will help meet the Eastside's need for additional outpatient ORs. It also will allow Swedish to better serve its Eastside patients and to offer another choice of provider on the Eastside.

Moreover, consistent with Swedish's non-profit mission, Swedish will serve Medicare and Medicaid patients, as well as provide charity care, at its new ASC, just as it does in its Seattle hospitals. This will help ensure that *all* residents of the service area, including low-income persons, will have adequate access to surgical care.

The Legislature created the Certificate of Need Program to promote access to healthcare services and control costs. Allowing Swedish to build an ASC on the Eastside will serve both of these goals. The Department correctly interpreted and applied its regulations in approving Swedish's ASC. Accordingly, Swedish respectfully requests that this Court reverse the Court of Appeals' opinion and reinstate the Department's decision granting a Certificate of Need to Swedish.

II. ASSIGNMENTS OF ERROR

“This Court reviews the [agency's] decision, not the decision of the superior court” or the Court of Appeals. *King County v. Central Puget Sound Growth Mgmt. Hearings Bd.*, 142 Wn.2d 543, 553, 14 P.3d 133 (2000). It “appl[ies] the standards of RCW 34.05 directly to the record before the agency, sitting in the same position as the superior court.” Accordingly, this Court reviews the Department's decision approving Swedish's facility, not the Court of Appeals' opinion.

Nevertheless, Swedish assigns the following errors to the Court of Appeals' opinion:

1. The Court of Appeals applied the wrong standard of review to the Department's final order;
2. The Court of Appeals misinterpreted WAC 246-310-270(9); and
3. The Court of Appeals reversed the Department's final order even though Overlake and Evergreen were not “substantially prejudiced” by the agency action.

III. STATEMENT OF THE CASE

A. Swedish Applied For a Certificate Of Need To Establish an Ambulatory Surgery Center in Bellevue.

Swedish plans to build a 5-OR, \$7.4 million, multi-specialty ambulatory surgery center in Bellevue. AR (1st) 128 *et seq.*¹ This facility will be available to all physicians in the community who have privileges to practice at Swedish. AR (1st) 135. This includes 280 surgeons on Swedish's active medical staff. AR (1st) 274. "Given the increasing emphasis on the provision of medical care in the outpatient setting," as well as patients' increasing "preference to obtain services close to home," Swedish believes "that this ambulatory surgery center will allow for Swedish's medical services to be provided to [its] patients in a more appropriate and cost-effective manner." AR (1st) 135.

Under the Certificate of Need ("CN") statutory framework, "[t]he construction, development, or other establishment of a new health care facility" requires approval by the Department of Health. RCW 70.38.105(4)(a); WAC 246-310-020(1)(a). "Health care facility" is defined to include "ambulatory surgical facilities" such as the one Swedish plans to build in Bellevue. RCW 70.38.025(6); WAC 246-310-010(26);

¹ The administrative record in this case is contained in two, separately-numbered parts. As it did in the Court of Appeals, Swedish will use "AR (1st)" to refer to the administrative record which preceded the first judicial review proceeding, and "AR (2d)" to refer to the additional administrative record on remand, which preceded the second judicial review proceeding.

see also WAC 246-310-010(5) (defining “ambulatory surgical facility”). Accordingly, on November 14, 2002, Swedish applied to the Department for a CN to establish its proposed ASC.

B. East King County Has a Shortage Of Operating Rooms.

In recent years, there has been substantial population growth in East King County. This has been coupled with an increasing demand for outpatient surgical procedures nationwide, both in absolute terms and as a percentage of total surgeries. AR (1st) 140. This trend is the result of several factors, including technological advances allowing more surgeries to be performed on an outpatient basis, and the preference of many patients to obtain surgery in an outpatient setting and closer to home. *Id.* A leading national survey has confirmed an “explosive growth of ambulatory surgery” across the U.S. AR (1st) 200.

The Eastside's healthcare infrastructure has not kept pace with either the area's population growth or the increasing demand for outpatient surgery. More than 500,000 people now live in East King County. AR (1st) 1969. This large population is served by only three CN-approved ASCs: Evergreen Surgery Center, approved in 1981; Overlake Surgery Center, approved in 1999; and Northwest Nasal Sinus Center, approved in 2002. AR (1st) 43.

These three ASCs, together with the hospital operating rooms available at Overlake and Evergreen, are insufficient to meet the needs of Eastside residents. This is evidenced by the fact that more than 4,000 ambulatory surgeries are performed on Eastside residents annually at Swedish's Seattle hospitals. AR (1st) 47. This is more than 10 outpatient surgeries for every day of the year on Eastside patients at Swedish alone.

The Department projected a shortage of approximately 12 operating rooms in East King County by 2009, including 5 outpatient ORs and 7 inpatient ORs. AR (2d) 265, 501. However, this is a *conservative* estimate. AR (1st) 2025. Swedish's calculations actually put the shortage at 23 operating rooms, including 11 outpatient ORs and 12 inpatient ORs. AR (2d) 264.

C. Swedish's Bellevue ASC Would Help Meet This Need.

It is noteworthy that the two petitioners, Overlake and Evergreen, not only have hospitals on the Eastside, but also already have their own ASCs on the Eastside. AR (1st) 42. Indeed, between their hospital ORs and ambulatory surgery center ORs, Overlake and Evergreen control virtually all of the generally-available operating rooms in the planning area. Moreover, Overlake and Evergreen are each expanding their own Eastside facilities. AR (1st) 431. Their argument against Swedish's

application—that there is not “need” for additional ORs in the planning area—is belied by their own actions.

Swedish is the logical choice to add operating-room capacity in East King County. Swedish already cares for thousands of Eastside families at its Seattle hospitals. Swedish Physicians, a primary-care medical group, cares for more than 34,000 Eastside patients out of its Factoria clinic. AR (1st) 417. This includes more than 2,700 pediatric patients. AR (1st) 426. Additionally, more than 400 physicians on Swedish’s medical staff live on the Eastside, including more than 175 with a surgery-related specialty. AR (1st) 416. Therefore, it only makes sense that Swedish be allowed to build an ASC in Bellevue, to provide outpatient surgery for its Eastside patients, in a non-hospital setting closer to home.

Swedish's ASC would also create another option for Medicare and Medicaid patients, as well as persons needing charity care. Swedish is a not-for-profit organization, with a strong history of serving low-income populations. AR (1st) 434. Its community-benefit contributions include health-related research, community health activities and non-billed services, charity care, medical education, and Medicaid subsidies. AR (1st) 434. Allowing a Swedish-owned ASC to be established will

therefore improve access to healthcare for low-income persons. AR (1st) 434.

D. The Department of Health Approved Swedish's Bellevue ASC.

The Certificate of Need Program of the Department of Health approved Swedish's application on August 25, 2004. AR (1st) 719-35. Following an adjudicative proceeding commenced by Overlake and Evergreen, the Program's decision ultimately was affirmed by Health Law Judge ("HLJ") John F. Kuntz on November 9, 2006. AR (2d) 491-509.²

E. The Court of Appeals Reversed the Department's Approval of Swedish's Facility.

Overlake and Evergreen sought judicial review of the Department's decision in King County Superior Court, where the Department's approval of Swedish's facility was affirmed by the Honorable Julie A. Spector on August 23, 2007. CP 403. Overlake and Evergreen next sought review of the Department's decision in the Washington Court of Appeals, Division I. On October 13, 2008, the Court of Appeals reversed the Department's approval of Swedish's facility. *See Overlake Hosp. Ass'n v. Dep't of Health*, 146 Wn. App. 1074, 2008 WL 4542868 (2008).

² This case's complicated procedural history is discussed in detail in Swedish's brief in the Court of Appeals, at pp. 8-9. The final agency action was HLJ Kuntz's November 9, 2006 order approving Swedish's facility.

IV. ARGUMENT

A. Standard of Review.

The Department's decision approving Swedish's CN application "is presumed correct" and Overlake and Evergreen "bear[] the burden of proof." *Univ. of Wash. Med. Ctr. v. Dep't of Health*, 164 Wn.2d 95, 102, 187 P.3d 243 (2008); *see also* RCW 34.05.570. Overlake and Evergreen must prove two things. First, they "ha[ve] the burden of showing the department misunderstood or violated the law[.]" *Univ. of Wash.*, 164 Wn.2d at 103. Second, they have the burden of showing that they have been "substantially prejudiced by the action complained of." RCW 34.05.570.

Where, as here, the interpretation of a regulation is at issue, the Court "accord[s] substantial deference to the agency's interpretation, particularly in regard to the law involving the agency's special knowledge and expertise." *Univ. of Wash.*, 164 Wn.2d at 102.

B. Overlake and Evergreen Have Not Established That the Department Misunderstood Or Violated the Law.

1. **Operating Room "Need" Is Determined By the Methodology Set Forth In WAC 246-310-270(9).**

The Department ordinarily will not approve a new ASC unless the Department projects a shortage of available operating rooms in the planning area. *See* WAC 246-310-270(4). In this case, the relevant

planning area is East King County. WAC 246-310-270(3). The Department's methodology for projecting operating room need is set forth in WAC 246-310-270(9). There are essentially three steps in the methodology: (1) determine the "existing capacity" of operating rooms in the planning area; (2) project the "future need" for operating room capacity in the planning area; and (3) consider whether the "future need" for operating room capacity is greater than or less than the "existing capacity." *See* WAC 246-310-270(9).

Not all new ASCs require CN approval, however. The regulations specifically carve out an exemption for facilities "in the offices of private physicians or dentists, whether for individual or group practice, if the privilege of using the facility is not extended to physicians or dentists outside the individual or group practice." WAC 246-310-010(5). These closed, private-practice facilities are frequently referred to as "CN-exempt" ASCs.

There are significant differences between CN-approved and CN-exempt ASCs. First, a CN-exempt ASC can only be used by the physicians in whose office it exists. Second, a physician who owns a CN-exempt ASC is not required to accept Medicare or Medicaid patients, or provide any charity care, whereas CN-approved ASCs are often required to do so as a condition of receiving a CN. Third, a physician with an OR

in her own office often will have a narrow specialty, and therefore that OR will only be used for certain types of procedures. Fourth, a CN-exempt OR often will be used less frequently than a CN-approved ASC, because it is available to fewer surgeons.

Overlake and Evergreen argue that the Department treats CN-exempt ASCs incorrectly within WAC 246-310-270(9). Specifically, the Department does not include CN-exempt ASCs when determining existing capacity (step 1, described above); however, the Department includes all surgeries performed in the planning area, including in CN-exempt ASCs, in its “use rate” calculation to project the number of surgeries that will be needed in the planning area (step 2, described above). The Department's interpretation of WAC 246-310-270(9) is correct. Indeed, the Department follows the regulation to the letter.

2. Existing Capacity: WAC 246-310-270(9) Provides That Operating Rooms In CN-Exempt ASCs Must Be Excluded From Existing Capacity.

WAC 246-310-270(9)(a) states how the Department will determine existing capacity of operating rooms. The regulation requires the Department to count two types of operating rooms when determining existing capacity. First, the Department counts the “dedicated outpatient operating rooms” in the planning area. WAC 246-310-270(9)(a)(iii).

These are operating rooms in ambulatory surgical facilities, as well as any operating rooms in hospitals that may be dedicated to outpatient surgery. Second, the Department counts the “remaining inpatient and outpatient operating rooms in the area[.]” WAC 246-310-270(9)(a)(iv). These are the operating rooms in hospitals which are not dedicated to outpatient surgery. *Compare* WAC 246-310-270(9)(a)(ii) *with* WAC 246-310-270(9)(a)(i).

The methodology in WAC 246-310-270(9) must be read in connection with the applicable “definitions” set forth in WAC 246-310-010. There, the Department specifically excludes CN-exempt ASCs from the definition of “ambulatory surgical facilities”—the facilities which, along with hospitals, are those whose operating rooms are being counted in WAC 246-310-270(9)(a). WAC 246-310-010(5). Private-practice, CN-exempt ASCs in the offices of individual physicians simply are not part of what is being considered. They are neither “dedicated outpatient operating rooms” counted under WAC 246-310-270(9)(a)(iii), nor are they hospital operating rooms not dedicated to outpatient surgery counted under WAC 246-310-270(9)(a)(iv).

This definition of “operating rooms”—i.e., excluding CN-exempt ASCs—is the definition that was intended by the Department when adopting WAC 246-310-270(9), and that has long been followed by the

Department. This precise issue was discussed at length by the Department's Health Law Judge in *In Re Pacific Rim Outpatient Surgery Center* (Wash. Dep't of Health October 17, 2003):

The parties each define operating room differently, and this ambiguity raises a statutory interpretation issue. What is important is the characterization or type of "operating room". The question is not "what is an operating room". The issue is "what type of operating room" is included in the WAC 246-310-270(9) calculation? Viewed in this manner, the Presiding Officer concludes the term "operating room" must be read in conjunction with the definition of "ambulatory surgical facilities". Counting all operating rooms in the service area is inconsistent with the other subsections contained in WAC 246-310-270 . . .

This reading is supported by the public policy of health planning set forth by the Legislature. RCW 70.38.015.

AR (2d) 390-91.

The Department's annual capacity assumptions in WAC 246-310-270(9)(a) also reflect the fact that the CN-exempt ASCs are excluded here. An OR whose use is restricted to an individual physician or group of physicians (the very *definition* of a CN-exempt ASC, under WAC 246-310-010(5)) obviously is not going to be "available" for as much of the time as an OR in a hospital or CN-approved ASC, which could be used by *many* surgeons, and for which the annual capacity assumptions are designed.³

³ The Department assumes that an operating room dedicated to ambulatory surgery has an annual capacity of 68,850 minutes. *See* WAC 246-310-270(9)(a)(ii). The "default"

The Department's use of the term "operating rooms" throughout WAC 246-310-270 also confirms that operating rooms in CN-exempt ASCs are not to be considered as part of existing capacity. For example, in subsection (1), the Department "plan[s] for operating rooms[.]" In subsection (4), the regulation states that "[o]utpatient operating rooms should ordinarily not be approved" unless certain conditions are met. In subsection (6), the regulation provides that "[a]n ambulatory surgical facility shall have a minimum of two operating rooms." Because the Department does not "plan for" or "approve" CN-exempt ASCs, and "ambulatory surgical facility" is defined as excluding CN-exempt ASCs, plainly the reference to "operating rooms" in the methodology *must* exclude operating rooms in CN-exempt ASCs.

Therefore, under the precise language of the Department's regulations, operating rooms in CN-exempt ASCs must be excluded from the "existing capacity" determination of WAC 246-310-270(9)(a). Moreover, as a practical matter, it would be impossible for the Department to include the operating rooms in CN-exempt ASCs in existing capacity.

length of surgery is 50 minutes per outpatient surgery. *See* WAC 246-310-270(9)(b)(i). Thus, a "typical" outpatient operating room in a hospital or CN-approved ASC could accommodate 1,377 surgeries per year. It would be a very busy physician indeed who could perform 3.8 surgeries per day, 7 days per week, herself, in the operating room in her own office. Plainly, the Department's methodology is not intended to include such private-practice, CN-exempt ASCs in the "available" existing capacity calculation, along with hospital-based and CN-approved ASCs for which these existing capacity assumptions are designed.

Because a physician does not need to obtain a CN before building an operating room in her own office, the Department does not actually know how many of these private-practice, CN-exempt ORs exist. Therefore, the Department cannot possibly have intended its regulation to require it to count facilities that it would be unable to count.

3. Projected Future Surgeries: WAC 246-310-270(9) Provides That Surgeries Performed In CN-Exempt ASCs Must Be Included When Determining the Surgical Procedure “Use Rate” Employed To Project the Number Of Future Surgeries In the Planning Area.

WAC 246-310-270(9) provides that surgeries performed at CN-exempt ASCs must be included when calculating the planning area’s “use rate,” used to project the total number of surgeries that will take place in the planning area in the future.

The regulation requires the Department to project the number of “*surgeries performed within the hospital planning area[.]*” WAC 246-310-270(9)(b)(i) (emphasis added). Unlike the “existing capacity” determination, this step simply counts all surgeries in a *geographic* area, regardless of the type of facility in which those surgeries were performed.

In other words, the “existing capacity” determination (subsection a) counts *operating rooms*, whereas the “future need” determination (subsection b) counts *surgeries*. More precisely, the “existing capacity”

calculation counts the number of operating rooms *in hospitals and ambulatory surgical facilities* (as defined under WAC 246-310-010(5)), whereas the “future need” projection counts surgeries *in the planning area*. The first determination considers *specific types of facilities*, whereas the second determination considers only the *geographic area*.

4. The Department's Methodology Is Consistently Used On All ASC Applications.

The Court of Appeals' opinion appears to be based on its conclusion that the Department's methodology is “biased toward need.” *Overlake Hosp.*, at *1. Indeed, the Court of Appeals could “envision no scenario where the Department's application of the formula will *not* result in a showing of need (except where there are no exempt facilities).” *Id.*, at *2 (emphasis added). The Court of Appeals simply misunderstood how the regulation works. The regulation's historic application demonstrates that it does not “inevitably” lead to approval of new facilities.

For example, in 2007 one of the Department's Health Law Judges, Zimmie Caner, denied MultiCare Health System's application to establish an ASC in Gig Harbor, which is in the Central Pierce planning area. Like the East King planning area, Central Pierce, which includes Tacoma, is a highly populated planning area with competing healthcare facilities, including CN-exempt ASCs. HLJ Caner applied the same methodology to MultiCare's application in that case as HLJ Kuntz applied to Swedish's

application in this case—in other words, she *included* the surgeries in CN-exempt ASCs (of which there were *seven* in Central Pierce) when calculating the “use rate,” but *excluded* these CN-exempt ASCs when determining existing capacity. Using this same methodology, HLJ Caner determined that Central Pierce had a large surplus of operating rooms and accordingly denied MultiCare's application. *See In Re MultiCare Health System Gig Harbor Ambulatory Surgery Center* (Wash. Dep’t of Health Dec. 13, 2007) (“*In re MultiCare*”) at 5.⁴

5. The Court Should Defer To the Department's Interpretation of the Regulation.

This Court should “limit its function to assuring that the agency has exercised its discretion in accordance with the law, and shall not itself undertake to exercise the discretion that the legislature has placed in the agency.” RCW 34.05.574(1); *see also Univ. of Wash.*, 187 P.3d at 245-46. Accordingly, the Court should defer to the Department’s policy decision,

⁴ It should not be surprising that the Department determined that East King (Bellevue/Issaquah) had a shortage of ORs (resulting in the Department’s approval of Swedish’s application) and that Central Pierce (Tacoma/Gig Harbor) had a surplus of ORs (resulting in the Department’s denial of MultiCare’s application), because East King has a *much larger population* than Central Pierce (500,000 vs. 300,000), but East King has *far fewer operating rooms* than Central Pierce (33 ORs vs. 59 ORs). *Compare* AR (1st) 1969 (East King population) with *In Re Franciscan Health System Gig Harbor Hospital* (Wash. Dep’t of Health May 14, 2004) at Appx. 10 (Central Pierce population); *compare* AR (1st) 1969 (East King ORs) with *In Re MultiCare* at 4, n.5 (Central Pierce ORs). *In Re MultiCare* and *In Re Franciscan Health System Gig Harbor Hospital* are attached as Exhibits 1 and 2, respectively, to Respondents' Motion for Reconsideration, filed October 27, 2008, in the Court of Appeals. Respondents may cite to the Department’s decisions on other applications, and this Court may rely upon them *See, e.g., Postema v. Snohomish County*, 83 Wn. App. 574, 583-84, 922 P.2d 176 (1996).

based on its expertise in health-facility planning, to approve enough generally-available ORs to satisfy the total surgical need of the public. The Department's regulation, WAC 246-310-270(9), is accurately designed to achieve this policy goal. Randy Huyck, the CN Program's analyst, explained this in detail in his hearing testimony. AR (1st) 2023-24, 2051.

The alternative policy, advocated by Overlake and Evergreen, effectively places planning for ASCs in the hands of individual physicians who choose to build operating rooms in their own offices, restricted to their own use, and free from CN-regulation. If enough of them were to do so, no generally-available, multi-specialty ASCs, required to treat Medicare and Medicare patients and provide charity care, such as the facility to be built by Swedish, would ever be approved. The Department has rejected this alternative, and instead adopted a methodology to ensure that enough generally-available outpatient operating rooms are available to meet the total surgical need of the public.

From a policy perspective, the Department's judgment may be criticized by some as too liberal; the alternative approach advocated by Overlake and Evergreen certainly would be better for preserving the status quo, and protecting existing providers from competition. However, the Legislature gave the *Department* the authority to decide what approach to

take to approving new ambulatory surgical facilities. In the complex balancing of interests that goes into healthcare planning, the Department has placed a high value on ensuring that there will be enough generally-available outpatient operating rooms in the future, and designed a methodology to achieve that goal.

C. Evergreen and Overlake Have Not Shown That They Were Substantially Prejudiced By the Department's Decision.

Under the APA, a “court shall grant relief only if it determines that a person seeking relief has been substantially prejudiced by the action complained of.” *Densley v. Dep't of Ret. Sys.*, 162 Wn.2d 210, 217, 173 P.3d 885 (2007) (quoting RCW 34.05.570(1)(d)). “The person seeking relief bears the burden of proof.” *Densley*, 162 Wn.2d at 217 (citing RCW 34.05.570(1)(a)). Because Overlake and Evergreen have failed to show “substantial prejudice,” they are not entitled to relief from the Department’s decision. Therefore, the Court should reinstate the Department's approval of Swedish's application even if it rejects the Department's need methodology.

D. The Court Should Reinstate the Department's Decision Approving Swedish's Facility.

Finally, although the Department's regulation provides that a proposed ASC should not “ordinarily” be approved if need is not demonstrated under the WAC 246-310-270(9) methodology, it does not

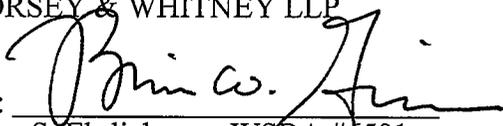
provide that an ASC will *never* be approved if numeric need is not shown. In this case, the large and growing Eastside population, the increasing demand for outpatient surgery, the benefits of having an additional choice of provider for local residents, and increasing access to healthcare all weigh in favor of approving Swedish's facility. The Court may affirm the Department's decision on any ground supported by the record. RAP 2.5(a). The Department's approval of Swedish's application therefore should be affirmed regardless of whether "numeric need" can be shown under WAC 246-310-270(9).

V. CONCLUSION

Swedish respectfully requests that the Court reverse the Court of Appeals' opinion and reinstate the Department's decision approving Swedish's Bellevue ASC.

Respectfully submitted this 28th day of August 2009.

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PROOF OF SERVICE

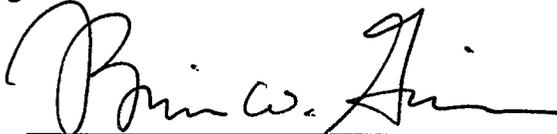
Today I caused the foregoing SUPPLEMENTAL BRIEF OF SWEDISH HEALTH SERVICES to be served on the following persons by first-class mail:

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DATED this 28th day of August 2009.



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APPENDIX

246-310-263 << 246-310-270 >> 246-310-280

WAC 246-310-270
Ambulatory surgery.

No agency filings affecting this section since 2003

(1) To receive approval, an ambulatory surgical facility must meet the following standards in addition to applicable review criteria in WAC 246-310-210, 246-310-220, 246-310-230, and 246-310-240.

(2) The area to be used to plan for operating rooms and ambulatory surgical facilities is the secondary health services planning area.

(3) Secondary health services planning areas are: San Juan, Whatcom, East Skagit, Whidbey-Fidalgo, Western North Olympic, East Clallam, East Jefferson, North Snohomish, Central Snohomish, East Snohomish, Southwest Snohomish, Kitsap, North King, East King, Central King, Southwest King, Southeast King, Central Pierce, West Pierce, East Pierce, Mason, West Grays Harbor, Southeast Grays Harbor, Thurston, North Pacific, South Pacific, West Lewis, East Lewis, Cowlitz-Wahkiakum-Skamania, Clark, West Klickitat, East Klickitat, Okanogan, Chelan-Douglas, Grant, Kittitas, Yakima, Benton-Franklin, Ferry, North Stevens, North Pend Oreille, South Stevens, South Pend Oreille, Southwest Lincoln, Central Lincoln, Spokane, Southwest Adams, Central Adams, Central Whitman, East Whitman, Walla Walla, Columbia, Garfield, and Asotin.

(4) Outpatient operating rooms should ordinarily not be approved in planning areas where the total number of operating rooms available for both inpatient and outpatient surgery exceeds the area need.

(5) When a need exists in planning areas for additional outpatient operating room capacity, preference shall be given to dedicated outpatient operating rooms.

(6) An ambulatory surgical facility shall have a minimum of two operating rooms.

(7) Ambulatory surgical facilities shall document and provide assurances of implementation of policies to provide access to individuals unable to pay consistent with charity care levels provided by hospitals affected by the proposed ambulatory surgical facility. The amount of an ambulatory surgical facility's annual revenue utilized to finance charity care shall be at least equal to or greater than the average percentage of total patient revenue, other than medicare or medicaid, that affected hospitals in the planning area utilized to provide charity care in the last available reporting year.

(8) The need for operating rooms will be determined using the method identified in subsection (9) of this section.

(9) Operating room need in a planning area shall be determined using the following method:

(a) Existing capacity.

(i) Assume the annual capacity of one operating room located in a hospital and not dedicated to outpatient surgery is ninety-four thousand two hundred fifty minutes. This is derived from scheduling forty-four hours per week, fifty-one weeks per year (allowing for five weekday holidays), a fifteen percent loss for preparation and clean-up time, and fifteen percent time loss to allow schedule flexibility. The resulting seventy percent productive time is comparable to the previously operating hospital commission's last definition of "billing minutes" which is the time lapse from administration of anesthesia until surgery is completed.

(ii) Assume the annual capacity of one operating room dedicated to ambulatory surgery is sixty-eight thousand eight hundred fifty minutes. The derivation is the same as (a)(i) of this subsection except for twenty-five percent loss for prep/clean-up time and scheduling is for a thirty-seven and one-half hour week. Divide the capacity minutes by the average minutes per outpatient surgery (see (a)(vii) of this subsection). Where survey data are unavailable, assume fifty minutes per outpatient surgery, resulting in a capacity for one thousand three hundred seventy-seven outpatient surgeries per room per year.

(iii) Calculate the total annual capacity (in number of surgeries) of all dedicated outpatient operating rooms in the area.

(iv) Calculate the total annual capacity (in number of minutes) of the remaining inpatient and outpatient operating rooms in the area, including dedicated specialized rooms except for twenty-four hour dedicated emergency rooms. When dedicated emergency operating rooms are excluded, emergency or minutes should also be excluded when calculating the need in an area. Exclude cystoscopic and other special purpose rooms (e.g., open heart surgery) and delivery rooms.

(b) Future need.

(i) Project number of inpatient and outpatient surgeries performed within the hospital planning area for the third year

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of operation. This shall be based on the current number of surgeries adjusted for forecasted growth in the population served and may be adjusted for trends in surgeries per capita.

(ii) Subtract the capacity of dedicated outpatient operating rooms from the forecasted number of outpatient surgeries. The difference continues into the calculation of (b)(iv) of this subsection.

(iii) Determine the average time per inpatient and outpatient surgery in the planning area. Where data are unavailable, assume one hundred minutes per inpatient and fifty minutes per outpatient surgery. This excludes preparation and cleanup time and is comparable to "billing minutes."

(iv) Calculate the sum of inpatient and remaining outpatient (from (b)(ii) of this subsection) operating room time needed in the third year of operation.

(c) Net need.

(i) If (b)(iv) of this subsection is less than (a)(iv) of this subsection, divide their difference by ninety-four thousand two hundred fifty minutes to obtain the area's surplus of operating rooms used for both inpatient and outpatient surgery.

(ii) If (b)(iv) of this subsection is greater than (a)(iv) of this subsection, subtract (a)(iv) of this subsection from the inpatient component of (b)(iv) of this subsection and divide by ninety-four thousand two hundred fifty minutes to obtain the area's shortage of inpatient operating rooms. Divide the outpatient component of (b)(iv) of this subsection by sixty-eight thousand eight hundred fifty to obtain the area's shortage of dedicated outpatient operating rooms.

[Statutory Authority: RCW 70.38.135 and 70.38.919. 92-02-018 (Order 224), § 246-310-270, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-310-270, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 70.38.919. 90-16-058 (Order 073), § 248-19-700, filed 7/27/90, effective 8/27/90.]

Superior Court appealing the order. The Superior Court remanded the matter for further action.

ISSUES

1. Whether Swedish correctly included the number of surgeries performed at exempt ambulatory surgery center operating rooms in its WAC 246-310-270 calculation of the surgical procedure, use rate, and correctly excluded the number of exempt ambulatory surgery center operating rooms in its calculation of the existing operating room capacity determination?
2. Whether the Program's decision to grant the Swedish certificate of need application should be granted?

SUMMARY OF THE EVIDENCE

Randall Huyck, Robin Edward MacStravic, and Jody Carona testified at the hearing. The following thirteen exhibits were admitted at the hearing:

- Exhibit 1: The Swedish Certificate of Need Application Record.
- Exhibit 2: Health Service Area Map showing Southeast (yellow) and East (blue) King County Service Areas.
- Exhibit A: Program analysis in the Northwest Nasal Sinus Center application (Certificate of Need No. 1250).
- Exhibit B: Resume of Robin Edward MacStravic, Ph.D.
- Exhibit C: Deposition of Program Analyst Randy Huyck, taken August 27, 2003 (pages 58 through 95).
- Exhibit D: Facsimile dated August 20, 2003, with Program work sheets used in the original analysis date of August 15, 2003.

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- Exhibit E: Four ambulatory surgery center need methodology worksheets prepared by Jody Carona, Health Service Planning & Development, based on the Program's worksheets and data in the record, demonstrating the numerical need:
- E-1: In the Swedish defined planning area if all exempt ambulatory surgery center operating rooms are included in the available supply;
 - E-2: In the Swedish planning area if all surgeries performed in all exempt ambulatory surgery center operating rooms are excluded from the use rate;
 - E-3: In the East King County planning area if all exempt ambulatory surgery center operating rooms are included in the available supply; and
 - E-4: In the East King County planning area if all surgeries performed in all exempt ambulatory surgery center operating rooms are excluded from the use rate.
- Exhibit F: Oversized Map of Proposed Service Area for Swedish ambulatory surgery center (Exhibit 7 from the Huyck deposition).
- Exhibit G: Swedish Defined Service Area (actual Swedish defined service area facilities per Department of Health directory of certified ambulatory surgery centers and Swedish application).
- Exhibit H: Summary of East King Surgery 2001 Utilization Data and Use Rate Calculations corrected Calculation of Need – Northwest Nasal Surgery Center.
- Exhibit I: 2006 East King Secondary Health Service Area – Excluding Exempt Facilities.
- Exhibit J: Swedish Bellevue Ambulatory Surgery Center Need Methodology:
- J-1: Methodology using 102/1000 use rate.
 - J-2: Methodology using 82/1000 use rate.
 - J-3: Methodology using 57/1000 use rate.

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J-4: Methodology using 76/1000 use rate.

Exhibit K: November 27, 2002 letter to Lori Aoyama, Health Facilities Planning & Development, from Randy Huyck (with attached copies of the Program's application of the ambulatory surgery center numeric need methodology contained in WAC 246-310-270:

K-1: Program methodology.

K-2: Methodology using Evergreen/Overlake number of surgeries (prepared November 27, 2002).

K-3: Methodology using Northwest Nasal Sinus Center projected surgeries (prepared November 27, 2002).

K-4: Methodology as prepared by applicant Northwest Nasal Sinus Center (prepared November 27, 2002).

K-5: East King Ambulatory Surgery Center Survey CN Facilities (prepared November 27, 2002).

K-6: East King Ambulatory Surgery Center Survey All Responding (prepared November 27, 2002).

Based on the evidence and exhibits in this matter, the Presiding Officer enters the following:

I. FINDINGS OF FACT

A. Background

1.1 The Certificate of Need Program (the Program) granted Swedish Health Services (Swedish) Certificate of Need No. 1264 to establish an ambulatory surgical facility in Bellevue, Washington. Overlake Hospital Medical Center and Evergreen Healthcare (the Petitioners) appealed the Program's decision. Swedish was permitted to intervene in the appeal.

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1.2 On July 8, 2005, the Presiding Officer issued an Amended Findings of Fact, Conclusions of Law and Final Order (the Final Order). The Final Order reversed the Program's decision that granted the certificate of need to Swedish.

1.3 On August 9, 2005, Swedish filed a Petition for Judicial Review in King County Superior Court pursuant to RCW 34.05.530. On April 19, 2006, King County Superior Court Judge Douglas North issued an Order Reversing the Presiding Officer's Amended Findings of Fact, Conclusions of Law and Final Order, and Remanding to the Presiding Officer for Further Proceedings (the Remand Order). Judge North ruled, in relevant part:

Accordingly, the Presiding Officer's Final Order is affirmed in part and reversed in part. The case is remanded to the Presiding Officer, based on the evidence presented by the parties to the Department of Health during the application process and the adjudicative proceeding, to (i) determine whether Swedish's proposed ASC satisfies the certificate of need criteria, using the East King County planning area; and (ii) address any other issues raised by the parties in the prior adjudicative proceeding and not previously addressed in the Final Order or this order.

The Remand Order at 2.

1.4 Surgery can be performed on an inpatient or outpatient basis.¹ Inpatient surgery is when a person's surgery requires board and room in a health care facility (i.e., a hospital) on a continuous twenty-four-hour-a-day basis.² Therefore, outpatient surgery is when a person's surgery requires less than twenty-four hour care. When a

¹ "Surgery" means that "branch of medicine dealing with the manual and operative procedures for correction of deformities and defects, repair of injuries, and diagnosis and cure of certain diseases." Taber's Cyclopedic Medical Dictionary (14th Edition, 1981), at 1395.

² See WAC 246-310-010.

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need exists for additional outpatient operating room capacity, preference is given to dedicated outpatient operating rooms.³

1.5 When a person receives surgery on an outpatient basis, that surgery can be performed in an ambulatory surgical facility. An "ambulatory surgical facility" is a free standing entity that operates primarily for the purpose of performing outpatient surgical procedures, that is surgery for patients who do not require hospitalization.⁴ To qualify as an ambulatory surgical facility, the facility must have a minimum of two operating rooms.⁵ The facility can be located in a private physician or dentist office. When the use of the facility is not restricted to a specific individual or group practice, the facility can qualify as an ambulatory surgical facility. When a facility's use is restricted to a specific individual or group practice, by definition, it is not an ambulatory surgical facility.⁶ These exempt facilities can be referred to as ambulatory surgical centers.⁷

1.6 Characterizing a facility as an ambulatory surgical facility or an ambulatory surgical center is important under the law. An ambulatory surgical facility must obtain a certificate of need to operate in the state of Washington.⁸ An ambulatory surgical center is exempt from the certificate of need requirement.

³ WAC 246-310-270(5).

⁴ WAC 246-310-010.

⁵ WAC 246-310-270(6) and WAC 246-310-010. To "operate" is "to perform an incision or to make a suture on the body or any of its organs or parts to restore health." Taber's Cyclopedic Medical Dictionary (Edition 14, 1981), at 990.

⁶ See WAC 246-310-010.

⁷ The term ambulatory surgical center is not defined in chapter 246-310 WAC. The term is being used to help to differentiate between exempt and non-exempt facilities.

⁸ WAC 246-310-270(1).

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1.7 The decision whether to grant or deny an ambulatory surgical facility certificate of need application is determined by using a mathematical formula or methodology to determine whether there is a "need" for an additional facility (that is, a requirement for additional operating room capacity).⁹ To determine whether need for an additional facility exists requires the identification of a geographic region known as a secondary health services planning area (the health planning area).¹⁰ If the applicant can show there is a net need for dedicated outpatient operating rooms in the relevant health planning area in the future (three years after the applicant anticipates starting the operation of the facility) the application is granted. If no need exists, the application is denied.

1.8 Need exists if more operating room capacity is required in the project year. Capacity speaks to the number of surgeries that can be performed in an operating room. The surgery information is obtained from information derived from surveys provided by facilities in the health planning area or by use of a default figure provided in the regulation. Facilities in a health planning area are not required to complete the surveys regarding surgical capacity at their respective facilities. Thus, the capacity calculations in any given application are affected by the number of facilities that reply to the submitted surveys.¹¹

⁹ WAC 246-310-270(9).

¹⁰ WAC 246-310-270(3).

¹¹ The Program analyst acknowledged at hearing that an issue exists with any use rate calculations, as the figure is calculated without receiving complete surgical statistics.

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1.9 Deciding whether future operating room capacity is necessary requires the calculation of a figure known as a "use rate." The use rate means a projection of the number of inpatient and outpatient surgeries within the applicant's health planning area for the applicant's target year (the third year of operation).¹² The projection is based on the current number of surgeries adjusted for the forecasted growth in the population served, and may be adjusted for trends in surgeries per capita (that is, surgeries according to the number of individuals). The use rate is represented by a percentage of surgeries required per each one thousand population (for example, 100 surgeries per each 1000 individuals, or 100/1000).

1.10 When calculating the use rate for a health planning area, it is necessary to include the surgical volume or number of surgeries that have been performed both in ambulatory surgical centers (that is, surgical centers that are exempt from the requirement of obtaining a certificate of need) and ambulatory surgical facilities (non-exempt facilities which are required to obtain a certificate of need). When calculating the number of existing facilities in a health service area, it is necessary to exclude from that count the number of operating rooms from ambulatory surgical centers (exempt facilities). The calculation performed under this regulation requires a comparison of separate concepts: (1) The total volume or number of inpatient and outpatient surgeries which have been performed in the planning area; and (2) the amount of capacity or facilities needed to accommodate the number of anticipated future surgeries (based on the anticipated increase in the population) in the health planning area.

¹² See WAC 246-310-270(9)(b)(i).

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1.11 The number of anticipated future surgeries can be calculated by applying the use rate to the anticipated future population. Determining whether an individual will obtain that future surgery, in an ambulatory surgical center (an exempt facility) or an ambulatory surgical facility (a non-exempt facility) cannot be reduced to a mathematical formula. The first concept (anticipated future surgeries) is a numerical value. The second concept (the location of the future surgery) cannot be determined with mathematical certainty. For example, a patient who may qualify for surgery at an exempt ambulatory surgical center in the present may not qualify for surgery in the future at the same exempt facility. Another example is a surgeon who holds surgical privileges at an exempt ambulatory surgical center in the present, may not hold surgical privileges at the same facility in future. Finally, the exempt ambulatory surgical center may no longer exist.

B. Need.

1.12 What does this mean for calculating the need methodology? It means capturing all current surgical capacity statistics from ambulatory surgical facilities (non-exempt facilities) and ambulatory surgical centers (exempt facilities) in calculating existing capacity, but calculating future need considering only ambulatory surgical facilities to ensure that the patients have access to surgical facilities in the future.

1.13 Swedish submitted its application to establish the free-standing ambulatory surgical facility in November 2002. Under its application, the third year of operation would be 2006. Swedish provided need calculation information as a part of its application. The Swedish information shows that with a use rate of 102/1000 (based on

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National Center for Health Statistics data) and a population of 533,055 in 2004 (based on the Northwest Nasal Sinus Center application) there existed a net need for 5.9 outpatient operating rooms. PR 316-317. With a use rate of 82/100 (obtained from the Northwest Nasal Sinus Center application) and using the same 2004 population figure, there existed a net need for 1.0 outpatient operating rooms. PR 319.

1.14 The Swedish need calculations under WAC 246-310-270(9) included all surgery date, whether those surgeries were performed in an ambulatory surgery center (an exempt facility) or an ambulatory surgical facility (a non-exempt facility). When calculating whether need existed, Swedish performed those calculations using only ambulatory surgical facility operating rooms to show the existence of a surplus or shortage of dedicated outpatient operating rooms.

1.15 The Program submitted need figures at hearing based on information contained in the Swedish application records. With a use rate of 82/1000 and a 2006 population figure of 546,288, there existed a net need for 5.39 dedicated outpatient operating rooms. Exhibit J-2.

1.16 The Program need calculations under WAC 246-310-270(9) included all surgery data, whether those surgeries were performed in an ambulatory surgical center (an exempt facility) or an ambulatory surgical facility (a non-exempt facility). When calculating whether need existed, the Program performed those calculations using only ambulatory surgical facility operating rooms to show the existence of a surplus or shortage of dedicated outpatient rooms.

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1.17 Information in both the Swedish application and the Program's certificate of need analysis show need exists. However, Swedish used 2004 population information as opposed to 2006 population figures (the third year of operation) as required under WAC 246-310-270(9)(b)(i). The Northwest Nasal Sinus Center use rate (82/1000) was based on state population information as opposed to national population figures from the National Center for Health Statistics (102/1000).

1.18 In calculating whether operating room need exists, the appropriate use rate is be 82/1000, as this figure is derived from state population information and the appropriate health planning area. The appropriate population information is the 2006 population information from the East King County health planning area. That population figure is 546,288. See Exhibit J-2. The calculations show a net need for an additional 5.39 dedicated outpatient operating rooms. Therefore, need exists.

1.19 All surgery data (the total number of surgeries performed) was included in the calculations in Finding of Fact 1.18 above, whether those surgeries were performed in an ambulatory surgical center (an exempt facility) or an ambulatory surgical facility (a non-exempt facility). When calculating whether need existed in Finding of Fact 1.18, calculations were performed using only ambulatory surgical facility outpatient operating rooms to show a shortage of dedicated outpatient operating rooms in the East King County health planning area.

C. Remaining Certificate of Need Criteria:

1.20 Swedish provided financial information to show that the immediate and long range capital and operating costs for its proposed ambulatory surgical facility

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project could be met. The Program considered whether the Swedish project was financially feasible by using a financial ratio analysis to assess the financial impact of the project on the overall facility operation. PR 563-564. The Program also compared costs of the project and determined the Swedish project would not result in an unreasonable impact on the costs and charges for health services within the service area. PR 565. Swedish provided sufficient information to show that it could finance the project from available cash reserves. PR 566.

1.21 Swedish provided information to show that it could meet the structure and process (quality) of care for the project. Swedish provided sufficient information in its application to show that it could meet staffing requirements, establish sufficient ancillary and support services and would conform to any applicable legal requirements.

PR 566-568.

1.22 Swedish provided information in its application to show that it could meet the cost containment requirements of the project. Swedish provided information to show it had considered whether there were any superior alternatives to its proposal to establish an ambulatory surgical facility, and that the project would not have an impact on the costs and charges to the public. PR 566-568.

II. CONCLUSIONS OF LAW

2.1 The certificate of need program is regulated pursuant to chapter 70.38 RCW and chapter 246-310 WAC. The development of health services and resources should be accomplished in a planned, orderly fashion, consistent with identified priorities and without unnecessary duplication or fragmentation.

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RCW 70.38.015(2).

2.2 In all license application cases, the burden shall be on the applicant to establish that the application meets all applicable criteria. WAC 246-10-606.¹³ The Program then decides whether to grant or deny a certificate of need application. The Program's written decision must contain sufficient information to support the Program's decision granting or denying the application. See WAC 246-310-200(2)(a); see also *In re Auburn Regional Medical Center*, Docket No. 01-05-C-1052CN (February 20, 2003). Evidence is admissible in certificate of need hearings if it is the kind of evidence on which reasonably prudent persons are accustomed to rely on in the conduct of their affairs. RCW 34.04.452; WAC 246-10-606.

2.3 In general a certificate of need hearing does not supplant the certificate of need application review process. Rather, the hearing assures that the procedural and substantive rights of the parties have been observed and factual record supports the Program's decision and analysis. *In re Ear, Nose, Throat*, Docket No. 00-09-C-1037CN (April 17, 2001) (Prehearing Order No. 6). While the hearing does not supplant the certificate of need review process under normal circumstances, the King County Superior Court remanded the proceeding to the Presiding Officer in this case to determine whether the application should be granted using information contained in the application record regarding the East King County planning area. The remand order also required the Presiding Officer to address any other issues raised by the parties in the prior

¹³ Certificate of need proceedings are governed by the Administrative Procedure Act (chapter 34.05 RCW), chapter 246-310 WAC and chapter 246-08 WAC. WAC 246-310-610. The relevant sections in chapter 246-08 WAC were replaced in 1993 by chapter 246-10 WAC. WAC 246-10-101

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adjudicative proceeding and not previously addressed in the Final Order or this order.

See the Remand Order, page 2.

A. First Remand Issue: Need.

2.4 There is sufficient information in the Swedish application file to answer the first issue identified in the Remand Order, specifically to determine whether the ambulatory surgical facility proposed by Swedish satisfied the certificate of need criteria using the East King County planning area. See Findings of Fact 1.13 through 1.18.

Regarding the 2006 project year, there is need for an additional 5.39 operating rooms in the East King County planning area. See Finding of Fact 1.18.

B. Second Remand Issue: Issue Not Previously Addressed in Earlier Final Order.

2.5 Answering the first issue (determining if need exists in the East King County planning area) requires answering another issue that was not addressed in the Amended Final Order. That issue is whether, when calculating operating room need under WAC 246-310-270(9), the applicant can include the number of surgeries performed at an exempt ambulatory surgical center when determining the surgical procedure use rate, but exclude the number of operating rooms in an exempt ambulatory surgical center from the count in existing capacity. The Certificate of Need Program has historically used this approach in reviewing ambulatory surgical facility applications.

2.6 The rule which is applied is WAC 246-310-270. That rule provides, in pertinent part:

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(9) Operating room need in a planning area shall be determined using the following method:

(a) Existing capacity.

(iii) Calculate the total annual capacity (in number of surgeries) of all dedicated outpatient operating rooms in the area.

(iv) Calculate the total annual capacity (in number of minutes) of the remaining inpatient and outpatient operating rooms in the area, including dedicated specialized rooms except for twenty-four hour dedicated emergency rooms. When dedicated emergency operating rooms are excluded, emergency or minutes should also be excluded when calculating the need in the area. Exclude cystoscopic and other special purpose rooms (e.g. open heart surgery) and delivery rooms.

(b) Future need.

(i) Project number of inpatient and outpatient surgeries performed within the third year of operation. This shall be based on current number of surgeries adjusted for forecasted growth in the population served and may be adjusted for trends in surgeries per capita.

(ii) Subtract the capacity of dedicated outpatient operating rooms from the forecasted number of outpatient surgeries. The difference continues into the calculations of (b)(iv) of this subsection.

(iii) Determine the average time per inpatient and outpatient surgery in the planning area. Where data are unavailable, assume one hundred minutes per inpatient and fifty minutes per outpatient surgery. This excludes preparation and cleanup time and is comparable to "billing minutes".

(iv) Calculate the sum of inpatient and remaining outpatient (from (b)(ii) of this subsection) operating room time needed in the third year of operation.

(c) Net Need.

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(i) If (b)(iv) of this subsection is less than (a)(iv) of this subsection, divide their difference by ninety-four thousand two hundred fifty minutes to obtain the area's surplus of operating rooms used for both inpatient and outpatient surgery.

(ii) If (b)(iv) of this subsection is greater than (a)(iv) of this subsection, subtract (a)(iv) of this subsection from the inpatient component of (b)(iv) of this subsection and divide by ninety-four thousand two hundred fifty minutes to obtain the area's shortage of inpatient operating rooms. Divide the outpatient component of (b)(iv) of this subsection by sixty-eight thousand eight hundred fifty to obtain the area's shortage of dedicated outpatient operating rooms.

WAC 246-310-270(9) (emphasis added).

2.7 When capturing outpatient surgery data (the number of surgeries) for use in calculating future need, all outpatient surgery data should be included in the final data figure. All outpatient surgery data means data from both exempt and non-exempt facilities. The plain language of WAC 246-310-270(9)(a)(iii) requires that operating room need shall be determined using the total annual capacity (in number of surgeries) of all dedicated outpatient operating rooms in the area. The plain language of the rule does not differentiate between exempt (ambulatory surgical centers) and non-exempt (ambulatory surgical facilities). Rules of statutory construction apply to administrative rules and regulations, particularly where they are adopted pursuant to express legislative authority. See *State v. Burke*, 92 Wn.2d 474, 478 (1979). Where the meaning of a provision is plain on its face, the court must give effect to that plain meaning as an expression of legislative intent. *City of Olympia v. Drebeck*, 156 Wn.2d 289, 295 (2006) (citing *Department of Ecology v. Campbell & Gwinn LLC*, 146 Wn.2d 1, 9-10 (2002)).

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2.8 The next question is whether the WAC 246-310-270(9)(b) and (c) language is equally clear regarding the calculation of operating room need? In other words is the operating room need calculation restricted to only the number of non-exempt (ambulatory surgical facility) operating rooms, or all operating rooms consistent with the reading of WAC 246-310-270(9)(a). A reading of the regulatory language in WAC 246-310-270(9)(b) speaks to projecting the number of inpatient and outpatient surgeries performed in the planning area. This language appears to be all inclusive, similar to a reading of the capacity language set forth in WAC 246-310-270(9)(a).

2.9 However, the language of WAC 246-310-270(9)(b) and (c) cannot be read in isolation. A provision's plain meaning may be ascertained by an examination of the statute in which the provision at issue is found, as well as related statutes or other provisions of the same act in which the provision is found. *City of Olympia v. Dreblick*, 156 Wn.2d at 295 (internal citations omitted). The legislative declaration of public policy states that health planning should promote, maintain, and assure that all citizens have accessible health services. See RCW 70.38.015(1). If the more inclusive approach were followed, the calculation of available operating rooms would include ambulatory surgery center (exempt) operating rooms that would not be available to many of the individuals within the health planning area. See Findings of Fact 1.11 and 1.12. For this reason, while all surgeries from whatever source should be included in the existing capacity calculations under WAC 246-310-270(9)(a), that inclusive approach should not

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be used in determining the future need/net need calculation under WAC 246-310-270(9)

(b) and (c).

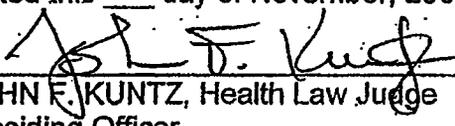
III. ORDER

Based on the foregoing Findings of Fact and Conclusions of Law of the Amended Final Order, and the above Findings of Fact and Conclusions of Law following the King County Superior Court remand order, it is ORDERED:

3.1 There is a net need for 5.39 additional dedicated outpatient operating rooms in the East King County planning area in the 2006 project year.

3.2 Certificate of Need No. 1264 for Swedish Health Services to establish an ambulatory surgical facility in Bellevue, Washington, is GRANTED.

Dated this 9th day of November, 2006.


JOHN F. KUNTZ, Health Law Judge
Presiding Officer

NOTICE TO PARTIES

Either party may file a petition for reconsideration. RCW 34.05.461(3); RCW 34.05.470. The petition for reconsideration must be filed within 10 days of service of this Order with:

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

And a copy must be sent to:

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

FINDINGS OF FACT,
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The petition must state the specific grounds upon which reconsideration is requested and the relief requested. The petition for reconsideration is considered denied 20 days after the petition is filed if the Adjudicative Service Unit has not responded to the petition or served written notice of the date by which action will be taken on the petition.

A petition for judicial review must be filed and served within 30 days after service of this Order. RCW 34.05.542. The procedures are identified in chapter 34.05 RCW, Part V, Judicial Review and Civil Enforcement. A petition for reconsideration is not required before seeking judicial review. If a petition for reconsideration is filed, however, the 30-day period will begin to run upon the resolution of that petition.

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

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