

NO. 82728-1

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**SUPREME COURT OF THE STATE OF WASHINGTON**

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

Appellants,

v.

WASHINGTON STATE DEPARTMENT OF HEALTH, and SWEDISH  
HEALTH SERVICES,

Respondents.

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*PETITIONER*  
**RESPONDENT WASHINGTON STATE DEPARTMENT OF  
HEALTH'S SUPPLEMENTAL BRIEF**

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## I. INTRODUCTION

An ambulatory surgery center (ASC) is a facility where physicians perform “outpatient” surgeries in operating rooms without hospitalization. Many procedures, including those requiring anesthesia, may be performed in an ASC. There is growing demand for outpatient surgery, fueled by lower costs and convenience, and by advances in surgical techniques. 1<sup>st</sup> AR 13, 200.

There are two very different types of ASCs. The first type is approved by the Department of Health (Department) through the Certificate of Need process. RCW 70.38. These publicly-available ASCs are open to all patients and physicians, for all types of outpatient surgery, and are required to accept Medicare/Medicaid and provide charity care. In sharp contrast, the second type of ASC is located in an office of a private physician, and does not require Certificate of Need approval. These exempt ASCs are not available for public use. They are used only by the physicians owning the facility and provide specialty surgery on only the physicians’ own patients. They need not accept Medicare/Medicaid or provide charity care.

The Certificate of Need law considers the needs of all patients, and determines the number of publicly-available ASCs required to meet the entire projected public need. Since the Department does not regulate

exempt ASCs, and cannot require them to serve the public, it cannot be assumed that these exempt ASCs will be available to meet future public need. In applying this principle, the Department's contested decision in this case assures that all East King County residents will have adequate access to ASCs to meet the growing demand for outpatient surgery.

## II. STATEMENT OF CASE

The Certificate of Need law is administered by the Department under RCW 70.38 and WAC 246-310. The law requires providers to obtain a Certificate of Need prior to establishing a new ambulatory surgery center (ASC). RCW 70.38.105(4)(a); RCW 70.38.025(6).<sup>1</sup> An ASC is a facility with operating rooms where physicians perform surgeries on patients not requiring hospitalization. WAC 246-310-010(5). An ASC Certificate of Need application seeks approval to establish a specific number of operating rooms within the proposed ASC.

Applicants must demonstrate "need" for the proposed facility in the planning area where the facility would be located. RCW 70.38.115(2)(a); WAC 246-310-210.<sup>2</sup> The methodology used to

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<sup>1</sup> Other facilities requiring Certificate of Need review are hospice, hospitals, nursing homes, kidney dialysis facilities, and home health. RCW 70.38.025(6).

<sup>2</sup> There are three other Certificate of Need requirements: Financial Feasibility (WAC 246-310-220); Structure and Process of Care (WAC 246-310-230); and Cost Containment (WAC 246-310-240). The Department found Swedish met these criteria. 2<sup>nd</sup> AR at 19-25. These criteria are not contested by Overlake/Evergreen and therefore are not at issue in this case.

determine whether need exists for additional publicly-available ASCs is set forth in WAC 246-310-270. App. at 1-2. WAC 246-310-270 (9)(a) determines “existing [operating room] capacity” in the planning area. WAC 246-310-270(9)(b) determines the “future [operating room] need” in the planning area. Need is forecast based on the third year of operation of the proposed facility. WAC 246-310-270(9)(b)(i). WAC 246-310-270(9)(c) then determines “net [operating room] need” in the planning area based on the future need for operating rooms minus the existing operating room capacity.

Applying the methodology, the Department found need for 5.39 additional outpatient operating rooms in East King in 2009, Swedish’s third year of operation. 2<sup>nd</sup> AR at 18. 265.<sup>3</sup> The Department therefore approved the application. Overlake Hospital and Evergreen Healthcare, which both operate a Certificate of Need ASC in East King, requested an adjudicative proceeding to contest the approval. No exempt ASC or private physician opposed the approval.

Approval was upheld by a Department Health Law Judge (HLJ) (2<sup>nd</sup> AR at 491-509) and by superior court (CP 402-03). The Court of Appeals overturned the approval and remanded the case to the Department

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<sup>3</sup> This case involved two petitions for judicial review, and therefore two administrative records, which are designated 1<sup>st</sup> AR and 2<sup>nd</sup> AR.

for further evaluation. Overlake Hosp. Ass'n v. Dep't of Health, 148 Wn. App. 1, 200 P.3d 248 (2008); App. at 3-10. The Supreme Court unanimously granted Swedish's and the Department's petitions for review.<sup>4</sup>

### III. ARGUMENT

#### A. **The Department Correctly Applied WAC 246-310-270 To Carry Out The Purpose Of The Certificate Of Need Law To Assure A Sufficient Number Of Publicly-Available ASC Operating Rooms To Meet The Public Demand**

A primary purpose of the Certificate of Need law is to assure that health care facilities are accessible to members of the public who need them. RCW 70.38.015(1) states that it is the public policy of the state to implement health resource strategies that:

... promote, maintain, and assure the health care of all citizens of the state, provide accessible health services, health manpower, health facilities, and other resources while controlling increases in costs...

(Emphasis added.)

Certificate of Need ASCs are available to all physicians to provide a full range of outpatient surgical procedures to the public. They serve a wide variety of patients, including those using Medicare/Medicaid or in need of charitable care. In contrast, ASCs that are exempt from Certificate

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<sup>4</sup> A more detailed factual history is contained at pages 2-3 of the Department's Court of Appeals brief.

of Need requirements are not intended to serve the general public and the state does not require them to do so. Rather, these facilities are owned by private physicians who provide outpatient surgery in a single area of medical specialty, such as fertility assistance or eye surgery.<sup>5</sup>

Certificate of Need applicants must show that additional ASC facilities are needed to meet public need in a given area. RCW 70.38.115(2)(a); WAC 246-310-210(1). The Department assesses need under WAC 246-310-270 by first determining the number of existing Certificate of Need operating rooms in the planning area. The Department then determines a “use rate” based on how many surgeries are performed in the planning area’s Certificate of Need operating rooms and exempt operating rooms.

After calculating the total use rate, the Department determines how many publicly-available operating rooms will be needed to serve patients three years in the future. It then subtracts the number of existing Certificate of Need operating rooms from the number of such publicly available operating rooms needed to meet all future need in the planning

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<sup>5</sup> This fact is evident from the names of the exempt facilities: Bellevue Urology Associates, Eastside Endoscopy Center; Eastside Podiatry ASC; Evergreen Endoscopy Center; Interventional Pain Program; Laboratory For Reproductive Health; Pacific Cataract and Laser Institute; Redmond Footcare Associates; Washington Sports Medicine Associates; Aesthetic Eye Associates; Dermatology and Cosmetic Associates of Issaquah; Elan Plastic Surgery; Remington Plastic Surgery; and Sammamish Center for Facial and Plastic Surgery. 1<sup>st</sup> AR at 850-51.

area. This methodology does not rely on exempt ASC – not open to the public – to meet the public demand for outpatient operating rooms.

For reasons explained below, the Department in this case properly interpreted WAC 246-310-270, consistent with the intent of the Certificate of Need law, to ensure a sufficient supply of publicly-available outpatient operating rooms to meet the public demand.

**1. In Excluding Existing Exempt ASC Operating Rooms, The Department Correctly Interpreted The Capacity Language In WAC 246-310-070(9)(a)**

Consistent with the statutory goal of regulating health care facilities to ensure public access, WAC 246-310-010(5) defines an ambulatory surgical facility as:

[A]ny 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.

(App. at 22). Thus, in-office ASC operating rooms located in private medical offices, which are not open to use by outside physicians, are exempt from Certificate of Need review.

WAC 246-310-270(9)(a)(iii) instructs the Department to calculate the “total annual capacity (number of surgeries) of all dedicated outpatient

operating rooms in the area.” These operating rooms are those used only for outpatient surgeries (as opposed to “inpatient” hospital surgeries). In performing the methodology, the Department counted 19 dedicated outpatient operating rooms in East King County. 2<sup>nd</sup> AR at 265.

WAC 246-310-270(9)(a)(iv) then instructs the Department to calculate the “total annual capacity of inpatient and outpatient [mixed use] operating rooms in the area.” In performing the methodology, the Department counted 14 mixed use operating rooms in East King County. 2<sup>nd</sup> AR at 265.

This 19/14 operating-room count included only the operating rooms in East King County hospital operating rooms and Certificate of Need-approved ASC operating rooms. The count did not include operating rooms located in exempt ASCs because they are outside the definition of ASC in WAC 246-310-010(5) and therefore not regulated under the Certificate of Need law. In other words, exempt ASCs located in physicians’ private offices are not considered “operating rooms” within the meaning of WAC 246-310-270(9)(a)(iii)-(iv).

**2. The Department Correctly Interpreted WAC 246-310-270(9)(b) To Include The Exempt ASC Patient Volume In Determining The Use Rate**

Next, following the above existing-capacity calculation, WAC 246-310-270(9)(b) states that in order to calculate future need, the Department must:

Project the number of inpatient and outpatient surgeries within . . . the planning area for the third year of operation [of the proposed new facility].

(Emphasis added.) This projection requires the Department to estimate the number of outpatient surgeries performed in East King County annually in order to project future need for operating rooms. The projection requires the Department to determine a “use rate” for the planning area. A use rate is based on the historical number of surgeries and the population in the planning area. In performing the methodology for the Swedish application, the Department used an 82 surgeries per 1,000 population use rate for East King County. 2<sup>nd</sup> AR at 265. This 82/1000 use rate was utilized in the Swedish evaluation because it was the use rate determined by the Department’s survey of existing providers in response to a different East King County ASC application approved in 2002. 2<sup>nd</sup> AR at 16, 499-500.

In approving this approach, the HLJ found that the language of WAC 246-310-270(9)(b) – projecting numbers of surgeries within the

planning area – was all inclusive, and therefore required the Department to consider the total volume of surgeries performed at both Certificate of Need ASCs and exempt ASCs in computing the need for additional Certificate of Need operating rooms in the planning area. 2<sup>nd</sup> AR at 507.

**3. The Department’s Application Of The Methodology Is Consistent With The Intent Of The Certificate of Need Law To Assure Adequate Public Access To Health Care For All Patients**

If the language of WAC 246-310-270 is not clear, the law should be interpreted in a manner consistent with the law’s intent. Quadrant Corp. v. Growth Mgmt. Hearings Bd., 154 Wn.2d 224, 110 P.3d 1132 (2005). Besides relying on the wording of the methodology, the HLJ found the Department’s interpretation consistent with the intent of the Certificate of Need law to provide “accessible” health services to all citizens of the state. 2<sup>nd</sup> AR at 507-08; RCW 70.38.015(1). RCW 70.38.115(2)(d)(ii) expressly requires the Department consider the “extent to which a proposed service will be accessible to all residents of the area to be served.” (Emphasis added.)

On the accessibility issue, HLJ noted that exempt ASCs are “not available to many of the individuals within the planning area,” since these facilities are used to operate only on the patients of physicians who own

the facilities. 2<sup>nd</sup> AR at 499. Nor can the Department be assured that an exempt ASC will continue to exist in the future. Id.

Consistent with the statutory directive to assure accessibility, WAC 246-310-210(2) imposes the following criterion for Certificate of Need approval:

All residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups are likely to have access [to the proposed ASC].

Accordingly, in its application, Swedish submitted extensive information about its charity care and indicated it accepted Medicare/Medicaid patients. 1<sup>st</sup> AR at 220-223. The Department conditioned its approval of the application on Swedish making reasonable efforts to provide an average level of charity care and keep records to demonstrate compliance. 2<sup>nd</sup> AR at 11.<sup>6</sup> By contrast, unregulated exempt ASCs cannot be required to accept Medicare/Medicaid or provide charity care.

Hence, in determining future need, the Department's application of the methodology, consistent with the statute, assures a sufficient supply of publicly-available Certificate of Need ASC operating rooms open to all physicians to serve all patients; that is, the Department's approach does

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<sup>6</sup> WAC 246-310-500(2) grants the Department authority to place conditions on a Certificate of Need. Violating the condition would constitute a misrepresentation, allowing the Department to suspend or revoke a Certificate of Need. WAC 246-310-500(3)(a)(ii), (6)(a)(ii).

not rely on unregulated exempt ASCs to meet any part of the public demand for the service. The HLJ's conclusion is supported by the following testimony at the adjudicative hearing from Department Analyst Randall Huyck:

Q: So what is the rationale for counting the volumes in an exempt facility but not counting the facility itself?

A: That's a longstanding rationale that the department has used for a number of years. The rationale behind that is that operating rooms that are approved by certificate of need or are included in community hospitals are available to the general surgical public if they are properly credentialed to use the rooms for treatment of their patients, whoever their patients may be.

The facilities that are described as exempt facilities, the use of those facilities is limited only to members of those group practices. And very frequently, we see that the use of these facilities is limited to one, sometimes two, different specialties of medicine, such as ENT surgery, oral surgery, or something like that. So those operating rooms are not really analogous to a generally available ambulatory surgery center, operating room, where a multitude of various services could be performed by a number of different physicians . . .

Q: So are you attempting to make sure that the [total] number of surgeries can be met by the facilities that are open and generally available to everyone?

A: Right. That's exactly what we're attempting to do . . .

CP 333, 335.

**4. The Court of Appeals Incorrectly Rejected The Department's Application Of The Methodology**

In reversing the Department's approval of Swedish's application, the Court of Appeals held that counting the exempt ASC volume in WAC 246-310-270(9)(b) was flawed and unsound, when under WAC 246-310-270(9)(a) the Department did not count the number of exempt ASC operating rooms in the existing operating room supply. Overlake, 148 Wn. App. at 3, 7. This holding is incorrect.

First, as explained above, the Department's interpretation is consistent with the language of the rule.

Moreover, contrary to the Court of Appeals' holding, the Department's interpretation does not frustrate the law's intent to control costs by limiting the number of providers. Id. at 6. One aim of the Certificate of Need law is to prevent establishment of unneeded facilities, since excess capacity in the healthcare care system may increase overall healthcare costs. St. Joseph Hosp. v. Dep't of Health, 125 Wn.2d 733, 741, 887 P.2d 891 (1995).

However, the Department's interpretation of the methodology does not promote excess capacity. Instead, it simply assures there is sufficient supply of publicly-available Certificate of Need operating rooms – open to all physicians and patients – to meet the total public demand for the

service. It does not rely on unregulated exempt ASCs to meet part of the public need, as these ASCs perform only specialized surgeries; are not open for use to all physicians; serve only patients of the physicians maintaining the operating rooms; and are under no obligation to accept Medicare/Medicaid or provide charity care. It is noteworthy that Overlake/Evergreen stands alone in objecting to the granting of the application. No physician operating an exempt ASC in East King County contested the granting of the application.

The Court of Appeals incorrectly stated that the Department's application of the methodology "makes no logical sense" because it would always "result in a showing of need except where there are no exempt facilities" in the planning area. Overlake, 148 Wn. App. at 6. However, if the use rate is sufficiently low, the methodology will show that no additional Certificate Of Need operating rooms are needed even when the exempt ASC volume is counted. For example, in 2007 the Department denied an application filed by The Doctors Clinic for a Certificate of Need to serve Kitsap County. The application was denied because the methodology showed a 1.48 operating room surplus, even though there were four exempt ASC facilities whose volumes were counted in the

methodology.<sup>7</sup> Similarly, under the same methodology, the Department denied Multicare's ASC application for operating rooms Central Pierce County. Despite the fact that volumes of seven exempt ASCs in the planning area were considered, the Department's application of the methodology showed no need for additional operating rooms in Central Pierce County.<sup>8</sup>

Swedish's case also illustrates that the Department's application of the methodology does not inevitably result in a calculation of unlimited need for additional operating rooms in a planning area. In fact, in Swedish's application, the Department found a finite need for just 5.29 ASC operating rooms in East King County. 2<sup>nd</sup> AR at 265. An application by Swedish or any other applicant for six or more operating rooms would have been denied for lack of need.

**B. Need For Swedish's ASC Is Demonstrated By Factors Aside From the WAC 246-310-270 Methodology**

Two important factors outside the WAC 246-310-270 methodology further support the Department's decision that the proposed Swedish operating rooms are needed in East King County. The

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<sup>7</sup> <http://www.doh.wa.gov/hsqa/FSL/CertNeed/Docs/DecisionsArchive/Arch2008/08-01eval.pdf>; App. at 8-22 (highlighted at 12, 13).

<sup>8</sup> <http://www.doh.wa.gov/hsqa/FSL/certneed/Docs/Decisions/Archieve/Arch2005/05-36eval.pdf>, App. at 23-35 (highlighted at 26, 29).

Department cited these factors in the evaluation approving the application.  
2<sup>nd</sup> AR at 18.<sup>9</sup>

As stated above, the methodology is based on the number of patients who receive surgery at a facility located inside the planning area. Swedish is one of Washington's largest health care providers, with three Seattle campuses. 1<sup>st</sup> AR at 133. One factor lowering the current East King County use rate is that, in its Seattle facilities outside East King County, Swedish performed over 4,000 outpatient surgeries on East King County residents in 2001. 1<sup>st</sup> AR at 139. This means that many Swedish patients currently leave East King County in order to receive outpatient surgery. Hence, a new Swedish ASC in Bellevue likely will significantly increase the number of surgeries performed in East King County for the convenience of patients who live there. Overlake has not disputed Swedish's assertion that a Swedish East King County ASC will allow treatment of its patients in a "more appropriate and cost-effective manner." 1<sup>st</sup> AR at 135.

Another factor demonstrating need outside the methodology is that the existing Certificate of Need operating rooms in East King County –

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<sup>9</sup> These additional factors were not actually cited by the Health Law Judge in his decision to approve Swedish's application. 2<sup>nd</sup> AR at 491-508. However, a court may reaffirm on agency's decision on any ground, even on grounds not cited by the agency in making its contested decision. LaMon v. Butler, 112 Wn.2d 200-01, 770 P.2d 1027 (1989).

open to all physicians and all patients – in 2001 were operating at 90 percent capacity, indicating a need for additional operating rooms to meet future need in a heavily-populated and fast-growing planning area. 2<sup>nd</sup> AR at 18.

**C. According Substantial Deference To The Department, The Court Should Affirm The Approval Of Swedish's Application**

In reversing the Department's decision to approve the Swedish application, the Court of Appeals failed to recognize two important principles of judicial review that favor affirming the Department's decision.

First, the burden is on Overlake to demonstrate that the Department's decision was incorrect. RCW 34.05.570(1)(a); Univ. of Wash. Med. Ctr. v. Dep't of Health, 164 Wn.2d 95, 103, 187 P.3d 243 (2008).

Second, in Certificate of Need cases, courts accord "substantial deference" to the Department's interpretation, "particularly in regard to the law involving the agency's special knowledge and expertise." Univ. of Wash., 164 Wn.2d at 102 (upholding Department's finding of need for a new liver transplant program). The Department properly utilized its special knowledge and expertise in applying WAC 246-310-270 to ensure that an adequate supply of Certificate of Need operating rooms to meet the

total public demand. Deference means that an agency's "reasonable" conclusions should be upheld, even though a court might find contrary conclusions more persuasive. Marsh v. Or. Natural Res. Council, 490 U.S. 360, 378, 109 S. Ct. 1851, 104 L.Ed.2d 377 (1989). Deference is particularly appropriate when an agency's interpretation of its own regulation is at issue. Tuerk v. Dep't of Licensing, 123 Wn.2d 120, 126, 864 P.2d 1382 (1994). Lands Council v. Martin, 529 F.3d 1219, 1226 (9<sup>th</sup> Cir. 2008) (deference to agency interpretation of its methodology).

For the reasons discussed above, Overlake has not met its burden to show the Department erred in approving Swedish's application. In applying the language of WAC 46-310-270 and the intent of the Certificate of Need statute, the Department properly concluded that the number of exempt ASC operating rooms is not counted when determining the existing supply of publicly-available ASC facilities, but the volume of patients served in those facilities is counted to determine the total ASC patient use rate for the planning area. If the Court finds there are different ways to interpret the methodology, it should give substantial deference to the Department's interpretation of its own rule, and should affirm the decision to grant Swedish's Certificate of Need application.

#### IV. CONCLUSION

The Department of Health respectfully requests that the Court reverse the Court of Appeals decision, and affirm the Department's decision granting Swedish's ASC Certificate of Need application.

RESPECTFULLY SUBMITTED this 28 day of August, 2009.

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APPENDIX

WAC 246-31.....1,2

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

**WAC 246-310-270**

**Ambulatory surgery.**

No agency filings affecting this section since 2003

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

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

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

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

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

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

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

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

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

(a) Existing capacity.

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

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

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

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

(b) Future need.

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

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

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

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

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

(c) Net need.

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

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

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

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▶

Court of Appeals of Washington,  
 Division 1.

**OVERLAKE HOSPITAL ASSOCIATION** and  
 Overlake Hospital Medical Center, a Washington  
 nonprofit corporation; 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.  
 No. 60554-2-I.

Oct. 13, 2008.

Publication Ordered Jan. 20, 2009.

**Background:** Objector appealed decision of health  
 law judge, upholding **Department of Health's** is-  
 suance of a certificate of need to health care pro-  
 vider to establish a five-bed ambulatory surgical fa-  
 cility. The Superior Court, King County, Julie A  
 Spector, J., affirmed, and objector appealed.

**Holding:** The Court of Appeals, Grosse, J., held  
 that Department decision was arbitrary and capri-  
 cious.

Reversed.

West Headnotes

[1] **Administrative Law and Procedure 15A** ↪  
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15A Administrative Law and Procedure  
 15AIV Powers and Proceedings of Administrat-  
 ive Agencies, Officers and Agents  
 15AIV(C) Rules and Regulations  
 15Ak412 Construction  
 15Ak413 k. Administrative Construc-  
 tion. Most Cited Cases  
 Although a high level of deference is accorded to

an agency's determination under the Administrative  
 Procedure Act, such deference will not lie where an  
 agency's decision is based on an implausible inter-  
 pretation of its regulations. West's RCWA 34.05.570.

[2] **Health 198H** ↪240

198H Health

198HI Regulation in General

198HI(C) Institutions and Facilities

198Hk236 Licenses, Permits, and Certi-  
 ficates

198Hk240 k. Need, Public Necessity.

Most Cited Cases

**Department of Health** decision, issuing a certifi-  
 cate of need to health care provider to establish a  
 five-bed ambulatory surgical facility, was arbitrary  
 and capricious, since decision was based on a  
 flawed mathematical formula to establish the num-  
 ber of current and projected surgeries; formula in-  
 cluded exempt surgical procedures in calculating  
 demand, but excluded the facilities where exempt  
 surgical procedures are performed from the calcula-  
 tion of existing capacity. West's RCWA 70.38.105;  
 WAC 246-310-270(9).

[3] **Health 198H** ↪104

198H Health

198HI Regulation in General

198HI(A) In General

198Hk102 Constitutional and Statutory  
 Provisions

198Hk104 k. Purpose. Most Cited Cases

In enacting the State Health Planning and Re-  
 sources Development Act, the Legislature wanted  
 to control health care costs to the public and to ac-  
 complish that control by limiting competition with-  
 in the health care industry. West's RCWA  
 70.38.015(2).

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**\*\*248** James Scott Fitzgerald, Gregory A. McBrook, Kirkland, WA, for King County Public Hosp.

Donald W. Black, Jeffrey Duane Dunbar, E. Ross Farr, Ogden Murphy Wallace, Seattle, WA, for Overlake Hosp. Ass'n and Overlake Hosp. Medical Center.

Brian William Grimm, Peter Scott Ehrlichman, Seattle, WA, for Swedish Health Services.

Richard Arthur McCartan, Atty. Gen., Olympia, WA, for Dept. of Health.

GROSSE, J.

[1] **\*3** ¶ 1 Although a high level of deference is accorded to an agency's determination under the Administrative Procedure Act,<sup>FN1</sup> such deference will not lie where an agency's decision is based on an implausible interpretation of its regulations. Here, the **Department of Health** promulgated rules for determining whether a need exists for additional ambulatory surgical facilities in Bellevue that employ a flawed mathematical formula to establish the number of current and **\*\*249** projected surgeries. That flawed formula included exempt surgical procedures in calculating demand, but excluded the facilities where exempt surgical procedures are performed from the calculation of existing capacity. Hence, in an area where there is much private, exempt care, as Bellevue, the calculation will inevitably be biased toward need. Accordingly, we reverse the determination that Swedish Health Services could establish a five-bed ambulatory surgical facility on the eastside.

FN1. RCW 34.05.570.

#### FACTS

¶ 2 The Washington Legislature enacted the State Health Planning and Resources Development Act in

1979, creating the certificate of need (CN) program to oversee health care development.<sup>FN2</sup> The CN program is an office within the **Department of Health** (Department) designed to effectuate the goals and principles of the Act. In **\*4** order to establish or expand health care facilities, a provider must obtain a CN.<sup>FN3</sup> For that, a health care provider must establish a need for a particular health care service or facility in that health care planning area. CN applications are evaluated based on specific criteria set forth in the statute and applicable rules.<sup>FN4</sup>

FN2. RCW 70.38.015(2).

FN3. RCW 70.38.105; *St. Joseph Hosp. v. Dep't of Health*, 125 Wash.2d 733, 735, 887 P.2d 891 (1995).

FN4. Chapter 70.38 RCW; WAC 246-310.

¶ 3 To determine whether additional inpatient and outpatient operating rooms are needed in a health planning area, the Department uses the mathematical formula set forth in WAC 246-310-270(9). This formula is a means to compare current operating room capacity in a particular health planning area against anticipated future need, if any. Essentially, the methodology requires three steps:

- Existing Capacity: calculate the capacity of existing operating rooms in the planning area;
- Future Need: project the anticipated number of surgeries in the planning area three years into the future; and
- Net Need: calculate whether the existing operating room capacity is sufficient to accommodate the projected number of future surgeries. If not, then a need exists for more ambulatory surgical facilities in the planning area.

¶ 4 Here, the Department issued a CN to Swedish Health Services (Swedish) to establish an ambulat-

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ory surgical facility with five operating rooms in Bellevue. 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."<sup>FN5</sup>

FN5. WAC 246-310-010(5).

¶ 5 Evergreen Healthcare and Overlake Hospital Medical Center (collectively, Overlake) filed an objection to the issuance of the CN to Swedish alleging that there was no need for additional ambulatory surgical facilities in the \*5 area. The health law judge rejected Overlake's appeal, upholding the methodology employed by the Department in granting Swedish the CN. Overlake appealed to the superior court which upheld the health law judge. Overlake appeals.

#### ANALYSIS

[2] ¶ 6 Certain surgical facilities are exempt under the CN scheme. Exempt facilities include those located in the offices of private physicians that are unavailable for outside use.<sup>FN6</sup> In determining current operating room capacity under the Existing Capacity step, the Department does not include exempt facilities where surgeries are currently performed. However, when computing whether additional operating rooms are needed under Future Need, the Department does include surgeries performed at exempt ambulatory surgical facilities. In short, the formula either undercounts the number of surgeries in the first step or over-counts the number of surgeries to be performed in the second step.

FN6. WAC 246-310-010(5).

\*\*250 ¶ 7 Overlake objects to the inclusion of surgeries at exempt facilities when the Department excludes those facilities to determine capacity. Both Existing Capacity and Future Need in the methodology use the terms "operating rooms" and

"surgeries." As noted by the health law judge, the plain language of the governing WAC rule does not differentiate surgeries in exempt facilities from surgeries in nonexempt facilities. Nonetheless, the health law judge acquiesced in the Department's interpretation, permitting it to include surgeries performed at exempt facilities when calculating projected surgeries, but exclude those very same facilities when calculating the number of operating rooms needed to meet the demand for projected surgeries. Such an application makes no logical sense and is contrary to the basic canons of statutory interpretation. \*6 Indeed, we can envision no scenario where the Department's application of the formula will not result in a showing of need (except where there are no exempt facilities).

[3] ¶ 8 Testimony at the administrative hearing indicated that the Department's rationale for this unsound practice lay in the Legislature's policy directive to provide "accessible" health care. But, access to health care, though important, was only one reason motivating the Legislature in creating the CN program. The Legislature's primary purpose was to control costs by limiting competition.<sup>FN7</sup> The Legislature clearly enunciated its goals in its declaration of public policy:

FN7. RCW 70.38.015(1).

That strategic health planning efforts must be supported by appropriately tailored regulatory activities that can effectuate the goals and principles of the statewide health resources strategy developed pursuant to chapter 43.370 RCW. The implementation of the strategy can promote, maintain, and assure the health of all citizens in the state, provide accessible health services, health manpower, health facilities, and other resources *while controlling increases in costs*, and recognize prevention as a high priority in health programs.<sup>[FN8]</sup>

FN8. RCW 70.38.015(1) (emphasis ad-

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ded).

As the Supreme Court in *Saint Joseph Hospital v. Department of Health* noted:

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.<sup>[FN9]</sup>

FN9. 125 Wash.2d 733, 741, 887 P.2d 891 (1995).

The formula as interpreted and applied here by the Department is not particularly helpful in achieving any of these \*7 goals as it results in a formula that is fundamentally unsound. Sound reasoning requires the concomitant inclusion or exclusion of exempt facilities. To do otherwise defies logic and the plain meaning of the language used throughout the pertinent WAC.

¶ 9 On remand, the Department may very well come to the same conclusion it reached. Indeed, there is nothing that would prevent the Department from discounting private surgical procedures and facilities entirely should it so choose. But here, the Department's decision to issue Swedish the CN was arbitrary and capricious because it was based on an erroneous interpretation of the governing statutes and a misapplication of its own regulations. The Department's calculation necessarily resulted in an over-calculation of future need for additional outpatient operating rooms in the East King County Planning Area. Because we find that the Department misapplied its own rule (WAC 246-310-270(9)),<sup>FN10</sup> we reverse.

FN10. The WAC provides in pertinent part:

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

(a) Existing capacity.

(i) Assume the annual capacity of one operating room located in a hospital and not dedicated to outpatient surgery is ninety-four thousand two hundred fifty minutes. This is derived from scheduling forty-four hours per week, fifty-one weeks per year (allowing for five week-day 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 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.

WE CONCUR: ELLINGTON and BECKER, JJ.  
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END OF DOCUMENT

**EVALUATION OF THE CERTIFICATE OF NEED APPLICATION SUBMITTED ON BEHALF  
OF THE DOCTORS CLINIC PROPOSING TO ESTABLISH AN AMBULATORY SURGERY  
CENTER IN KITSAP COUNTY**

**PROJECT DESCRIPTION**

On January 2, 1992, The Doctors Clinic was established as a professional corporation licensed in the state of Washington. On January 28, 2005, The Doctors Clinic obtained a Determination of Non-Reviewability related to the establishment of an exempt ambulatory surgery center (ASC) to be located at 2200 Northwest Myhre Road in the city of Silverdale, within Kitsap County. The exempt ASC would have three operating rooms and at least one procedure room. The ownership of The Doctors Clinic was comprised of 14 physicians, and each would have surgical privileges at the proposed exempt ASC. As an exempt ASC, physician access is limited to those physicians that are part of The Doctors Clinic corporation or employed by the corporation.<sup>1</sup> Services to be provided include ENT, general GI, orthopedic; and gynecology procedures. Department files indicate that The Doctors Clinic received its Medicare certification and became operational in May 2005. [source: January 28, 2005, Determination of Non-Reviewability; October 24, 2005, supplemental documents; DOH, FSL database]

On July 12, 2007, The Doctors Clinic (TDC) submitted its Certificate of Need application to establish an ASC in Silverdale. Within the application, TDC acknowledged that it had been operational since May 2005 as an exempt ASC, and the impetus for submission of the application is to allow physicians, not part of the TDC corporation, access to the ASC. [source: Application cover sheet and p4] Between the date the exempt ASC became operational—May 2005—and submission of the application—July 2007—an additional 41 physicians have joined the corporation. Each physician has equal ownership in the TDC corporation and surgical privileges at the exempt ASC. [source: September 14, 2007, supplemental information, p5] With the additional physicians, services at the exempt ASC have expanded to include ENT, gynecology, general surgery, dental, podiatry, pain management, plastics, urology, ophthalmology, GI, and vascular. [source: Application, p5]

For this project, TDC does not propose to change the location of the ASC at 2200 Northwest Myhre Road in the city of Silverdale, the current number of ORs (3), or the number of procedure rooms (4). Given that the facility became operational in year 2005, there are no additional capital costs beyond those already expended for the establishment of the exempt facility in May 2005. [source: Application pp4, 6, 7]

If this project is approved, TDC anticipates commencement and completion of the project within six months of approval. Under this timeline, the ASC would become operational in mid year 2008, and year 2009 would be the facility's first full calendar year of operation; year 2011 would be the third full year of operation. [source: September 14, 2007, supplemental information p10]

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<sup>1</sup> Additional limitations are required in order to maintain exempt ASC status; however, those limitations are not relevant in this evaluation.

### APPLICABILITY OF CERTIFICATE OF NEED LAW

This project is subject to Certificate of Need review as the establishment of a new health care facility under the provisions of Revised Code of Washington (RCW) 70.38.105(4)(a) and Washington Administrative Code (WAC) 246-310-020(1)(a).

### APPLICATION CHRONOLOGY

January 18, 2007	Letter of Intent Submitted
July 12, 2007	Application Submitted
July 13, 2007, through December 2, 2007	Department's Pre-Review Activities <ul style="list-style-type: none"><li>• 1<sup>st</sup> screening activities and responses</li><li>• 2<sup>nd</sup> screening activities and responses</li></ul>
December 3, 2007	Department Begins Review of Application
January 28, 2008	Public Hearing Conducted/End of Public Comment
February 12, 2008	Rebuttal Documents Received at Department
March 28, 2008	Department's Anticipated Decision Date
March 28, 2008	Department's Actual Decision Date

### AFFECTED PERSONS

Throughout the review of this project, two CN approved ASCs located in Kitsap County sought and received affected person status under WAC 246-310-010.

- 1) Olympic Ambulatory Surgery Center located at 2613 Wheaton Way in Bremerton;
- 2) Surgery Center of Silverdale located at 9800 Levin Road, #102 in Silverdale.<sup>2</sup>

### SOURCE INFORMATION REVIEWED

- The Doctors Clinic Certificate of Need Application received July 12, 2007
- The Doctors Clinic supplemental information dated September 14, 2007, and November 21, 2007
- Public comment received throughout the review of the application
- Public hearing documents received at the January 28, 2008, public hearing
- The Doctors Clinic rebuttal comments received February 12, 2008
- Olympic Ambulatory Surgery Center's rebuttal comments received February 12, 2008
- Kitsap County ASC and/or operating room utilization survey responses
- Historical charity care data obtained from the Department of Health's Office of Hospital and Patient Data Systems (2004, 2003, and 2006 summaries)
- Population data obtained from the Office Financial Management based on year 2000 census published November 2007
- Licensing and/or survey data provided by the Department of Health's Office of Health Care Survey
- Comprehensive Hospital Abstract Reporting System (CHARS) data obtained from the Department of Health's Office of Hospital and Patient Data Systems
- Certificate of Need Historical files

<sup>2</sup> While Surgery Center of Silverdale sought and received affected person status, it chose to neither oppose nor support The Doctors Clinic project.

### CRITERIA EVALUATION

To obtain Certificate of Need approval, the applicant must demonstrate compliance with the criteria found in WAC 246-310-210 (need); 246-310-220 (financial feasibility); 246-310-230 (structure and process of care); 246-310-240 (cost containment) and WAC 246-310-270 (ambulatory surgery).<sup>3</sup>

### CONCLUSION

For the reasons stated in this evaluation, the application submitted on behalf of The Doctors Clinic proposing to establish an ambulatory surgery center in Silverdale, within Kitsap County is not consistent with applicable criteria of the Certificate of Need Program, and a Certificate of Need should be denied.

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<sup>3</sup> Each criterion contains certain sub-criteria. The following sub-criteria are not relevant to this project: WAC 246-310-210(3), (4), (5), and (6); WAC 246-310-220(2) and (3); and WAC 246-310-240(2).

**A. Need (WAC 246-310-210)**

Based on the source information reviewed, the department determines that the applicant has not met the need criteria in WAC 246-310-210 and WAC 246-310-270.

- (1) The population served or to be served has need for the project and other services and facilities of the type proposed are not or will not be sufficiently available or accessible to meet that need

The Department of Health's Certificate of Need Program uses the numeric methodology found in WAC 246-310-270 for determining the need for additional ASCs in Washington State. The numeric methodology provides a basis of comparison of existing operating room (OR) capacity for both outpatient and inpatient OR's in a planning area using the current utilization of existing providers. The methodology separates Washington State into 54 separate secondary health services planning areas. The proposed ASC would be located in the Kitsap County planning area.

The methodology estimates operating room (OR) need in a planning area using multi-steps as defined in WAC 246-310-270(9). This methodology relies on a variety of assumptions and initially determines existing capacity of dedicated outpatient and mixed-use operating rooms in the planning area, subtracts this capacity from the forecast number of surgeries to be expected in the planning area in the target year, and examines the difference to determine:

- a) whether a surplus or shortage of OR's is predicted to exist in the target year, and
- b) if a shortage of OR's is predicted, the shortage of dedicated outpatient and mixed-use rooms are calculated.

Applicant's Methodology

To determine need for additional ORs in the planning area under WAC 246-310-270, the applicant provided a copy of the department's methodology for Kitsap County calculated in July 2006 and used for a previous project. Assumptions and data used in that methodology are shown below.

Assumption	Data Used
Planning Area	Kitsap County
Population Estimates and Forecasts	Office of Financial Management's Kitsap County-medium series, published year 2002 Target year 2010
Use Rate	Derived from a utilization survey completed by existing providers in year 2005. The use rate of 90.43/1,000 is based on 2004 historical data.
Percent of surgery ambulatory vs. inpatient	Based on 2004 DOH survey results, 78.4% ambulatory setting; 21.6% inpatient setting
Average minutes per case	Based on 2004 DOH survey results. Outpatient cases = 47.05 minutes; Inpatient cases 128.55 minutes
OR Annual capacity in minutes	68,850 outpatient surgery minutes; 94,250 inpatient or mixed-use surgery minutes (per methodology in rule)
Existing providers	Based on a 2004 listing of Kitsap County providers

The department's application of the numeric methodology in year 2006 using 2004 survey and capacity responses indicated a surplus of 3 inpatient ORs and a need of 5 outpatient ORs for the Kitsap planning area in year 2010.<sup>4</sup>

In summary, TDC did not provide an updated methodology to determine need for the additional ORs in the Kitsap planning area. Rather, TDC simply relied on a 2006 numeric methodology performed by the department for another project and based on 2004 utilization survey data.

Department's Methodology

Given that the ASC would be located in Kitsap County, the department will apply the methodology to that health service planning area. There are eight providers in the Kitsap County planning area, including the applicant. The eight providers are listed below. [source: CN historical files-FSL database]

<b>Kitsap Planning Area Providers</b>	
<b>1 Hospital / City</b>	<b>7 ASCs / City</b>
Harrison Medical Center / Bremerton & Silverdale campuses	Digestive Disease & Endoscopy Center, PLLC / Bremerton North Kitsap ASC/Poulsbo Olympic ASC, Inc. / Bremerton Olympic Plastic Surgery Suite / Bremerton Pacific Cataract & Laser Institute / Silverdale Surgery Center of Silverdale/Silverdale The Doctors Clinic / Silverdale (applicant)

As shown above, the eight facilities include one hospital and seven ASCs. Harrison Medical Center is the only hospital operating in the planning area. All appropriate OR capacity will be used in the numeric methodology calculations under WAC 246-310-270.

Of the seven ASCs shown above, four—including the applicant, TDC—are located within a solo or group practice (considered an exempt ASC) and therefore, the use of these ASCs is restricted to physicians that are employees or members of the clinical practices that operate the facilities. Therefore, these four facilities do not meet the ASC definition found in WAC 246-310-010 and the ORs are not included in the capacity calculations of available ORs for the Kitsap planning area.

The three remaining ASCs—North Kitsap ASC in Poulsbo; Olympic ASC, Inc. in Bremerton; and Surgery Center of Silverdale in Silverdale—are ASCs as defined in WAC 246-310-010 and the OR capacity of the three ASCs will be included in the capacity calculations of available ORs for the Kitsap planning area.<sup>5</sup>

<sup>4</sup> On December 26, 2006, the CN Program released a 'Reconsideration Evaluation' of the project that TDC relied on for its need methodology. In the reconsideration evaluation, the Program acknowledged that the previous methodology contained a mathematical error in the numeric calculations. When the error is corrected, the methodology indicates a surplus of 3 inpatient ORs and a need of 4 outpatient ORs for the Kitsap planning area in year 2010, rather than the 5 ORs initially identified.

<sup>5</sup> North Kitsap ASC was issued CN #1124 on June 29, 1995; Olympic ASC was issued CN #0-490 on March 5, 1980; and Surgery Center of Silverdale was issued CN #1334 on July 14, 2006.

To assist in its application of the numeric methodology for this project, on December 11, 2007, the department requested utilization information from each of the facilities identified above. Responses were received from six of the eight facilities.<sup>6</sup> Further, the department relied on the following assumptions to apply its methodology.

Assumption	Data Used
Planning Area	Kitsap County
Population Estimates and Forecasts	Office of Financial Management's Kitsap County-medium series, published November 2007. Target year 2011
Use Rate	Divide estimated current surgical cases by estimated 2006 populations results in the service area use rate of 100.55/1,000
Percent of surgery ambulatory vs. inpatient	Based on DOH survey results, 75% ambulatory setting; 25% inpatient setting
Average minutes per case	Based on DOH survey results, Outpatient cases = 45.09 minutes; inpatient cases 100.0 minutes
OR Annual capacity in minutes	68,850 outpatient surgery minutes; 94,250 inpatient or mixed-use surgery minutes
Existing providers	Based on 2007 listing of Kitsap County providers

The department's application of the numeric methodology using available survey responses and hospital data indicates a surplus of 1.48 mixed-use ORs, resulting in no need for additional outpatient ORs for the Kitsap planning area in year 2011. The department's methodology is Appendix A attached to this evaluation

Olympic Ambulatory Surgery Center (OASC) provided concerns related to the methodology approach used by TDC. OASC's concerns are summarized below. [source: Olympic Ambulatory Surgery Center public hearing documents submitted April 19, 2006, pp2-17]

WAC 246-310-270

- The applicant failed to provide a meaningful need calculation as required by WAC 246-310-270...instead, TDC relies on the department's findings from a prior CN project in the planning area.
- TDC fails to provide any evidence to support its assertions that improved access to needed services will result from transitioning TDC's CN exempt ORs to CN-approved ORs.
- TDC fails to provide any evidence that a need exists for additional operating rooms in Kitsap County.

<sup>6</sup> Completed utilization surveys were not submitted by Harrison Medical Center and Olympic Plastic Surgery Suite. For Harrison Medical Center's utilization, the Program used quarterly data reported by the hospital to the Department of Health's Office of Hospital and Patient Data Systems. Data for Olympic Plastic Surgery Suite was not available.

Given that the department did not accept TDC's approach of reliance on a previous need methodology calculated in year 2006 and based on 2004 data, OASC's concern regarding the need methodology has been addressed. In summary, based solely on the numeric methodology contained in WAC 246-310-270, need for additional outpatient OR capacity in the Kitsap planning area is not demonstrated. [source: department's methodology and utilization surveys]

WAC 246-310-270(4) states:

*"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."*

This section of the rule implies that under extraordinary circumstances, an applicant proposing additional ORs in a planning area may be approved, even if the numeric methodology calculations result in no need for additional OR capacity.

For this project, the numeric methodology results in no need for additional outpatient ORs for the Kitsap planning area through at least year 2011. TDC provided its rationale for submitting its application to convert its existing CN exempt facility to a CN approved facility. A summary of TDC's rationale is below. [source: Application p13; September 14, 2007, supplemental information, pp13-15]

- The numeric methodology demonstrates that not approving this CON leaves an ASC access void in the Kitsap planning area.
- There are certain procedures that TDC physicians perform that require the co-surgical skills of a surgeon from outside the TDC organization. Currently, in these cases, the patient must be admitted to the hospital.
- Permitting outside surgeons to use the TDC will allow surgeons with super-specialized skills from tertiary care centers to work in the community. Currently this type of surgical care would have to be done in Seattle or Tacoma.

TDC's numeric method, as previously stated, relied on a need methodology calculated in year 2006, based on 2004 data, and projected to target year 2010. The Office of Financial Management released updated population projections on November 2007. When the numeric methodology is updated using 2006 utilization data and projected to target year 2011 based on updated population data, numeric need is not demonstrated.

Other than the statements provided above regarding the benefit of outside physician access to the ASC, TDC did not provide any documentation to demonstrate extraordinary circumstances exist in the planning area. The desire for non-TDC physician access to the ASC is not a demonstration of extraordinary circumstances.

In conclusion, TDC has not demonstrated that the population served or to be served has need for the project and other services and facilities of the type proposed are not or will not be sufficiently available or accessible to meet that need as required in WAC 246-310-210. Further, TDC did not demonstrate extraordinary circumstances exist in the Kitsap planning

area that should result in approval of this project when no numeric need is demonstrated. This sub-criterion is not met.

- (2) All residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly are likely to have adequate access to the proposed health service or services.

TDC states that it became operational as an exempt ASC in year 2005, and since that time, has been providing health care services to residents of Kitsap County and surrounding areas, including low-income, racial and ethnic minorities, handicapped and other underserved groups. To demonstrate compliance with this sub-criterion, TDC provided a copy of its current Admission Policy and Charity Care Policy used at the exempt ASC.

The Admission Policy provides the overall guiding principles of the facility as to the types of patients that are appropriate candidates to use the facility and any assurances regarding access to treatment. TDC's Admission Policy outlines the process used for admission into the ASC. The admission policy does not include language to demonstrate that patients are admitted to the ASC without regard to age, race, color, religion, sex, national origin, handicap, or sexual preference and will be treated with respect and dignity. [source: September 14, 2007, supplemental information, Appendix 3] As a result, this policy does not substantiate TDC's assertion that all residents of the service area would have access to the ASC.

To determine whether low income residents would have access to the services at TDC, the department uses the facility's Medicaid eligibility or contracting with Medicaid as the measure to make that determination. To determine whether the elderly would have access to the hospital, the department uses Medicare certification as the measure to make that determination. Information provided by the applicant verifies that the exempt ASC currently contracts with Medicaid, and if this project is approved, the CN approved ASC would maintain its Medicaid contract. Further, within the application, TDC provided its projected sources of revenues, which identifies 7.51% Medicaid. [source: Application, pp2 and 6]

To determine whether uninsured or underinsured patients would have access to the ASC, the department reviewed the facility's current Charity Care Policy. The policy outlines the process used by TDC to determine eligibility of charity care. [source: Application, Appendix A] Further, WAC 246-310-270(7) states that ASCs shall implement policies to provide access to individuals unable to pay consistent with charity care levels reported by the hospitals affected by the proposed ASC. For charity care reporting purposes, the Department of Health's Office of Hospital and Patient Data Systems (OHPDS), divides Washington State into five regions: King County, Puget Sound (less King County), Southwest, Central, and Eastern. TDC's ASC would be located in Kitsap County within the Puget Sound region. For charity care reporting purposes, the affected hospital includes Harrison Medical Center located in Bremerton within Kitsap County. For this project, the department reviewed charity care data for Harrison Medical Center and the 18 existing hospitals currently operating within the Puget Sound Region.

According to 2004-2006<sup>7</sup> charity care data obtained from OHPDS, the three-year average for the Puget Sound Region is 1.90% for gross revenue and 4.07% for adjusted revenue. The three-year charity care data reported by Harrison Medical Center is 1.55% of gross revenue and 3.86% of adjusted revenue. [source: OHPDS 2004-2006 charity care summaries]

The applicant's pro formas indicate that the ASC will provide charity care at approximately 1.20% of gross revenue, and 2.00% of adjusted revenue. [source: November 21, 2007, supplemental information, p5] These averages are below the average charity care provided in the Puget Sound Region and Harrison Medical Center for its gross revenues. Given that the amount of charity care proposed to be provided at TDC is below to the three-year historical gross revenue averages for the region and the local hospital, if this project is approved, the department concludes that a condition related to the percentage of charity care to be provided at the ASC would be necessary.

Based on the omitted statements in the Admission Policy provided in the application, the department concludes that this sub-criterion is not met.

**B. Financial Feasibility (WAC 246-310-220)**

Based on the source information reviewed, if this project is approved, the department determines that the applicant has met the financial feasibility criteria in WAC 246-310-220, provided that the applicant agrees to a condition related to charity care percentages.

*(1) The immediate and long-range capital and operating costs of the project can be met.*

If this project is approved, TDC anticipates commencement and completion within six months of approval. Under this timeline, the ASC would become operational in mid-year 2008, and years 2009 through 2011 would be the facility's first three full calendar year of operation. [source: September 14, 2007, supplemental information, p10] To determine whether TDC would meet its immediate and long range operating costs, the department reviewed TDC projected revenue/expense statements and projected balance sheets for the first three full years of operation.

Table 1 below shows a summary of the balance sheets provided by the applicant. [source: November 21, 2007, supplemental information, p6, p10, & p12]

**Table 1  
The Doctors Clinic ASC Projected Balance Sheets for Years 2009-2011  
Year 2009**

Assets		Liabilities	
Current Assets	\$ 6,598,566	Current Liabilities	\$ 428,332
Other Assets (Fixed)	2,038,589	Other Liabilities (incl long term debt)	3,871,778
<b>Total Assets</b>	<b>\$ 8,637,155</b>	<b>Total Liabilities</b>	<b>\$ 4,300,110</b>
		Equity	4,337,045
		<b>Total Liabilities and Equity</b>	<b>\$ 8,637,155</b>

<sup>7</sup> Year 2007 charity care data is not available as of the writing of this evaluation.

**Year 2010**

<b>Assets</b>		<b>Liabilities</b>	
Current Assets	\$ 8,292,993	Current Liabilities	\$ 434,707
Other Assets (Fixed)	1,538,745	Other Liabilities (incl long term debt)	3,715,333
<b>Total Assets</b>	<b>\$ 9,831,738</b>	<b>Total Liabilities</b>	<b>\$ 4,150,040</b>
		Equity	5,681,698
		<b>Total Liabilities and Equity</b>	<b>\$ 9,831,738</b>

**Year 2011**

<b>Assets</b>		<b>Liabilities</b>	
Current Assets	\$ 10,050,152	Current Liabilities	\$ 441,238
Other Assets (Fixed)	1,038,898	Other Liabilities (incl long term debt)	3,558,892
<b>Total Assets</b>	<b>\$ 11,089,050</b>	<b>Total Liabilities</b>	<b>\$ 4,000,130</b>
		Equity	7,088,920
		<b>Total Liabilities and Equity</b>	<b>\$ 11,089,050</b>

Based on the projected balance sheets shown above, it is clear that the ASC would be financially stable. Further, a review of the balance sheets provided in the application indicates that the ASC would not increase the long term debt for TDC. It appears from the balance sheets that TDC intends to pay off its debt fairly quickly. While this approach by TDC is ambitious, it is not an unusual approach for an ASC project.

Table 2 below is a summary of TDC's projected revenues and expenses for the first three full years of operation. [source: November 21, 2007, supplemental information, p5, p9, and p11]

**Table 2**  
**The Doctors Clinic ASC Revenue and Expense Summary**

	<b>Full Year 1-2009</b>	<b>Full Year 2-2010</b>	<b>Full Year 3-2011</b>
Number of Cases	3,437	3,506	3,576
Net Revenue*	\$ 5,806,541	\$ 5,964,506	\$ 6,127,546
Total Expense	\$ 4,603,475	\$ 4,704,259	\$ 4,807,682
Net Profit or (Loss)	\$ 1,203,066	\$ 1,260,247	\$ 1,319,864
Net Revenue per Case	\$ 869.63	\$ 876.36	\$ 882.68
Total Expenses per v	\$ 689.45	\$ 691.19	\$ 692.55
Net Profit or (Loss) per Cases	\$ 180.18	\$ 185.17	\$ 190.13

\*Includes deductions for charity care, bad debt, and contractual allowances

As shown in Table 2 above, TDC projects a profit in each of the facility's first three full years of operation. However, as stated in the need section of this evaluation, TDC's projected charity care percentages are less than both the 3-year regional average and Harrison Medical Center's 3-year average. If approved, the net revenue would be overstated by approximately 2.0%, however, even with the percentage adjustments, TDC would be operating at a profit.

In addition to the pro forma projections summarized above, TDC also provided the following statements related to the assumptions used as a basis for the projected number of cases at the ASC. [source: September 14, 2007, supplemental information, p10]

*"The following assumptions were used in developing surgery case projections:*

- *2006 is actual TDC volumes.*
- *2007 - prior year 2006 actual volumes plus 5.5% inflation. The 5.5% inflation represents additional orthopedic cases related to a new hand surgeon, general population increases, and ramp-up related to physicians practicing less than 5 years with TDC who are still building their practices.*
- *2008—2010 - prior year plus 2% inflation. The 2.0% increase assumes additional cases related to general population increases and continued physician ramp-up."*

OASC provided comments related to the financial feasibility criteria, which is summarized below. [source: Olympic Ambulatory Surgery Center January 28, 2008, public hearing documents; and February 12, 2008, rebuttal documents, p8]

- TDC fails to consider the fees and costs related to filing and defending its application.
- TDC fails to consider the costs for supporting additional physicians who practice at the facility if TDC obtains its requested CN.
- The department should question the financial data provided by TDC, such as the lease expenses and costs, to determine whether the financial data is, in fact, all related to TDC's proposed project. If TDC is using financing that is not directly related to the facility and the services provided therein, then TDC's claim that its proposed project is financially feasible is undermined.

Within its rebuttal documents, TDC addressed OASC concerns regarding the lease expenses. TDC leases a 50,000 sf building; the majority of the building is used for advanced imaging and physician office space. The ASC uses only 8,000 sf, or 16%, of the building. Within its pro forma financials, TDC allocated its total lease costs based on the percentage of square footage used by the ASC. This facility allocation approach to determine lease, utility, and other costs allocated to the proposed ASC has been used by past applicants, and is considered by the department to be a reasonable approach.

Regarding OASC's assertion that TDC should have included costs for physician recruitment, filing, and defending its application, WAC 246-310-010 provides the following definition for "capital expenditure."

*"Capital expenditure": Except for WAC 246-310-280, capital expenditure means an expenditure, including a force account expenditure (i.e., an expenditure for a construction project undertaken by a nursing home facility as its own contractor), which, under generally accepted accounting principles, is not properly chargeable as an expense of operation or maintenance. The costs of any studies, surveys, designs, plans, working drawings, specifications, and other activities (including staff effort, consulting and other services which, under generally accepted accounting principles,*

*are not properly chargeable as an expense of operation and maintenance) shall be considered capital expenditures. Where a person makes an acquisition under lease or comparable arrangement, or through donation, which would have required certificate of need review if the acquisition had been made by purchase, this acquisition shall be deemed a capital expenditure. Capital expenditures include donations of equipment or facilities to a nursing home facility, which if acquired directly by the facility, would be subject to review under this chapter and transfer of equipment or facilities for less than fair market value if a transfer of the equipment or facilities at fair market value would be subject to the review.*

Physician recruitment and CN filing fees are not included in the list above, TDC may, but is not required to, include those costs. The costs for defending an application are not considered part of a project's capital expenditure, and TDC was correct to exclude them. The department concludes that the issues raised by OASC have been adequately addressed.

Based on the financial information above, the department concludes that if this project is approved, TDC must provide demonstration that its long-term capital and operating costs of this project could be met with the charity care condition requirement attached to the approval. With a condition related to charity care percentages, this sub-criterion is met.

**C. Structure and Process (Quality) of Care (WAC 246-310-230)**

Based on the source information reviewed, the department determines that the applicant has not met the structure and process of care criteria in WAC 246-310-230.

**(1) A sufficient supply of qualified staff for the project, including both health personnel and management personnel, are available or can be recruited.**

As stated in the project description portion of this evaluation, TDC anticipates commencement and completion of the project within six months. Under this timeline, the ASC would become operational in mid-year 2008, and year 2009 would be the facility's first full calendar year of operation. [source: September 14, 2007, supplemental information, p10] Given that TDC is currently operating as an exempt ASC, the addition of staff is not anticipated. Table 3 below summarizes the current staffing at TDC. [source: September 14, 2007, p22]

**Table 3  
The Doctors Clinic 2008 Current Staffing**

Type of Staff	# of FTEs
Administration	4.00
RNs	7.80
Clinical (OR techs, X-ray Tech, etc)	6.00
Scheduling/Clerical	2.00
Reception/Admission	1.00
Billing/Bookkeeper	1.60
<b>Total FTEs</b>	<b>22.40</b>

To further demonstrate that current staff of the ASC would be adequate for the project, TDC provided the following statements:

*"The reason for this [application] is simply stated in the intent of this CON, which is to allow physicians that are not partners of TDC to assist with procedures. As such, The Doctors Clinic is projecting only a slight increase in ASC volumes, 2% per year, and has adequate staff in place to handle this growth."*

[source: September 14, 2007 supplemental information, p22]

Comments provided by OASC related to the staffing sub-criterion focused on the availability of anesthesiologist. OASC states the Kitsap County has historically faced challenges of recruiting and retaining adequate anesthesiology staff to the area. There are two available anesthesiology groups in the area, and OASC asserts that approval of TDC would exacerbate the shortage in the planning area. [source: OASC public hearing documents, p12]

In its rebuttal responses, TDC disagreed with OASC's assertions regarding lack of anesthesiologists in the planning area. TDC states that it has never experienced issues with shortage of anesthesiologists. TDC further asserts that approval of this project would have no different effect on the availability of anesthesiologists than TDC's natural growth rate. [source: TDC rebuttal comments, p3]

The department concludes that the staffing issue raised by OASC was adequately addressed by TDC. Further, TDC provided a comprehensive approach to retain staff necessary for the ASC. This sub-criterion is met.

- (2) The proposed service(s) will have an appropriate relationship, including organizational relationship, to ancillary and support services, and ancillary and support services will be sufficient to support any health services included in the proposed project.

As an operating exempt ASC, TDC currently has ancillary and support contracts in place. To demonstrate compliance with this sub-criterion, TDC provided a listing of those entities. [source: September 14, 2007, supplemental information, p24]

The documents demonstrate TDC currently has, and intends to continue, appropriate relationships with ancillary and support services for the health care services to be provided. This sub-criterion is met.

- (3) There is reasonable assurance that the project will be in conformance with applicable state licensing requirements and, if the applicant is or plans to be certified under the Medicaid or Medicare program, with the applicable conditions of participation related to those programs.

TDC has been operating as an exempt, Medicare certified ASC in the state of Washington since May 2005. TDC does not own or operate any other healthcare facilities in Washington or any other state. From May 2005 through February 2008, the Department of Health's Office of Health Care Survey (OHCS), which surveys ASCs within Washington State, has completed one compliance survey for TDC.<sup>8</sup> The survey revealed minor deficiencies typical for an ASC and TDC submitted a plan of corrections and demonstrated implementation of

<sup>8</sup> Initial Medicare and life safety survey completed May 16, 2005.

the required corrections. [source: compliance survey data provided by Office of Health Care Survey]

The Department of Health's Medical Quality Assurance Commission credentials medical staff in Washington State and is used to review of the compliance history for all medical staff, which includes physicians, RNs, and LPNs, associated with TDC. A compliance history review of all medical staff associated with TDC reveals no recorded sanctions for all. [source: compliance history provided by Medical Quality Assurance Commission]

Given the compliance history of the ASC and the compliance history of the medical staff associated with the ASC, there is reasonable assurance that TDC would operate the ASC in conformance with applicable state and federal licensing and certification requirements. This sub-criterion is met.

- (4) The proposed project will promote continuity in the provision of health care, not result in an unwarranted fragmentation of services, and have an appropriate relationship to the service area's existing health care system.

To demonstrate compliance with this sub-criterion, TDC provided a summary of its main rationale for submission of this project. Primarily, TDC would like to allow physicians, not associated with the TDC practice, access to the ASC. TDC states approval of this project would be in the best interest of TDC's patients and the community. [source: September 14, 2007, supplemental information, p25]

However, as previously stated, TDC relied on a perceived need for additional ORs in the Kitsap County planning area. Results of the numeric methodology demonstrate a surplus of OR capacity in the planning area. Based on this information, the department must reasonably conclude that approval of another ASC in the planning area has the potential to cause unwarranted fragmentation of the existing healthcare system. Therefore, this sub-criterion is not met.

- (5) There is reasonable assurance that the services to be provided through the proposed project will be provided in a manner that ensures safe and adequate care to the public to be served and in accord with applicable federal and state laws, rules, and regulations.

This sub-criterion is evaluated in sub-section (3) above, and based on that evaluation, the department concludes that this sub-criterion is met.

#### **D. Cost Containment (WAC 246-310-240)**

Based on the source information reviewed, the department determines that determines that the applicant has not met the applicable cost containment criteria in WAC 246-310-240.

- (1) Superior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable.

To demonstrate conformance with this sub-criterion, TDC first assumed, based on the department's numeric methodology conducted in year 2006, that additional ORs are needed in Kitsap County. TDC then provided a decision matrix comparing the various alternatives for meeting the projected outpatient OR need. The decision matrix concluded that

submission of this application was the superior alternative. [source: September 14, 2007, supplemental information, p26]

As stated in the need portion of this evaluation, when the numeric methodology is applied using 2006 utilization data and projected to target year 2011 based on population data released November 2007, numeric need is not demonstrated. Within its application, TDC did not provide any rationale to consider if need for additional ORs in Kitsap County is not demonstrated.

In summary, the applicant chose an alternative based on its perception of need for additional ORs in the planning area. The department concludes that the best available alternative for this project is TDC's continuous operation as an exempt ASC in the planning area. Based on the discussion above, the department concludes that this project is not the best alternative for the community, and this sub-criterion is not met.

**EVALUATION OF THE CERTIFICATE OF NEED APPLICATION SUBMITTED ON BEHALF OF  
MULTICARE HEALTH SYSTEM PROPOSING TO ESTABLISH AN AMBULATORY SURGERY  
CENTER IN THE CITY OF GIG HARBOR WITHIN PIERCE COUNTY**

**PROJECT DESCRIPTION**

MultiCare Health System is a not-for-profit health system serving the residents of southwestern Washington State. MultiCare Health System includes three hospitals, nearly 20 physician clinics, six urgent care facilities, and a variety of health care services, including home health and hospice services in the state. Below is a list of the health care facilities owned and/or operated by MultiCare Health System. [source: CN historical files, MultiCare Health System website, and Application pp5-6]

**HOSPITALS**

Tacoma General / Allenmore, Tacoma<sup>1</sup>  
Mary Bridge Children's Hospital/Tacoma<sup>2</sup>

**OUTPATIENT FACILITIES**

Day Surgery of Tacoma/Tacoma

**MULTICARE CLINICS**

Located in the cities of Auburn, Covington, East Hill, Fife, Gig Harbor, Kent, Lakewood, Northshore, Spanaway, Tacoma, University Place, and Westgate

**MULTICARE URGENT CARE CENTERS**

Located in the cities of Covington, Gig Harbor, Kent, Lakewood, University Place, and Westgate

**HOME HEALTH AGENCY**

MultiCare Home Health

**HOSPICE AGENCY**

MultiCare Hospice of Tacoma

This project is related to the establishment of an ambulatory surgery center (ASC) that would be located in a new medical office park within Gig Harbor. The medical park--to be known as MultiCare Gig Harbor Medical Park--will be a 3-story, hospital-owned medical office building and health center. While the establishment of the new medical park itself does not require prior Certificate of Need review and approval, the ASC requires prior Certificate of Need review and approval before its establishment. The proposed, 19,500 sq ft ASC would be located on the first floor of the MultiCare Gig Harbor Medical Park, with two operating rooms, two procedures rooms (one shelled), pre- and post-operative rooms, recovery space, and support/staff areas. [source: Application, p11]

For clarification purposes, in this document, the department will refer to MultiCare Health System as "MHS," the MultiCare Gig Harbor Medical Park as "MGHMP," and the proposed ASC as "MHS-GH."

Services proposed to be offered at MHS-GH include orthopedic, gynecology, obstetrics, ENT, back procedures, urology, podiatry, plastic surgery, dermatology, and pediatric care (patients under 14 years of age). Included in back procedures are minimally invasive endoscopic spine procedures. The ASC would also include some sub-specialties, which may include plastic surgery, spinal surgery, or orthopedic hand surgery. [source: Application, p14 and July 5, 2005, supplemental information, pp5-6]

For the larger project--establishment of the medical office park--MHS intends to build MGHMP regardless of whether the ASC portion of the project is approved. MHS has already begun preliminary work on the larger project by providing the funding and preparing final construction drawings. MGHMP is anticipated to be open in January 2007. For the ASC portion of the project, MHS intends to submit the final drawings in January 2006, and the ASC is expected to become operational in January 2007.

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<sup>1</sup> While Tacoma General Hospital and Allenmore Hospital are located at two separate sites, they are operated under the same hospital license of "Tacoma General/Allenmore Hospital."

<sup>2</sup> While Mary Bridge Children's Hospital is located within Tacoma General Hospital, each facility is licensed separately.

The total capital expenditure associated with the larger project, including the ASC portion, is \$35,500,000, and of that amount, 1.8% is related to the ASC portion of the project. The establishment of the ASC is estimated at \$6,521,000, and of that amount, 77% is related to construction and 23% is related to both fixed and moveable equipment. [source: Application, Appendix L, and July 5, 2005, supplemental information, p14]

### **APPLICABILITY OF CERTIFICATE OF NEED LAW**

This project is subject to Certificate of Need review as the establishment of a new health care facility under the provisions of Revised Code of Washington (RCW) 70.38.105(4)(a) and Washington Administrative Code (WAC) 246-310-020(1)(a).

### **APPLICATION CHRONOLOGY**

April 15, 2005	Letter of Intent Submitted
May 17, 2005	Application Submitted
May 18, 2005 through July 14, 2005	Department's Pre-Review Activities <ul style="list-style-type: none"><li>• 1<sup>st</sup> screening activities and responses</li><li>• 2<sup>nd</sup> screening activities and responses</li></ul>
July 15, 2005	Department Begins Review of the Application <ul style="list-style-type: none"><li>• public comments accepted throughout review</li></ul>
September 6, 2005	Public Hearing Conducted/End of Public Comment
September 21, 2005	Rebuttal Documents Received at Department
November 7, 2005	Department's Anticipated Decision Date
November 1, 2005	Department's Actual Decision Date

### **AFFECTED PERSONS**

Throughout the review of this project, the following two entities sought and received affected person status under WAC 246-310-010:

- Franciscan Health System's St. Joseph Medical Center, located in the city of Tacoma within Pierce County; and
- Harrison Hospital, located in the city of Bremerton within Kitsap County.<sup>3</sup>

### **SOURCE INFORMATION REVIEWED**

- MultiCare Health System's Certificate of Need Application received May 17, 2005
- MultiCare Health System's supplemental information received July 6, 2005, and July 21, 2005
- Public comment received throughout the review of the application
- Public hearing documents received at the September 6, 2005, public hearing
- Franciscan Health System's rebuttal comments dated September 20, 2005
- MultiCare Health System's rebuttal comments dated September 21, 2005
- Pierce County ASC and/or operating room utilization survey responses
- Historical charity care data obtained from the Department of Health's Office of Hospital and Patient Data Systems (2001, 2002, and 2003 summaries)
- Population data obtained from the Office Financial Management based on year 2000 census published January 2002
- Licensing and/or survey data provided by the Department of Health's Office of Health Care Survey

<sup>3</sup> Although Harrison Hospital received affected persons status, Harrison Hospital did not provide rebuttal statement related to this project.

**SOURCE INFORMATION REVIEWED (continued)**

- Comprehensive Hospital Abstract Reporting System (CHARS) data obtained from the Department of Health's Office of Hospital and Patient Data Systems
- Data obtained from the Internet regarding health care worker shortages in Washington State
- Data obtained from the Internet regarding mileage and distance
- Certificate of Need Historical files

**CRITERIA EVALUATION**

To obtain Certificate of Need approval, the applicant must demonstrate compliance with the criteria found in WAC 246-310-210 (need); 246-310-220 (financial feasibility); 246-310-230 (structure and process of care); 246-310-240 (cost containment) and WAC 246-310-270 (ambulatory surgery).<sup>4</sup>

**CONCLUSION**

For the reasons stated in this evaluation, MultiCare Health System's application to establish an ambulatory surgery center in the city of Gig Harbor is not consistent with applicable criteria of the Certificate of Need Program, and a Certificate of Need is denied.

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<sup>4</sup> Each criterion contains certain sub-criteria. The following sub-criteria are not relevant to this project: WAC 246-310-210(3), (4), (5), and (6).

**A. Need (WAC 246-310-210)**

Based on the source information reviewed the department determines that the application is not consistent with the applicable need criteria in WAC 246-310-210.

**(1) The population served or to be served has need for the project and other services and facilities of the type proposed are not or will not be sufficiently available or accessible to meet that need**

The Department of Health's Certificate of Need Program uses the numeric methodology found in WAC 246-310-270 for determining the need for additional ASCs in Washington State. The numeric methodology provides a basis of comparison of existing operating room (OR) capacity for both outpatient and inpatient OR's in a planning area using the current utilization of existing providers. The methodology separates Washington State into 54 separate secondary health services planning areas.

The methodology estimates operating room (OR) need in a planning area using multi-steps as defined in WAC 246-310-270(9). This methodology initially determines existing capacity of dedicated outpatient and mixed-use operating rooms in the planning area, subtracts this capacity from the forecast number of surgeries to be expected in the planning area in the target year, and examines the difference to determine:

- a) whether a surplus or shortage of OR's is predicted to exist in the target year, and
- b) if a shortage of OR's is predicted, the shortage of dedicated outpatient and mixed-use rooms are calculated.

MHS-GH is proposed to be located in the city of Gig Harbor, which is included in the central Pierce planning area. MHS applied the methodology to the central Pierce planning area and calculated a surplus of 11.3 mixed use ORs in the planning area. [source: Application, pp21-21C]

Given that MHS-GH would be located in central Pierce County, the department will also apply the methodology to that health service planning area. There are a total of 13 facilities with OR capacity either currently operating in the central Pierce planning area, or CN approved to be operating in the planning area. The 13 providers are listed below.

<b>Central Pierce Planning Area Providers</b>	
<b>4 Hospitals / City</b>	<b>9 ASCs / City</b>
MHS - Tacoma General/Allenmore, Tacoma	Cedar Laser and Surgery Center, Tacoma
MHS - Mary Bridge Children's Hospital, Tacoma	Gig Harbor ASC, Gig Harbor
FHS - St. Joseph Medical Center, Tacoma	Group Health-Tacoma Specialty ASU, Tacoma
FHS - St. Anthony Hospital, Gig Harbor	Narrows Eye Surgery Center, Tacoma
	Pacific Cataract & Laser Institute, Inc, Tacoma
	Pacific NW Eye Associates, Tacoma
	St. Marks Microsurgical Center, Tacoma
	Tacoma ASC, Tacoma
	West Tacoma Surgery Center, LLC, Tacoma

As shown above, the 13 facilities include four hospitals and nine ASCs. Of the four hospitals, three are currently operating—Tacoma General/Allenmore (the applicant), Mary Bridge Children's Hospital, and St. Joseph Medical Center. The remaining hospital—St. Anthony Hospital, is CN approved, yet not operational. All four hospitals have OR capacity that will be counted for this project.

Of the nine ASC's, seven are located within a solo or group practice (considered an exempt ASC) and therefore, the use of these ASCs is restricted to physicians that are employees or members of the clinical practices that operate the facilities. These seven facilities do not meet the ASC definition within WAC 246-310-010 and should not be included in the capacity calculations of available ORs for the central Pierce County planning area.

The two remaining ASCs--Gig Harbor ASC and Tacoma ASC—are ASCs as defined in WAC 246-310-010 and the OR capacity of the two ASCs will be included in the capacity calculations of available ORs for the central Pierce County planning area.

To assist in its application of the numeric methodology for this project, in July 2005, the department requested utilization information from each of the 13 facilities identified above. Neither of the two hospital entities (FHS or MHS) returned completed surveys, and only two of the nine ASCs in the planning area responded.<sup>5</sup> As a result, as required in WAC 246-310-270(9)(b)(ii), the department applied the methodology using the default minutes of 100 per inpatient surgery and 50 per outpatient surgery.

Application of the numeric methodology using survey responses, historical CN files, and applicable default data, indicates a surplus of 57 mixed used ORs for the central Pierce County planning area. As a result, based solely on the numeric methodology, need for additional OR capacity in the secondary health service planning area is not demonstrated. [source: department's methodology and utilization surveys]

Even though MHS recognized within the application that MHS-GH would be located in the central Pierce planning area and applied the numeric methodology accordingly, MHS then provided modifications to the planning area by limiting to those zip codes west of the Tacoma Narrows Bridge, the area known as Gig Harbor and the Key Peninsula. MHS referred to this modification as MHS-GH's "primary service area." MHS provided its definition of the ASC's "primary service area" below. [source: July 5, 2005, supplemental information, p11]

*"The definition of primary service area used here is that set of zip codes from which [MHS-GH] expects to receive 80% of its patients. This definition is based on the concept of "primary" as meaning "essential" or "basic" These "primary" zip codes are those that predictably generate the core patient demand for a services. In most cases, the facility will also have its highest market shares in the same area."*

MHS then further clarified that the remaining 20% of MHS-GH's patients would come from a combination of the ASC's "secondary" service area and "out-of-area" patients. These two terms are described below. [source: July 5, 2005, supplemental information, p11]

secondary service area

*"The secondary service area generates a large share of the 20% of patients served by the facility but who do not live in the essential or basic core of the ...primary service area."*

out-of-area

*"Inevitably, a patient origin analysis includes a very long list of zip codes across the state or even the country in which fewer than 5 and frequently only 1 patient resides. This erratic source of patients will include a changing list of zip codes from year-to-year but can range between 1-5% of total patient origin."*

To determine the number of patients that would be served at MHS-GH, MHS conducted a patient origin analysis of MHS's three same day surgery centers that serve patients residing in its definition of "primary service area" above.<sup>6</sup> [source: July 5, 2005, supplemental information, p11] Based on this patient origin data, the applicant projected a total of 1,118 cases at MHS-GH in year 2007, which would increase to 1,354 cases by the end of year 2009. [source: July 5, 2005, supplemental information, pp7 and 7B]

<sup>5</sup> Gig Harbor ASC and West Tacoma Surgery Center.

<sup>6</sup> The three facilities used as a basis for patient origin data were not identified.

WAC 246-310-270 does not allow for modifications to the service areas as defined in subsections (2) and (3), therefore, MHS did not apply the numeric methodology to its defined modified planning area. However, for demonstrative purposes only, the department did. Using the two ORs within Gig Harbor ASC and the five mixed use ORs to be located within St. Anthony Hospital, yields a surplus of six ORs in the defined MHS "primary service area." As a result, even applying the numeric methodology using MHS's defined "primary service area," need is not demonstrated. [source: department's methodology, utilization surveys, and WAC 246-310-270]

The department received approximately 750 letters and post cards from Gig Harbor and surrounding community members and employees of MHS in support of this project. Generally, the letters and post cards in support attributed the need for additional ORs to the growth in the community.

Concerns raised in opposition to this project provided by Franciscan Health System focused on this project's impact to the recently approved FHS-St. Anthony Hospital. Specifically, FHS states that the proposed ASC represents a duplication of services either available in the community or already planned and approved under the department's recent approval of the new 80-bed hospital, to be know as St. Anthony Hospital. Within its CN application for the new hospital, FHS provided its underlying assumptions used as a basis for its projected patient days, as well as its financial projections for the hospital. Within those assumptions, FHS relied on market share shifts of patients that would typically receive services in one of the two central Pierce County hospitals-- FHS-St. Joseph Hospital and MHS-Tacoma General/Allenmore. [source: FHS September 20, 2005, rebuttal documents, pp1-10]

Additional concerns raised in opposition to this project were provided by community members within the Gig Harbor / Peninsula area. Those concerns also focused on this project's impact to St. Anthony Hospital. Generally, the community is concerned that approval of this project would negatively affect St. Anthony Hospital's ability to either 1) become operational; or 2) remain operational to serve the residents of the Gig Harbor / Peninsula area. [source: Public comment and public hearing documents]

In response to the concerns raised above, MHS recognizes that FHS has ownership interest in both of the two recently approved facilities in the Gig Harbor / Peninsula area—Gig Harbor ASC and St. Anthony Hospital. MHS contends that FHS has overstated the available OR capacity in the Gig Harbor / Peninsula area because both of the FHS facilities are not yet operational as proposed in their respective CN applications. A brief summary of each facility and its progress toward completion is shown below.

Gig Harbor ASC [source: CN historical files and quarterly progress reports submitted by FHS]

When this ASC was initially established in 1991, it was included under the St. Joseph Medical Center hospital license. At that time, a hospital could establish an ASC without prior CN review and approval if the ASC would be included in the hospital license. The applicant for this project was Gig Harbor Day Surgery, LLC comprised of 50% FHS and the remaining 50% equally divided among three physicians. Services to be provided at the ASC include general surgery, orthopedic, gynecology, and ophthalmology. On March 12, 2004, CN #1282 was issued to Gig Harbor Day Surgery, LLC approving the purchase of the ASC from St. Joseph Hospital. Within the application, the applicant indicated that the purchase of the ASC would be complete by December 2004, and the ASC's first year of operation under the new LLC would be year 2005. As of the writing of this evaluation, FHS has encountered delays in implementation of CN #1282 because at least one, and possibly two, of the proposed owning physicians may elect to not participate in the project. On September 2, 2005, representatives from FHS stated that by the end of September, or early October 2005, FHS would reassess the project and determine whether to recruit new physicians or relinquish CN #1282. [source:

CN #1282 progress report file<sup>7</sup>] As of the writing of this evaluation, FHS has not yet informed the department of its intentions regarding CN #1282.

However, given that the ASC is currently licensed under FHS-St. Joseph Medical Center's hospital license, the number of ORs at the ASC are already included in the OR count for methodology purposes. Therefore, whether CN #1282 is implemented or relinquished is not relevant to this project.

FHS-St. Anthony Hospital [source: CN historical files and quarterly progress reports submitted by FHS] On May 26, 2004, FHS was issued an "Intent to Issue a Certificate of Need" for the establishment of a new, 80-bed hospital in the city of Gig Harbor.<sup>8</sup> St. Anthony would have 5 ORs, and services to be provided at the hospital include short stay outpatient, emergency, surgery, diagnostic imaging, pulmonary function, nuclear medicine, diagnostic cardiac, rehabilitation services, lab services, and pharmacy services. Within its application, FHS anticipated the project would commence by July 2005 and the 80-bed hospital would be operational in July 2007. Year 2008 would be the hospital's first full year of operation. [source: FHS - St. Anthony Hospital progress report file]

As described above, while MHS's position that the ORs for the ASC and the proposed hospital are not yet available is correct; however the ORs in both must be counted as "existing capacity" when applying the methodology under WAC 246-310-270. Further, the methodology provides a default number of minutes to be used for both inpatient and outpatient surgeries if data is not available. This recognition within the methodology further supports the counting of CN approved ORs as existing capacity. Further, even if the department were to exclude St. Anthony Hospital's 5 ORs from the existing capacity, the numeric methodology continues to show no need for ORs in the central Pierce planning area through 2009.

As a result, based on the numeric methodology, the department recognizes that need for additional OR capacity is not necessary at this time. Further, WAC 246-310-210 requires the applicant to demonstrate that existing providers are neither available nor accessible. MHS did not provide this demonstration within its application. As a result, the department concludes that this sub-criterion is not met.

- (2) All residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly are likely to have adequate access to the proposed health service or services.

As previously stated, MHS currently owns or operates a variety of health care facilities in Washington State. Through these health care facilities, MHS has provided health care services to residents of the service area including low-income, racial and ethnic minorities, handicapped and other underserved groups. To demonstrate compliance with this sub-criterion, the applicant provided a copy of MHS's current admission policies that would also be used for the ASC. The policies indicate that patients are admitted to any MHS facility without regard to age, race, color, religion, sex, national origin, handicap, or sexual preference and will be treated with respect and dignity. [source: Application, Appendix I]

To determine whether low income residents would have access to the ASC, the department uses the facility's Medicaid eligibility or contracting with Medicaid as the measure to make that determination. Concerns related to this project centered on whether the medical park—MGHMP—would accept Medicaid patients, and if not, whether the proposed ASC would contract

<sup>7</sup> Progress reports for December 2004; March 2005; and June 2005.

<sup>8</sup> In accordance with WAC 246-03-030(4), the department may not issue a Certificate of Need for a new healthcare facility until it has received a copy of a determination of non-significance or a final environmental impact statement pertaining to the site.

with Medicaid. Information provided by the applicant in response to these concerns verifies that both MGHMP and MHS-GH would contract with Medicaid and serve those patients. Further, within the application, MHS provided its sources of revenues, which identifies 4% Medicaid. [source: August 9, 2005, inquiry from Diane Combs, MD; Application, p14; and public hearing documents submitted by MHS.]

WAC 246-310-270(7) states that ASC's shall implement policies to provide access to individuals unable to pay consistent with charity care levels reported by the hospitals affected by the proposed ASC. For charity care reporting purposes, the Department of Health's Office of Hospital and Patient Data Systems (OHPDS), divides Washington State into five regions: King County, Puget Sound (less King County), Southwest, Central, and Eastern. MHS-GH would be located in central Pierce County within the Puget Sound region. For charity care reporting purposes, affected hospitals include both MHS facilities of Tacoma General/Allenmore and Mary Bridge Children's Hospital, in addition, FHS's St. Joseph Medical Center and St. Anthony Hospital would also be affected by approval of this project. Given that St. Anthony is not yet operational, charity care data is not yet available. For this project, the department reviewed charity care data for the three operational hospitals and the 18 existing hospitals currently operating within the Puget Sound Region.

According to 2001-2003<sup>9</sup> charity care data obtained from OHPDS, the three-year average for the Puget Sound Region is .99% for gross revenue and 1.99% for adjusted revenue. [source: OHPDS 2001-2003 charity care summaries] The department also reviewed 3-year charity care data reported by the three operational hospitals. The 2001-2003 averages are .70% of gross revenue and 1.3% of adjusted revenue. [source: OHPDS 2001-2003 charity care summaries]

The applicant's pro formas indicate that the ASC will provide charity care at approximately 2% of gross revenue, and 5% of adjusted revenue, which is considerably greater than the average charity care provided in the Puget Sound Region. Further, it is also considerably greater than the amount of charity care provided by either of the two operational MHS facilities and the combined three-year average of the three operational hospitals in central Pierce County. Given that the amount of charity care proposed to be provided at MHS-GH is inconsistent with historical practices at existing MHS facilities, if this project is approved, the department concludes that a condition related to the charity care to be provided at the ASC would be necessary.

The department concludes that any approval of this project must be conditional upon the proposed ASC providing charity care at the level outlined above. With this condition, this sub-criterion is met.

#### **B. Financial Feasibility (WAC 246-310-220)**

Based on the source information reviewed, the department determines that the application is not consistent with the applicable financial feasibility criteria in WAC 246-310-220.

##### **(1) The immediate and long-range capital and operating costs of the project can be met.**

To analyze short- and long-term financial feasibility of hospital projects and to assess the financial impact of a project on overall facility operations, the department uses financial ratio analysis. The analysis assesses the financial position of an applicant, both historically and prospectively. The financial ratios utilized are 1) long-term debt to equity ratio; 2) current assets to current liabilities ratio; 3) assets financed by liabilities ratio; 4) total operating expense to total operating revenue ratio; and 5) debt service coverage ratio. If a project's ratios are within the expected value range, the project can be expected to be financially feasible.

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<sup>9</sup> Year 2004 charity care data is not available as of the writing of this evaluation.

For this project, MHS proposes the ASC to be part of a department of Tacoma General/Allenmore Hospital. As such, MHS did not provide a separate balance sheet for the ASC. All of the ratios above, with the exception of 4) total operating expense to total operating revenue ratio, require data from the balance sheet. Without the balance sheet, the department's Office of Hospital and Patient Data Systems (OHPDS) was able to compute only the total operating expense to total operating revenue ratio. Results for that ratio are favorable for this project. [source: OHPDS analysis, p3]

After reviewing the financial ratios above, staff from OHPDS stated the following:

*"The project Operating Expense/Operating Revenue ratio is appropriate. The applicant projects an above average financial return. MultiCare ratios for 2004 are slightly below average for three categories compared to 2003 statewide ratios; however these are within acceptable range of the average. The applicant projects positive operating margins for the project starting in the first year of operation. [source: OHPDS analysis, p3]"*

Based on the financial information above, the department concludes that the long-term capital and operating costs of this project can be met, and this sub-criterion is satisfied.

(2) The costs of the project, including any construction costs, will probably not result in an unreasonable impact on the costs and charges for health services.

OHPDS also compared MHS-GH's projected costs and charges to the available data and determined that the costs and charges are reasonable. [source: OHPDS analysis, pp3-4]

As stated in the need section of this evaluation, to determine the number of patients that would be served at MHS-GH, MHS conducted a patient origin analysis of MHS's three same day surgeries that serve patients residing in its definition of primary service area.<sup>10</sup> [source: July 5, 2005, supplemental information, p11] Based on this patient origin data, the applicant projected the number of surgical cases for the Gig Harbor / Peninsula area for years 2005 and 2006, which was used as a basis to project revenues and expenses for MHS-GH for years 2007 through 2009. MHS-GH projections for its first three full years of operation--years 2007 through 2009--are shown in Table I below. [source: July 5, 2005, supplemental information, pp7-8 & Appendix 6]

**Table I  
MHS-GH Revenue and Expense Summary**

	Year 1 - 2007	Year 2 -2008	Year 3 - 2009
# of Surgeries	1,396	1,542	1,695
Net Revenue*	\$ 3,870,352	\$ 4,274,191	\$ 4,698,932
Total Expense	\$ 2,891,536	\$ 3,133,407	\$ 3,435,565
Net Profit or (Loss)	\$ 978,816	\$ 1,140,784	\$ 1,263,367
Net Revenue per Surgery	\$ 2,771.81	\$ 2,771.81	\$ 2,771.81
Total Expenses per Surgery	\$ 2,070.82	\$ 2,032.01	\$ 2,026.57
Net Profit or (Loss) per Surgery	\$ 700.99	\$ 739.80	\$ 745.24

\*Includes deductions for bad debt, charity care, and contractual allowances

MHS states in order to present a conservative scenario, estimates for years 2005 and 2006 maintained the year 2004 baseline. For year 2007, MHS-GH's first full year of operation, the applicant anticipates the number of cases provided in Gig Harbor would increase based on program enhancements and the location of the ASC in relation to the patients. [source: July 5, 2005, supplemental information, pp7-8] As shown in Table I above, based on this approach, MHS anticipates a profit in the first three of operation.

<sup>10</sup> The three facilities used as a basis for patient origin data were not identified.

CN program staff also compared the projected costs and charges above to those of recent ASC applications. That comparison reveals that the costs and charges identified above are comparable to those shown in like-type ASC applications.

In the need section of this evaluation, the department concluded that need for ORs in the central Pierce County planning area had not been demonstrated. The department, therefore, concludes that the costs of the project would result in an unreasonable impact on the costs and charges for health services within the service area. This sub-criterion is not met.

(3) The project can be appropriately financed.

As previously stated, MHS-GH would be housed in a new medical office park within Gig Harbor. Regardless of whether this project is approved, the medical office park would be built and operational approximately January 2007. The capital expenditure associated with the establishment of the medical office park, including the ASC portion, is \$35,500,000. The establishment of the ASC in the medical office park is estimated at \$6,521,000. Of that amount, \$5,001,000 (77%) is related to construction and \$1,520,000 (23%) is related to both fixed and moveable equipment. [source: Application, Appendix L, and July 5, 2005, supplemental information, p14]

Funding for the larger project, including the ASC portion is from MHS reserves. To demonstrate that the funding for the project is available, MHS submitted its year 2004 audited balance sheet for MHS as a whole. A review of the balance sheet indicates that the funds are available for the entire \$35,500,000 project. [source: Application, p32; and July 5, 2005, supplemental information, Appendix SC-5]

After reviewing the financial reports and historical financial data for MHS, OHPDS provided the following analysis.

*"The financial status of MultiCare Health System is adequate to fund their participation in this project. This project will not adversely impact reserves, or total assets, total liability or the general health of MultiCare Health System. Due to the good financial health of the project, the applicant should not have any trouble meeting the immediate and long term needs of this project. This office does not have much data on outpatient surgery costs. The data we have is reported under a cost center called 'short stay' that covers ambulatory surgery, but also can cover other treatments which result in stays less than 24 hours. The applicant's charges and expenses are similar to the actual 2003 short stay cost center data"* [source: OHPDS analysis, pp2-4]

As noted above, this project will not adversely affect the reserves, total assets, total liability, or general financial health of MHS or its two hospitals. OHPDS staff concluded that MHS has the financial capacity to proceed with this project. Based on this information, the department concludes that the proposed financing is appropriate, and this sub-criterion is met.

**C. Structure and Process (Quality) of Care (WAC 246-310-230)**

Based on the source information reviewed, the department determines that the application is not consistent with the applicable structure and process of care criteria in WAC 246-310-230.

(1) A sufficient supply of qualified staff for the project, including both health personnel and management personnel, are available or can be recruited.

Given that the ASC is not currently operating, MHS anticipates recruitment of all necessary staff for the ASC. Table II on the following page summarizes the projected staffing of MHS-GH. [source: Application, Appendix M]

**Table II  
MHS-GH Projected Staffing (FTE)**

Projected Staffing	Year 1 - 2007	Year 2 -2008	Year 3 - 2009
Manager	1.0	1.0	1.0
RN	3.0	3.5	4.0
Technical	2.0	2.0	2.0
Service/Maintenance	2.5	3.0	4.0
<b>Total FTEs</b>	<b>8.5</b>	<b>9.5</b>	<b>11.0</b>

MHS states that the technical staff above includes equipment technicians, central processing, secretarial, patient records, billing, and registration staff. [source: July 5, 2005, supplemental information, p16] As shown in Table II above, MHS anticipates a total of 8.5 FTEs in the first year of operation and an increase of 2.5 FTEs by the end of year three.

To further demonstrate that staff for the ASC either would be available or can be recruited, MHS provided the following statements:

*"A large number of MHS employees live in the Gig Harbor area. This includes many nursing staff and other employees in MultiCare's Surgery Departments. The opportunity to transfer from their current sites of employment to Gig Harbor will be very attractive to them."*

Further, the applicant indicates that any increase in staff would be based on the increase in surgeries at the ASC, and vacancies will be filled via advertising. Additionally, within the application, MHS provided a comprehensive approach to back filling vacant positions resulting from employee transfers. [source: Application, p14; July 5, 2005, supplemental information, p17]

Based on the information provided in the application, the department concludes that the applicant provided a comprehensive approach to recruit and retain staff necessary for the ASC. This sub-criterion is met.

(2) The proposed service(s) will have an appropriate relationship, including organizational relationship, to ancillary and support services, and ancillary and support services will be sufficient to support any health services included in the proposed project.

Given that the ASC would be part of the larger MHS organization and located within a medical office park, necessary ancillary and support agreements would be provided on site within the medical office park. Examples of services to be provided within the medical office park include laboratory, diagnostic radiology, environment of care, and information technology. [source: Application, p34-35]

Further, MHS provided the following listing of services that would be provided through one of the MHS currently operating hospitals. [source: July 5, 2005, supplemental information, Appendix SC-7]

clinical engineering	imaging	medical staff services
customer service	infection control	pharmacy
engineering	linen services	quality management
human resources	materials management	safety/security

After reviewing the information above, the department concludes that the applicant demonstrated intent for the ASC to have appropriate relationships with ancillary and support services for the health care services to be provided. Additionally, the applicant intends to meet all of the necessary documentation required for the operation and management of the ASC. However, given that MHS did not provide any draft documents, any approval should be conditional upon the applicant agreeing to provide final or executed documents to the department prior to

commencement of the project for those agreements not provided by either MHS or at the medical office park. With this term, this sub-criterion would be met.

- (3) There is reasonable assurance that the project will be in conformance with applicable state licensing requirements and, if the applicant is or plans to be certified under the Medicaid or Medicare program, with the applicable conditions of participation related to those programs.

As stated in the project description portion of this evaluation, MHS is currently serving the residents of southwestern Washington State through its various healthcare facilities. MHS includes three hospitals, nearly 20 physician clinics, six urgent care facilities, and a variety of health care services, including home health and hospice services in the state. [source: CN historical files, MultiCare Health System website, and Application pp5-6]

The Department of Health's Office of Health Care Survey (OHCS), which surveys hospitals, ASCs, home health, and hospice providers within Washington State, has completed a total of 19 compliance surveys for the MHS health care facilities.<sup>11</sup> The surveys revealed minor deficiencies typical for the type of healthcare facility and MHS submitted plans of correction and demonstrated implementation of the required corrections. [source: compliance survey data provided by Office of Health Care Survey]

As indicated by MHS, some ancillary and support services will be provided either on site within the medical office park or through one of the currently operating MHS facilities. Within the application, MHS did not identify the proposed medical director or provide agreement for the services. Given that the medical office park and the ASC are not scheduled to open until approximately January 2007, ancillary and support service agreements have not yet been established. As previously concluded, based on the information provided in the application, the department concludes that MHS intends to employ a medical director; however, it is unclear whether the position would be considered part of the physician's employment or duties in addition to employment. If this project is approved, the department would require the applicant to agree to the following term regarding the medical director.

Prior to providing services at MHS-GH, the applicant will identify the proposed medical director and provide an executed copy of the medical director agreement if an agreement is established. Compensation for medical director services shall be consistent with those costs identified in the application.

Provided that the applicant agree to the term outlined above, the department concludes that there is reasonable assurance that MHS-GH would operate in conformance with applicable state and federal licensing and certification requirements, and this sub-criterion is met.

- (4) The proposed project will promote continuity in the provision of health care, not result in an unwarranted fragmentation of services, and have an appropriate relationship to the service area's existing health care system.

In response to this criterion, MHS identified three factors that demonstrated its perception of continuity of care and unwarranted fragmentation of services. Those three factors include:

- continuity within MultiCare Gig Harbor Medical park;
- continuity between the ASC and [MHS] hospitals; and
- continuity within the MultiCare system.

[source: Application, pp34-35]

The promotion of continuity of care and unwarranted fragmentation of services does not require nor is it intended, to have a single facility provide each and every service a patient might require.

<sup>11</sup> ASC surveys in 1993, 1995, 1997, & 2002; home health surveys 2003 & 2004; hospice surveys in 2004; Mary Bridge Children's Hospital surveys in 1993, 1994, 1995, 1996, 2000, & 2003; Tacoma General/Allenmore Hospital surveys in 1993, 1994, 1995, 1996, 2000, & 2003.

If that was the intent, there would be no concern about unnecessary duplication of services. The application guidelines provide guidance as to the intent of this criterion. The application guidelines ask for identification of existing and proposed formal working relationships with hospitals, nursing homes, and other health services and resources serving the applicant's primary service area. This description should include recent, current, and pending cooperative planning activities, shared services agreements and transfer agreements. Because MultiCare is already operating several healthcare facilities, there are some established relationships with the existing health care system. The department would expect many of these to remain even if the proposed project is approved.

However, in the need section of this evaluation, the department concluded that need for the ASC had not been demonstrated; therefore, the department concludes that approval of this project has the added potential of fragmentation of services within the service area. Therefore, this sub-criterion is not met.

- (5) *There is reasonable assurance that the services to be provided through the proposed project will be provided in a manner that ensures safe and adequate care to the public to be served and in accord with applicable federal and state laws, rules, and regulations.*

This sub-criterion is evaluated in sub-section (3) above, and based on that evaluation, the department concludes that this sub-criterion is met.

#### **D. Cost Containment (WAC 246-310-240)**

Based on the source information reviewed, the department determines that the application is not consistent with the applicable cost containment criteria in WAC 246-310-240.

- (1) *Superior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable.*  
In response to this criterion, the applicant provided alternatives to the establishment of building the medical office park which would house the ASC; however, as previously stated, the establishment of the medical office park as a whole does not require prior CN review and approval. As a result, MHS could continue with the establishment of medical office park in Gig Harbor.

For the ASC portion of this project, however, the department concluded in the need section of this evaluation that OR capacity has not been demonstrated to be needed in the central Pierce County service area. Therefore, the department cannot consider this project to be the best available option for the community, and this sub-criterion is not met.

- (2) *In the case of a project involving construction:*

- (a) *The costs, scope, and methods of construction and energy conservation are reasonable;*

As stated in the project description portion of this evaluation, this project involves construction. This sub-criterion is evaluated within the financial feasibility criterion under WAC 246-310-220(2). Based on that evaluation, the department concludes that this sub-criterion is not met.

- (b) *The project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.*

This sub-criterion is also evaluated within the financial feasibility criterion under WAC 246-310-220(2). Based on that evaluation, the department concludes that this sub-criterion is not met.