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COURT OF APPEALS,
DIVISION I
OF THE STATE OF WASHINGTON

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.

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**

Overlake Hospital Medical Center and Overlake Hospital Association (collectively, “Overlake”) and Evergreen Healthcare (“Evergreen”) ask this Court to set aside the decision of the Department of Health (the “Department”) finding a need for Swedish Health Services’ (“Swedish’s”) proposed ambulatory surgery facility in Bellevue, Washington. The Department erred by skewing the numeric methodology used to determine whether a need exists for a new ambulatory surgery facility when it counted surgeries performed in a large set of operating rooms to determine the rate of surgeries performed, but then looked at a smaller set of operating rooms to determine whether capacity existed to meet the need for these surgeries (adjusted for future population growth). This misapplication of the methodology almost inevitably wrongly finds a need for new operating rooms, as it did in the present case. The Department’s misapplication of the methodology is contrary to the language of the methodology, the mandate of the Legislature to determine need for new health care facilities, and violates common sense.

Overlake and Evergreen ask this Court to require the Department to correctly apply the methodology for determining whether there is a need for more operating rooms. This requires using the same set of operating rooms when counting the number of existing surgeries, as well as when determining whether capacity exists in current facilities for these

surgeries (adjusted for population growth). This brief refers to this as “balancing the need/capacity equation” because the same set of operating room data is used to compare existing capacity against future need.

When the need/capacity equation is balanced and the methodology is correctly applied to the facts of the present case, the methodology accurately reflects that no need exists for Swedish’s proposed ambulatory surgery facility.

B. ASSIGNMENTS OF ERROR

Assignments of Error

1. The Department and trial court erred in applying the need methodology for ambulatory surgical facilities contrary to the plain language found at WAC 246-310-270(9) in its evaluation of Swedish’s certificate of need application to establish a new five operating room ambulatory surgical facility in Bellevue, Washington.

2. The trial court erred in failing to find that no need exists for Swedish’s proposed ambulatory surgical facility in the East King planning area when the need methodology set forth in WAC 246-310-270(9) is correctly applied.

3. The Department erred in speculating, without factual support in the record, that the number of operating rooms that are exempt from certificate of need regulation is shrinking, and in basing its erroneous interpretation of WAC 246-310-270(9) on this speculation.

4. The trial court erred in failing to remand the matter to the Department with instructions to correctly apply the need methodology found at WAC 246-310-270(9) to the Swedish certificate of need application.

Issues Pertaining to Assignments of Error

1. Whether the Program incorrectly applied the need methodology found at WAC 246-310-270(9) in the evaluation of the Swedish certificate of need application (Assignment of Error No. 1).

2. Whether a need for additional ambulatory surgical facilities exists in the East King planning area when the need methodology set forth in WAC 246-310-270 is correctly applied (Assignment of Error No. 2).

3. Whether the Program erroneously issued certificate of need No. 1264 to Swedish to establish a new five operating room ambulatory surgical facility in Bellevue, Washington (Assignments of Error Nos. 1 and 2).

4. Whether the Department's Final Order was arbitrary and capricious because it is logically inconsistent and insufficient evidence exists to support its conclusions (Assignment of Error No. 3).

5. In the alternative, whether the matter should be remanded to the Program for a determination of need based on the correct application of the need methodology found at WAC 246-310-270(9) (Assignment of Error No. 4).

C. STATEMENT OF THE CASE

1. Regulatory Background: The Department of Health's Certificate of Need Program

In 1979, the Legislature enacted the State Health Planning and Resources Development Act, chapter 70.38 RCW, which created the Certificate of Need Program (the "CN Program") to oversee health care planning "in a planned, orderly fashion, consistent with identified priorities and without unnecessary duplication or fragmentation." RCW 70.38.015(2). The CN Program is an office within the Department. Health care providers seeking to establish or expand certain health care facilities and services, including ambulatory surgical facilities, are required to obtain a certificate of need, which is a non-exclusive license to operate. RCW 70.38.105; *St. Joseph Hosp. and Health Care Ctr. v. Dep't of Health*, 125 Wn.2d 733, 735, 887 P.2d 891 (1995). The CN Program evaluates an application for a certificate of need based on specific criteria set forth in chapter 70.38 RCW and chapter 246-310 WAC. In general terms, the CN Program issues a certificate of need if a need exists for a particular health care service or facility within a particular health care planning area and the applicant can effectively meet that need.

2. "Ambulatory Surgical Facilities" and "Exempt Surgical Facilities"

The present case involves Swedish's application for a certificate of need to establish an ambulatory surgical facility in Bellevue, Washington,

which is within the East King planning area (as identified in WAC 246-310-270(3). An ambulatory surgical facility is defined as “any free-standing entity, including an ambulatory surgery center, that operates primarily for the purpose of performing surgical procedures to treat patients not requiring hospitalization.” WAC 246-310-010(5) (Appendix A-1 hereto).

Not all free-standing operating rooms, however, require a certificate of need to operate. Some free-standing operating rooms are exempt from the CN Program’s review if they are found to be “in the offices of private physicians or dentists” and “the privilege of using such facility is not extended to physicians or dentists outside the individual or group practice.” WAC 246-310-010(5). This is known as the “group practice” exemption.

The term “Ambulatory Surgical Facilities” (also referred to as “Ambulatory Surgical Centers” or “ASFs” or “ASCs”) will be used in this brief to refer to only those free-standing operating rooms that require a certificate of need to operate. Free-standing operating rooms that do not require a certificate of need will be referred to as “Exempt Surgical Facilities.” (Operating rooms in hospitals fall into neither category).

This distinction between certificate of need regulated Ambulatory Surgical Facilities and Exempt Surgical Facilities is integral to understanding the Department’s error in applying the methodology for determining the future projected need for Ambulatory Surgical Facilities.

3. Certificate of Need Criteria for Ambulatory Surgical Facilities

The four general criteria for granting a certificate of need are set forth in RCW 70.38.115(2) and chapter 246-310 WAC. These four criteria are: (1) **need** (WAC 246-310-210); (2) **financial feasibility** (WAC 246-310-220); (3) **structure and process of care** (WAC 246-310-230); and (4) **cost containment** (WAC 246-310-240). For certain types of facilities and services, the Department has adopted additional, more specific methodologies to determine whether there is a need for such facilities. WAC 246-310-270(9) (Appendix A-2 hereto) contains the specific numeric methodology (the "Methodology") that must be used to determine whether there is a numeric need for an Ambulatory Surgical Facility in a given planning area. The present case involves the correct application of the Methodology.

The Methodology can be broken down into three basic steps: (1) calculating the capacity of existing operating rooms in the planning area; (2) projecting the number of surgeries needed in the planning area three years into the future; and (3) calculating whether the existing operating rooms can accommodate the projected future surgeries. If existing capacity cannot accommodate the projected future ambulatory surgeries, then a need exists for more Ambulatory Surgical Facilities in the planning area.

The issue before this Court is whether Exempt Surgical Facilities should be counted in Step 1 as part of a planning area's capacity when the surgeries performed within Exempt Surgical Facilities are used in Step 2 to calculate future need, or put another way, whether the need/capacity equation should be balanced with comparable sets of data. Each of these three steps is described in detail as follows:

a. Step 1: Calculate Existing Capacity.

The first step of the Methodology requires calculating the capacity of existing operating rooms in a planning area.¹ To calculate the existing operating room capacity, the Methodology first requires calculating the capacity of all dedicated outpatient operating rooms:

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

WAC 246-310-270(9)(a)(iii).

The Methodology then requires calculating the capacity of all of the remaining operating rooms, which are not dedicated to outpatient surgeries (with some exceptions):

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 rooms are excluded, emergency minutes should also be**

¹ Step 1 of the Methodology is set forth in WAC 246-310-270(9)(a) and is sometimes referred to herein as the calculation pursuant to "subsection (a)."

excluded when calculating the need in an area. Exclude cystoscopic and other special purpose rooms (e.g. open heart surgery) and delivery rooms.

WAC 246-310-270(9)(a)(iv).² Because these “remaining” operating rooms can be used for both inpatient and outpatient surgeries, they are sometimes referred to as “mixed-use” operating rooms. The sum of these two calculations in Step 1 represents the total capacity of the existing operating rooms in a planning area.

Nowhere in the description of how to calculate the capacity does the Methodology instruct one to disregard the operating rooms in Exempt Surgical Facilities. In fact, the Methodology requires counting “total annual capacity of *“all* dedicated outpatient operating rooms in the area” and also the capacity of “the remaining inpatient and outpatient [mixed use] operating rooms.” WAC 246-310-270(9) (a)(iii-iv). Significantly, the Methodology requires a rebalancing of the need/capacity equation when some operating rooms, such as dedicated emergency rooms, are excluded from the capacity side of the equation by also excluding them “when calculating the need in an area.” WAC 246-310-270(9)(a)(iv).

² Preceding sections of the Methodology provide guidance and assumptions about the number of annual surgical minutes per operating room and how many minutes per surgery.

b. Step 2: Calculate Future Need.

The second step of the Methodology requires calculating the future need for operating rooms.³ This step is the most involved and is performed in several sub-steps. First, the Methodology requires, the following:

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

WAC 246-310-270(9)(b)(i).

The Methodology does not specify how to project future need, but this is generally done by determining the current number of surgeries performed within the planning area per 1,000 residents of the planning area – a “use rate.” The population growth within the planning area is then projected three years into the future and this projected future population is multiplied by the use rate, for a projection of the future surgeries, both inpatient and outpatient.

Prior litigation in the present case has established that the appropriate use rate for the East King planning area for purposes of Swedish’s present certificate of need application is 82 surgeries performed within the planning area per 1,000 residents of the planning area

³ Step 2 of the Methodology is set forth in WAC 246-310-270(9)(b) and is sometimes referred to herein as the calculation pursuant to “subsection (b).”

(“82/1000”). CP 277. This is not at issue before this Court. However, it is significant to the issue before this Court that 82/1000 is based on operating rooms in Ambulatory Surgical Facilities, *and* Exempt Surgical Facilities (as well as hospitals⁴) within the East King planning area. CP 277.

The second sub-step subtracts the capacity of dedicated outpatient operating rooms from the projected need for outpatient surgeries:

- (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.

WAC 246-310-270(9)(b)(ii). The methodology presumes that there will be a greater need for outpatient surgery than there is capacity in dedicated outpatient operating rooms due to population growth, resulting in an “overflow” of outpatient surgeries that cannot be performed in dedicated outpatient operating rooms. This “overflow” number is carried forward into the next sub-step. As will be explained below, this “overflow” of outpatient surgeries is artificially inflated when too few operating rooms are included in the capacity for outpatient surgeries because Exempt Surgical Facilities are excluded.

⁴ The Methodology requires consistently counting operating rooms in hospitals on both sides of the need/capacity equation, but this is not at issue in the present case.

The third sub-step⁵ recombines the need for all inpatient surgeries, with the “overflow” of outpatient surgeries from sub-step (ii):

(iv) Calculate the sum of inpatient and remaining outpatient (from sub-step ii above) operating room time needed in the third year of operation.

WAC 246-310-270(9)(b)(iv).

c. Step 3: Calculate Net Need for Dedicated Outpatient Operating Rooms.

The final step in the Methodology requires comparing the results of the two previous steps, i.e. existing operating room capacity and the projected future operating room need, to determine the net need for dedicated outpatient operating rooms in a particular planning area.⁶ The comparison of capacity against future need results in either a surplus of operating rooms used for both inpatient and outpatient surgeries, or a shortage of dedicated outpatient operating rooms.

This step provides as follows:

(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.

WAC 246-310-270(9)(c)(i).

⁵ Subsection WAC 246-310-270(9)(b)(iii) of the Methodology explains how to determine average times for inpatient and outpatient surgeries, and will not be explained in detail here.

⁶ Step 3 of the Methodology is set forth in WAC 246-310-270(9)(c) and is sometimes referred to herein as the calculation pursuant to “subsection (c).”

In other words, if the projected future need for inpatient and “overflow” outpatient surgeries is less than the capacity of mixed-use operating rooms, then the planning area has a surplus of operating rooms that can accommodate both the projected inpatient surgeries and projected “overflow” outpatient surgeries.

However,

(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)(c)(ii).

Put another way, if the need for inpatient and “overflow” outpatient surgeries is greater than the capacity of mixed-use operating rooms, then a shortage of operating rooms will exist. The outpatient surgeries are again separated from the inpatient surgeries to determine how many dedicated outpatient operating rooms will be needed to accommodate all of the “overflow” outpatient surgeries. (This reflects a preference in the Methodology for outpatient surgeries being performed in dedicated outpatient operating rooms.)

In sum, the three steps of the Methodology calculate the future projected need for Ambulatory Surgical Facilities in a given health

planning area by comparing the existing capacity of operating rooms in the particular planning area (Step 1) with the projected number of surgeries to be performed in that planning area three years into the future (Step 2). These two steps, calculated pursuant to subsections (a) and (b) of WAC 246-310-270(9), represent the two sides of the need/capacity equation, and result in either a surplus of mixed-use operating rooms or a need for outpatient operating rooms in Step 3.

4. Procedural History of the Present Case.

A summary of Swedish's certificate of need application and the two proceedings before the King County Superior Court are briefly outlined below to orient the Court to the present issues before it.

a. Procedure Leading to First Judicial Review.

On November 14, 2002, Swedish submitted a certificate of need application to the Program seeking to establish an Ambulatory Surgical Facility with two operating rooms initially, expanding to five operating rooms in the fourth year of operation. CP 60-211.⁷ Overlake and Evergreen were recognized by the Department as interested and affected parties regarding Swedish's certificate of need application. CP 213-215. On May 14, 2003, the Program issued certificate of need No. 1264 to Swedish for its proposed Ambulatory Surgical Facility.

⁷ Relevant portions of the administrative record from the *first* judicial review are included as attachments to briefing below and are therefore found in the Clerk's Papers ("CP").

On February 16, 2003, an adjudicative hearing was held before a health law judge (“HLJ” or “Presiding Officer”) at the Department regarding the certificate of need issued to Swedish. Overlake and Evergreen raised two main issues at the adjudicative proceeding: (1) whether the Program erred in using a hybrid planning area; and (2) whether the Program erred in applying the need calculation methodology set forth in WAC 246-310-270(9) – the issue presently before the Court. CP 248-67 (*see* CP 253). The Presiding Officer addressed only the first of these two issues and ruled against the planning area advocated for by Swedish, reversing the CN Program’s approval of Swedish’s certificate of need. CP 269-84 (*see* CP 282).

b. First Petition for Judicial Review

Swedish petitioned for judicial review of the Presiding Officer’s final order. The King County Superior Court affirmed the Presiding Officer’s final order on the planning area issue, and remanded this matter to the Presiding Officer to determine whether Swedish’s certificate of need application met the need criteria when the correct planning area was used. The court also directed the Presiding Officer to address any other issues not previously addressed in the prior adjudicative proceeding. CP 33-35 (*see* CP 34, lines 19-24).

c. Remand to Department of Health Leading to Second Petition for Judicial Review

On remand, Overlake and Evergreen again briefed the issue that is the subject of the present appeal: whether the Program erred in applying the need methodology found at WAC 246-310-270(9) because it failed to balance both sides of the need/capacity equation. AR 229-40.⁸

In its Final Order, the Department initially addressed this argument by correctly explaining that “the plain language of the rule does not differentiate between exempt (ambulatory surgical centers) and non-exempt (ASFs).” CP 28 (also AR 506), Paragraph 2.7 (the Final Order is attached hereto as Appendix A-3). The Final Order then logically reasoned that “[w]here the plain meaning of a provision is plain on its face, the court must give effect to that plain meaning as an expression of legislative intent.” CP 28 (also AR 506), Paragraph 2.7. The Final Order correctly concluded that existing operating room capacity should be calculated under Step 1 of the Methodology using data from all operating rooms (i.e., hospitals, Ambulatory Surgical Facilities, *and* Exempt Surgical Facilities). CP 28 (also AR 506), Paragraph 2.7.

The Final Order then analyzed Step 2 and Step 3 of the Methodology as set forth in WAC 246-310-270(b) and (c) to determine

⁸ Citations to the administrative record in this brief (“AR”) refer to the administrative record provided to the King County Superior Court in *second* the Petition for Judicial Review, King County Superior Court Cause Number 06-2-38641-8 SEA, which the King County Superior Court Clerk provided to the Court of Appeals in its entirety, and has no Clerk’s Papers designations.

whether the plain language of those sections indicated that future need should also be determined by using data from hospitals, Ambulatory Surgical Facilities, *and* Exempt Surgical Facilities. The Final Order correctly acknowledged that “[t]his language appears to be all inclusive, similar to a reading of the capacity language set forth in WAC 246-310-270(9)(a).” CP 29 (AR 507), Paragraph 2.8. Logically, then, the Final Order should have concluded that data from the same set of operating rooms used to calculate current capacity (hospitals, Ambulatory Surgical Facilities *and* Exempt Surgical Facilities) must also be used to determine future capacity, consistent with its analysis of Step 1 of the Methodology. The Final Order, however, abandoned the logical approach and rejected reading the language consistently between the Steps of the Methodology, in favor of an unbalanced approach because “[i]f 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.” CP 29 (also AR 507), Paragraph 2.9.

However, the Final Order’s reasoning is illogical and even contradicts itself because it does not support its own conclusion. The Final Order posits that capacity under the Methodology should *include* Exempt Surgical Facilities, but future need should *exclude* Exempt Surgical Facilities. CP 29-30 (also AR 506-07). This reasoning contradicts the Final Order’s own conclusion because instead of inevitably

resulting in more need than capacity (for which the Program and Swedish advocate), it would inevitably result in surplus capacity. Ironically, this is precisely the inverse of the reasoning advocated for by the CN Program and Swedish at the adjudicative proceeding, but no less of an error because it still unbalances the need/capacity equation.

Nevertheless, the Final Order ignored the inconsistencies of this logic and concluded that the Methodology required an over-projection of need for Ambulatory Surgical Facilities, despite the plain language of WAC 246-310-270(9)(b) and (c). As a result, the Department erroneously granted Swedish certificate of need No. 1264 to establish an ambulatory surgical facility in Bellevue. CP 29-30 (also AR 507-08).

d. Second Petition for Judicial Review

Overlake and Evergreen petitioned for judicial review regarding the Department's incorrect application of the Methodology, described above. CP 1-9. The King County Superior Court denied Petitioner's Petition for Judicial Review without explanation. CP 406. This appeal followed.

D. SUMMARY OF ARGUMENT

The Methodology accurately determines need for additional Ambulatory Surgical Facilities only when the same set of operating rooms used to calculate existing surgical capacity is also used to derive the projections for future surgeries. This is what is meant as "balancing the

need/capacity equation.” Conversely, the equation is unbalanced if the existing capacity in a planning area is determined by counting only the operating room capacity of hospitals and Ambulatory Surgical Facilities **but not** Exempt Surgical Facilities, and the projected need of operating rooms is calculated by counting all surgeries in the planning area, including hospitals,⁹ Ambulatory Surgical Facilities **and** Exempt Surgical Facilities. This application of the Methodology is inconsistent with the plain language of the rule, is unreasonable, and leads to absurd results because when the need/capacity equation is unbalanced, the Methodology will inevitably incorrectly over-project a need for more operating rooms.

The Final Order wrongly interpreted the Methodology in this way, resulting in an erroneous finding of need for Swedish’s proposed Ambulatory Surgical Facility in Bellevue. The Final Order also does not logically support its own wrong conclusions.

E. ARGUMENT

1. Standard of Review

The interpretation of an agency rule is a question of law that the court reviews de novo. *DaVita, Inc. v. Wash. State Dep’t of Health*, 137 Wn. App. 174, 184, 151 P.3d 1095 (2007). The court applies the standards set forth in Washington Administrative Procedures Act (“APA”)

⁹ When determining current capacity and future need, the methodology also counts the surgeries performed in, and the capacity of, hospitals. See WAC 246-310-270(9)(a), (b), and (c). The inclusion of operating rooms in hospitals in the set of data used by the methodology on either side of the need equation is not at issue here.

directly to the agency record, sitting in the same position as the agency. *See Burnham v. State Dep't of Social and Health Serv.*, 115 Wn. App. 435, 438, 63 P.3d 816 (2003); *see also Skamania County v. Columbia River Gorge Comm'n*, 144 Wn.2d 30, 42, 26 P.3d 241 (2001) (agency's conclusions of law reviewed *de novo*, permitting the court to substitute its judgment for that of the agency); *R.D. Merrill Co. v. Pollution Control Hearings Bd.*, 137 Wn.2d 118, 142-43, 969 P.2d 458 (1999) (“Under the error of law standard of RCW 34.05.570(3)(d), a court may substitute its interpretation of the law for that of the agency.”)

This Court's review of the Department's action is governed by RCW 34.05.570. *Burnham*, 115 Wn. App. at 438. Overlake and Evergreen are entitled to relief because substantial evidence does not support the Department's order under RCW 34.05.570(3)(e). Overlake and Evergreen are also entitled to relief because the Department has erroneously interpreted or applied the law under RCW 34.05.570(3)(d). In addition, the Department's final order is internally inconsistent, inconsistent with the rule, and the Department has failed to demonstrate a rational basis for the inconsistency under RCW 34.05.570(3)(h). Because the Department's Final Order is internally inconsistent, it is also arbitrary and capricious under RCW 34.05.570(3)(i).

When an agency commits an error of law, a court may substitute its own interpretations for that of the agency. *Roller v. Dep't of Labor & Indus.*, 128 Wn. App. 922, 926, 117 P.3d 885 (2005). The rules of

statutory construction apply to regulations. *Children's Hosp. and Medical Ctr. v. Dep't of Health*, 95 Wn. App. 858, 864, 975 P.2d 567 (1999). An agency rule must be given its "rational sensible construction." *Children's Hosp.*, 95 Wn. App. at 864 (quoting *State v. McGinty*, 80 Wn. App. 157, 160, 906 P.2d 1006 (1995)). Although a court may defer to an agency's specialized knowledge and expertise in some instances, "such deference does not extend to agency actions that are arbitrary, capricious, and contrary to law." *Children's Hosp.*, 95 Wn. App. at 871. Moreover, an agency is not entitled to deference when the issue does not invoke the agency's specialized knowledge. *Children's Hosp.*, 95 Wn. App. at 873. The court has the "ultimate responsibility to see that the rules are applied consistently with the policy underlying the statute." *Children's Hosp.*, 95 Wn. App. at 864.

2. The Department Erred in Interpreting the Methodology

The Department erred by failing to consistently interpret the terms "operating rooms" and "surgeries" within the Methodology. When the Department interpreted those terms in the context of determining a use rate to determine the future need of operating rooms, the Final Order's conclusion¹⁰ supports *including* Exempt Surgical Facilities and *excluding* these same Exempt Surgical Facilities for purposes of determining existing capacity. CP 29-30 (also AR 507-08). Overlake and Evergreen

¹⁰ As described above, the reasoning in the Department's Final Order does not support its own conclusion – although both are wrong. The fact of the Final Order's internal inconsistency is addressed in a later section of this brief.

anticipate that Swedish and the Department will argue in favor of this conclusion, despite the Final Order's confused logic.

There is no coherent rationale for unbalancing the need/capacity equation with the same set of data on each side. For the Methodology to make sense, Exempt Surgical Facilities must be consistently included when calculating both the future need and the capacity to meet that need. In other words, Exempt Surgical Facilities must be consistently included on both sides of the need/capacity equation. Otherwise, the Methodology yields an incorrect result by creating an over-projection of need for additional operating rooms in the future.

- a. The Plain Language of WAC 246-310-270(9) Requires Consistent Inclusion or Exclusion of Operating Rooms in Exempt Surgical Facilities.

The plain language of the Methodology uses the terms "operating rooms" and "surgeries" without distinguishing between Exempt Surgical Facilities or Ambulatory Surgical Facilities. WAC 246-310-270(9). In fact, the Department's Final Order itself acknowledged that the language of the methodology appears to be "all inclusive," suggesting the inclusion of Ambulatory Surgical Facilities and Exempt Surgical Facilities when calculating both future need and existing capacity. CP 28-29 (also AR 506-07), Paragraph 2.7, 2.8. Despite this acknowledgement, the Department and Swedish advocate for inconsistently interpreting the terms "operating rooms" and "surgeries" throughout the Methodology. The

Department's rationale for excluding Exempt Surgical Facilities in calculating future need is simply without a basis in logic or fact.

The Department states that it applied the plain meaning rule in interpreting the rules related to the Methodology. CP 28 (also AR 506). However, the Department erred in applying that rule. The plain meaning rule of statutory or regulatory construction requires examining "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," to determine "whether a plain meaning can be ascertained." *City of Seattle v. Allison*, 148 Wn.2d 75, 81, 59 P.3d 85 (2002) (citing *Dep't of Ecology v. Campbell & Gwinn, L.L.C.*, 146 Wn.2d 1, 10, 43 P.3d 4 (2002)). Additionally, an agency rule must be interpreted in a "rational, sensible" manner. *Mader v. Health Care Auth.*, 149 Wn.2d 458, 472, 70 P.3d 931 (2003). It should not be construed "in a manner that is strained or leads to absurd results." *Allison*, 148 Wn.2d at 81. An agency rule should be "interpreted as a whole, giving effect to all language and harmonizing all provisions." *Dep't of Licensing v. Cannon*, 147 Wn.2d 41, 57, 50 P.3d 627 (2002).

The Department justifies its inconsistent definition of the same terms by looking outside of the language of the Methodology for the plain meaning of the terms "surgeries" and "operating rooms" for Step 2 (future need *includes* surgeries in Exempt Surgical Facilities) of the Methodology, but not Step 1 (existing capacity *excludes* Exempt Surgical Facilities) of this same Methodology. CP 302. While the plain meaning rule may allow

for examining the legislative context of the language to determine its plain meaning, the resulting plain meaning must be applied consistently.

(1) It is Error to Not Apply the Same Plain Meaning the Same Terms Throughout the Methodology.

The terms “operating rooms” and “surgeries” must be interpreted consistently for *all* the parts of the Methodology for it to be harmonized in a rational, sensible manner and reflect whether an actual need exists. If the meaning of the term “operating rooms” is plain in subsection (a) (Step 1) of the Methodology, it should be plain and must be interpreted consistently in subsections (b) and (c) (Steps 2 and 3) of the same Methodology, especially when nothing in the language of the Methodology itself indicates otherwise.

The terms “operating room” and “surgery” are used throughout the Methodology, and there is no indication that they should be defined differently in different parts of the need methodology. WAC 246-310-270(2) in particular provides no indication that the Department must (or even should) differentiate between the types of operating rooms when applying the Methodology (WAC 246-310-270(9)(a) and (b)), and specifically, in determining whether Exempt Surgical Facilities should be counted in both the future need and also the capacity side of the need/capacity equation. WAC 246-310-270(2) uses the term “operating rooms” in a way that is broader and distinct from the term “Ambulatory

Surgical Facility”¹¹ by stating that the planning areas are to be used to plan for “operating rooms *and* ambulatory surgical facilities.”

Thus the term “operating rooms” must include a more expansive group than Ambulatory Surgical Facilities; it must include *all* operating rooms – in hospitals, Ambulatory Surgical Facilities, and Exempt Surgical Facilities. Therefore, operating rooms in hospitals, Ambulatory Surgical Facilities, *and* Exempt Surgical Facilities should be used whenever “operating rooms” are called for in all parts of the Methodology (WAC 246-310-270(9)). Surgeries performed in Exempt Surgical Facilities should be treated consistently on both sides of the need/capacity equation. Applying different meanings to the same terms within the Methodology is simply internally inconsistent on a textual basis, as well as resulting in an inaccurate determination of future projected need.

In sum, the Department’s interpretation of the “plain meaning” of the Methodology is inconsistent and does not harmonize the language found within the very statute to which it cites. Instead, it contradicts the statute by inflating the determination of future need for Ambulatory Surgical Facilities.

¹¹ The term “Ambulatory Surgical Facility,” is restrictive, as explained above, because it excludes operating rooms that are facilities “in the offices of private physicians or dentists . . . if the privilege of using such facility is not extended to physicians or dentists outside the individual or group practice.” WAC 246-310-010.

(2) Legislative Intent Does Not Support the Department's Inconsistent Interpretation of Terms Used Throughout the Methodology.

The Department is wrong to selectively pick a particular phrase from the Legislature's statement of intent and disregard other language within the same statement of intent. Although a rule may be interpreted within its legislative context, an agency rule should be "interpreted as a whole, giving effect to *all* language and harmonizing *all* provisions." *Cannon*, 147 Wn.2d at 57.

The Department argued below that the legislative statement of intent provides support for the Department's selective and inconsistent "plain meaning" interpretation of "operating room" and "surgery" within the Methodology. CP 302. The Department selectively relied on the phrase "accessible health services in the public policy statement in RCW 70.38.015(1). However, this phrase must be read in context. RCW 70.38.015(1) provides that it is the public policy of the state:

That health planning to promote, maintain, and assure the health of all citizens in the state, to provide accessible health services, health manpower, health facilities, and other resources *while controlling excessive increases in costs*, and to recognize prevention as a high priority in health programs, is essential to the health, safety, and welfare of the people of the state. Health planning should be responsive to changing health and social needs and conditions. Involvement in health planning from both

consumers and providers throughout the state should be encouraged[.]

RCW 70.38.015(1) (emphasis added).

The Department's reliance on the statement of legislative purpose fails because the Department ignores the policy that counterbalances "accessible health services," by "controlling excessive increases in costs." RCW 70.38.015(1). The Department also ignores another section of the declaration of public policy that provides that "the development of health services and resources . . . should be accomplished in a planned, orderly fashion . . . *without unnecessary duplication or fragmentation.*" RCW 70.38.015(2) (emphasis added).

Unnecessary duplication of facilities leads to more expensive, less accessible health care. Preventing an oversupply of costly health care facilities, such as Ambulatory Surgical Facilities, is precisely how the CN regulations control excessive increases in costs. The Washington State Supreme Court has explicitly recognized this function of the CN Program:

While the Legislature clearly wanted to control health care costs to the public, equally clear is its intention to accomplish that control by limiting competition within the health care industry. The United States Congress and our Legislature made the judgment that *competition had a tendency to drive health care costs up rather than down and government therefore needed to restrain marketplace forces.* The means and end here are inextricably tied.

St. Joseph 125 Wn.2d at 741 (emphasis added).

Thus, the very statement of public policy that the Department relies upon is violated by the Department's intentional misreading of the Methodology to create an oversupply of Ambulatory Surgical Facilities.

(3) The Plain Meaning Rule Should Not Create Absurd Results.

The Department's incorrect application of the plain meaning rule creates inconsistent and absurd results. The plain meaning rule of statutory construction is meant to avoid absurd results, not create them. *See Allison*, 148 Wn.2d at 81. The Department's inconsistent interpretation here creates an absurd result because it virtually guarantees that the Methodology will project a need for additional Ambulatory Surgical Facilities, even if there is no increase in population or use rate. This is because the Department's approach purports to count the total surgeries in both existing Ambulatory Surgical Facilities *and* Exempt Surgical Facilities, as well as hospitals when calculating future demand, but anticipates that only existing Ambulatory Surgical Facilities and hospitals should be counted when calculating existing capacity.

If the Methodology excluded Exempt Surgical Facilities when calculating capacity, but included surgeries performed in Exempt Surgical Facilities when calculating the number of surgeries performed, the Methodology would erroneously indicate that current operating room capacity would not likely even meet the need for *current* surgeries, let alone the number of projected future surgeries. Therefore, excluding

operating rooms in Exempt Surgical Facilities when determining current capacity leads to an absurd result because it will lead to an artificial indication of need for more operating rooms in almost every instance, and result in approval of more operating rooms than are actually needed.

The undisputed testimony of health planning experts Dr. Scott MacStravic and Jody Carona confirm the Department's error. Both testified during the adjudicative proceeding that, from a health planning perspective, there is no supportable rationale to treat the two sides of this equation inconsistently. Specifically, Dr. MacStravic testified:

Q. In, again, your opinion, and based on your education and experience in health planning, is there any recognized principal for why you would want to view the two sides of the equation in an unbalanced manner?

A. I can think of none. It makes no logical sense. It has the predictable impact of generating conclusions that there is need for additional capacity when there is likely not.

CP 288-89 (Appendix A-4 hereto).

Similarly, Ms. Carona testified:

Q. In the State's remand analysis, in your opinion, and based on your experience, do you believe that the analysis properly balanced the capacity and the utilization?

A. I do not.

Q. Again, based on your experience and education, is that a reasonable thing to do when you're doing Certificate of Need

planning, and given the data that we have available?

A. I think it's unreasonable when you're doing any kind of planning, whether be it Certificate of Need or any business planning. You really need to understand what the need of the service area will be against what the supply of the service area is, to be able to calculate a net.

CP 286 (Appendix A-5) hereto.

The expert testimony of Dr. MacStravic and Ms. Carona remains uncontroverted. The effect of the Department's mismatching or unbalancing is to overstate need. By performing the need methodology in this manner, the Program is comparing "apples to oranges" rather than "apples to apples" and guaranteeing that the methodology will show a need for more operating rooms.

b. Deference to the Department is Inappropriate Because It Committed an Error of Law and the Department's Interpretation of the Agency Rule Does Not Require Specialized Knowledge or Expertise.

A court should not defer to an agency's wrong interpretation of an agency rule when the rule is unambiguous. *Mader*, 149 Wn. 2d at 473. Deference is also not given to any agency action in which the agency did not utilize any specialized knowledge or expertise. *Children's Hosp.*, 95 Wn. App. at 873.

In *Children's Hospital*, the court did not give the Department deference regarding the Department's decision not to require certificate of need review of Tacoma General Hospital performing pediatric open heart surgeries. *Children's Hosp.*, 95 Wn. App. at 869, 871. The court held that the Department did not utilize specialized knowledge and expertise when "the Department's determination appears to have been based on an erroneous interpretation of the statutes and its own [certificate of need] regulations" *Children's Hosp.*, 95 Wn. App. at 873. Cf. *Providence Hosp. of Everett v. State of Wash., Dep't of Social & Health Serv. et al.*, 112 Wn. 2d 353, 356, 770 P. 2d 1040 (1989) (holding an interpretation not inconsistent with the plain language and within the specialized knowledge of the agency is entitled to deference).

In the present case, like *Children's Hospital*, the Department made a clear error of law in interpreting the plain language of the operating room need methodology found in WAC 246-310-270(9). As explained above, the Department defines the same terms within the Methodology differently. No specialized knowledge of certificate of need procedures or methods is required for the Court to exercise its ultimate responsibility to ensure that the methodology in WAC 246-310-270(9) is correctly interpreted. This Court can read the methodology, determine the plain meaning of the terms within it, and require their consistent application, without any deference to the Department's illogical rationale.

c. The Final Order is Arbitrary and Capricious Because it is Internally Inconsistent and Not Supported by the Record.

“Agency action is arbitrary and capricious if it is willful and unreasoning and without regard to the facts or circumstances.” *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). Here, the Final Order is arbitrary and capricious because there is insufficient support in the administrative record for its conclusions, and there is no rational connection between its reasoning and conclusions.

The Final Order’s analysis is internally inconsistent because it supports a conclusion that is opposite to its logic. The Final Order’s analysis of the Methodology would always *underestimate* the future need, because it included Exempt Surgical Facilities when determining capacity (Step 1) (CP 28, paragraph 2.7), but did not count Exempt Surgical Facilities when counting future need (Step 2) (CP. 29, paragraph 2.9). Regardless of this confusion, both the Final Order (CP 28-30 (AR 506-08)) and the Department’s arguments to the superior court below are erroneous because they both fail to balance the need/capacity equation. However, the fact that the Final Order’s logic does not support its own conclusion is further indication that it is not entitled to any deference and should be reversed as arbitrary and capricious.

The Final Order's sole justification for this inconsistent inverted approach is similar to the argument the Department made before the superior court:

[i]f 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.

CP 29 (also AR 507).

This argument fails for the same reasons described above. This rationale ignores the "plain meaning" approach announced by the Department as the basis for its decision. Furthermore, this rationale is based on pure speculation and is not supported by anything in the administrative record. The Department bases this statement on its own finding of fact that:

a patient who may qualify for surgery an exempt ASF [Exempt Surgical Facility] 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 facility at an exempt facility in the present, may not hold surgical privileges at the same facility in the future. Finally, the exempt ambulatory surgical center may no longer exist.

CP 9 (AR 499), Paragraph 1.11.

This speculative finding is based on an unsupported assumption that the capacity for Exempt Surgical Facilities is shrinking, which has no

evidentiary support in the administrative record. “[I]he existence of a fact cannot rest of guess, speculation or conjecture.” *State v. Hutton*, 7 Wn. App. 726, 728, 502 P.2d 1037 (1972). Because this conjecture is without support in the administrative record, it must be rejected and cannot be a basis for the Department’s erroneous interpretation of the Methodology.

Moreover, even if this assumption was appropriate (which it is not), the reasoning that flows from it works both ways. For example, a patient who obtains a surgery at an Ambulatory Surgical Facility may later qualify for a future surgery at an Exempt Surgical Facility in a private office. In fact, almost all surgeons who use Exempt Surgical Facilities also have privileges to perform surgeries in hospitals. Likewise, a surgeon who holds privileges at an Ambulatory Surgical Facility may join a private group and obtain ownership in an Exempt Surgical Facility. New Exempt Surgical Facilities are created on a regular basis. There is absolutely nothing in the record to suggest that the availability of Exempt Surgical Facilities is shrinking. Nor is there anything else that could possibly justify the Department refusing to count Exempt Surgical Facilities in the current supply of operating rooms, especially when it does count the surgeries that are performed within them when calculating the future need for surgeries.

The Final Order is therefore arbitrary and capricious, not only because its inverted reasoning does not support its own conclusion, but also because nothing in the record exists to support this justification for its departure from the plain language of the Methodology.

3. When the Need/Capacity Equation is Balanced, No Need Exists.

The administrative record before this Court demonstrates that when the methodology in WAC 246-310-270(9) is correctly applied, as described above, no need exists for Swedish's proposed Ambulatory Surgical Facility in the East King planning area. The Department's Final Order determined that the appropriate use rate when projecting future need under WAC 246-310-270(9)(b) is 82 surgeries per 1,000 residents in the service area ("82/1000") for the East King service area. CP 23 (AR 501). This use rate takes into account all surgeries in the planning area, including hospitals, Ambulatory Surgical Facilities, *and* Exempt Surgical Facilities. CP 291-92.

Overlake and Evergreen's expert, Jody Carona, prepared a worksheet (Exhibit E3 from the adjudicative hearing, located at CP 294) (Appendix A-6 hereto) to illustrate the results of an analysis that properly applied the need methodology for the East King planning area. These worksheets were based on the best available data in the record. Ms. Carona's worksheet utilized the use rate of 82/1000, consistent with the

use rate utilized by the Department in its Final Order. CP 294. This worksheet appropriately calculated capacity within the planning area using data from hospitals, Ambulatory Surgical Facilities, *and* Exempt Surgical Facilities in steps (a.i) through (a.iv). The worksheet then projected future surgeries by applying the population projections to the appropriate 82/1000 use rate, at steps (b.i.) through (b.iv.). The result of this analysis demonstrates that there is a surplus of 2.6 operating rooms in the East King planning area, at step (c.i). CP 294.

In sum, when both sides of the need/capacity equation calculation in WAC 246-310-270(9) are properly balanced and the best data available in the administrative record is applied, no need exists for Swedish's proposed Ambulatory Surgical Facility in Bellevue.

4. Evaluation of Need in the East King Planning Area on Remand to the Program.

In the alternative, the Court may determine that a remand of this matter to the Department is appropriate, with instructions to properly apply the need methodology found at WAC 246-310-270(9), using the balanced equation approach described above. In this event, the Department should apply the methodology as instructed based on the facts in the record in order to make a definitive determination on whether a true need actually exists in the East King planning area.

F. CONCLUSION

For the reasons stated above, the Department erred by failing to properly apply the Methodology found at WAC 246-310-270(9) because it failed to balance both sides of the need/capacity equation by failing to include surgeries performed in Exempt Surgical Facilities when calculating both future need and capacity to meet that need. The result is mathematically nonsensical and naturally results in an oversupply of Ambulatory Surgical Facilities in the East King planning area. The methodology of WAC 246-310-270(9) should be interpreted and applied consistently rather than differently within different parts of the same rule. This Court should find that no need exists for Swedish's proposed Ambulatory Surgical Facility in the East King planning area when the need methodology is correctly applied. Alternatively, this matter should be remanded to the Department with instructions to correctly apply the need methodology according to the plain language set out at WAC 246-310-270(9).

RESPECTFULLY SUBMITTED ___ day of _____, 2007.

Respectfully submitted,

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APPENDIX

A-1	WAC 246-310-010
A-2	WAC 246-310-270
A-3	Department's Final Order (CP 13-31)
A-4	McStravic Testimony (CP288-89)
A-5	Carona Testimony (CP 286)
A-6	Correct Methodology Application (CP 294)

APPENDIX 1

Westlaw.

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**WASHINGTON ADMINISTRATIVE CODE
TITLE 246. HEALTH, DEPARTMENT OF
CHAPTER 246-310. CERTIFICATE OF NEED**

Current with amendments adopted through October 3, 2007.

246-310-010. Definitions.

For the purposes of chapter 246-310 WAC, the following words and phrases have the following meanings unless the context clearly indicates otherwise.

- (1) 'Acute care facilities' means hospitals and ambulatory surgical facilities.
- (2) 'Affected person' means an interested person who:
 - (a) Is located or resides in the applicant's health service area;
 - (b) Testified at a public hearing or submitted written evidence; and
 - (c) Requested in writing to be informed of the department's decision.
- (3) 'Alterations,' see 'construction, renovation, or alteration.'
- (4) 'Ambulatory care facility' means any place, building, institution, or distinct part thereof not a health care facility as defined in this section and operated for the purpose of providing health services to individuals without providing such services with board and room on a continuous twenty-four-hour basis. The term 'ambulatory care facility' includes the offices of private physicians, whether for individual or group practice.
- (5) 'Ambulatory surgical facility' means any free-standing entity, including an ambulatory surgery center that operates primarily for the purpose of performing surgical procedures to treat patients not requiring hospitalization. This term does not include a facility 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.
- (6) 'Applicant,' means:
 - (a) Any person proposing to engage in any undertaking subject to review under chapter 70.38 RCW; or
 - (b) Any person or individual with a ten percent or greater financial interest in a partnership or corporation or other comparable legal entity engaging in any undertaking subject to review under chapter 70.38 RCW.
- (7) 'Bed banking' means the process of retaining the rights to nursing home bed allocations which are not licensed

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APPENDIX 2



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**WASHINGTON ADMINISTRATIVE CODE
TITLE 246. HEALTH, DEPARTMENT OF
CHAPTER 246-310. CERTIFICATE OF NEED**

Current with amendments adopted through October 3, 2007.

246-310-270. Ambulatory surgery.

(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.

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(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 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

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

<General Materials (GM) - References, Annotations, or Tables>

WAC 246-310-270, **WA ADC 246-310-270**

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APPENDIX 3

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STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE SERVICE UNIT

OGDEN MURPHY WALLACE, PLLC

In the Matter of:)	
)	Docket No. 03-06-C-2001CN
OVERLAKE HOSPITAL MEDICAL)	
CENTER, a Washington non-profit)	FINDINGS OF FACT,
corporation; and KING COUNTY)	CONCLUSIONS OF LAW
PUBLIC HOSPITAL DISTRICT NO. 2,)	AND FINAL ORDER ON
dba EVERGREEN HEALTHCARE,)	REMAND
a Washington public hospital district,)	
)	
Petitioners.)	
_____)	

APPEARANCES:

Petitioner, Overlake Hospital Medical Center, by
Ogden Murphy Wallace PLLC, per
Donald W. Black, Attorney at Law

Petitioner, King County Public Health District No. 2,
dba Evergreen Healthcare, by
Livengood, Fitzgerald, & Alskog, PLLC, per
James S. Fitzgerald, Attorney at Law

Intervenor, Swedish Health Services,
dba Swedish Medical Center, by
Bennett Bigelow & Leedom, P.S. per
Stephen I. Pentz, Attorney at Law

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

PRESIDING OFFICER: John F. Kuntz, Health Law Judge

Following the issuance of the Amended Findings of Fact, Conclusions of Law
and Final Order, Swedish Health Services (Swedish) filed a petition in King County

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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.

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.

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).

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.

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).

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

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.

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 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

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.

(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. Drebeck*, 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

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

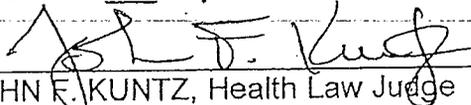
III. ORDER

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 95204-7852

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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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1 the equation in the same way. One was to count all the
2 utilization from which you have data in all the
3 capacities, and the other is to count only the capacity
4 for the nonexempt facilities and the utilization from
5 those facilities.

6 And the question was, in your opinion and based on
7 your education and experience, forced with those as the
8 two options, which is preferable?

9 A In general, I would prefer the option where I have the
10 most information. And in a situation where utilization
11 information is incomplete or, for that matter,
12 questionable accuracy, I don't know which applies --

13 either one, in this case. But as I understand it, it is
14 incomplete, in that the nonexempt ambulatory surgery
15 facilities did not report utilization. But they do
16 report capacity.

17 So because that is likely to provide an erroneous
18 view if you count everything, the better alternative
19 would be to count where you have the most information,
20 which is information on utilization and capacity in
21 nonexempt facilities.

22 Q In, again, your opinion, and based on your education and
23 experience in health planning, is there any recognized
24 principal for why you would want to view the two sides
25 of the equation in an unbalanced manner?

1 A I can think of none. It makes no logical sense. It has
2 the predictable impact of generating conclusions that
3 there is need for additional capacity when there is
4 likely not.

5 MR. BLACK: May I have a minute, Your
6 Honor, to confer with counsel?

7 JUDGE KUNTZ: Yes.

8 *(Pause in the proceedings.)*

9 MR. BLACK: Thank you very much. I have
10 no further questions.

11 JUDGE KUNTZ: Thank you, Mr. Black.

12 Mr. McCartan, is there an order in which you want
13 to cross-examine?

14 MR. McCARTAN: Your Honor, could we have
15 five minutes?

16 MR. PENTZ: 2:00.

17 JUDGE KUNTZ: I have five minutes to
18 2:00. So five minutes would put us at 2:00, yes.

19 *(Recess taken.)*

20 Back on the record in the Swedish Health Care
21 matter, Health Services.

22 We are at that stage where the program or
23 Swedish can cross-examine Dr. Macstravic.

24 MR. McCARTAN: I'll defer to Mr. Pentz.

25

APPENDIX 5

1 JUDGE KUNTZ: Back on the record.

2 MR. BLACK: A couple final questions to conclude
3 this.

4 In the State's remand analysis, in your opinion,
5 and based on your experience, do you believe that the
6 analysis properly balanced the capacity and the
7 utilization?

8 A. I do not.

9 Q. Again, based on your experience and education, is
10 that a reasonable thing to do when you're doing Certificate
11 of Need planning, and given the data that we have
12 available?

13 A. I think it's unreasonable when you're doing any
14 kind of planning, whether be it Certificate of Need or any
15 business planning. You really need to understand what the
16 need of the service area will be against what the supply of
17 the service area is, to be able to calculate a net.

18 MR. BLACK: I have no further questions.

19 JUDGE KUNTZ: Thank you. Cross-examination, who
20 should I start with?

21 MR. MCCARTAN: Mr. Pentz, please.

22 MR. PENTZ: May we have five minutes, Your Honor?

23 JUDGE KUNTZ: Yes, we will take a five-minute
24 recess.

25 (A recess was taken.)

286 002137

APPENDIX 6

**TITLE: 2006 EAST KING SECONDARY HEALTH SERVICE AREA - INCLUDING EXEMPT FACILITIES
 USE RATE: PER NORTHWEST NASAL CN - INCLUDES MOST EAST KING FACILITIES**

*the year
 "E"
 E-3*

CAPACITY/SUPPLY: ACTUAL EAST KING DEFINED SVC AREA FACILITIES PER NORTHWEST NASAL DECISION

Population	546,012	Projected Surgeries	44,773
Use Rate	82	Projected Outpatient	72.5%
		Projected Inpatient	27.5%

a.i. 94,250 minutes/year/mixed-use OR

a.ii. 68,850 minutes/year/ dedicated outpatient OR

a.iii. 31 dedicated outpatient OR's x 68,850 minutes =

a.iv. 16 mixed-use COR's x 94,250 minutes = 2,134,350 minutes dedicated OR capacity

b.i. projected inpatient surgeries= 12,302 = 1,445,438 minutes inpatient surgeries

b.ii. projected outpatient surgeries= 32,471 = 1,948,283 minutes outpatient surgeries

b.iii. Forecast # of outpatient surgeries-capacity of dedicated outpatient OR's
 32,471 - 35,573 = -3,101 outpatient surgeries (SURPLUS)

b.iii. average time of inpatient surgeries. = 117.5 minutes
 average time of outpatient surgeries = 60 minutes

b.iv. inpatient surgeries average time = 1,445,438 minutes
 remaining outpatient surgeries (b.ii.) * ave time = -186,067 minutes
 = 1,259,371 minutes

c.i. if b.iv. < a.iv., divide (a.iv.-b.iv.) by 94,250 to determine surplus of mixed-use OR's
 1,508,000
 1,259,371

c.ii. if b.iv. > a.iv., divide (inpatient part of b.iv.-a.iv.) by 94,250 to determine shortage of inpatient OR's
 248,629 / 94,250 = 2.64 (SURPLUS)

NOT APPLICABLE

divide outpatient part of b.iv by 68,850 to determine shortage of dedicated outpatient ORs.
 NOT APPLICABLE