STATE OF WASHINGTON
DEPARTMENT OF HEALTH

August 24, 2016

John F. Sullivan
Attorney at Law
1420 NW Gilman Blvd Suite #2-2206
Issaquah, WA 98027

Brian Grimm
Matthew Gordon
Perkins Coie LLP
1201 Third Ave Suite 4900
Seattle, WA 98101-3099

Richard McCartan, AAG
Office of the Attorney General
PO Box 40109
Olympia, WA 98504-0109

RE: Master Case No. M2014-1290

Dear Parties:

Enclosed please find Findings of Fact,Conclusions of Law,and Final Order dated August 23, 2016.

Any questions regarding the terms and conditions of the Order should be directed to Janis Sigman, Program Manager at (360) 236-2956.

Sincerely,

Michelle Singer, Lead Adjudicative Clerk
Adjudicative Clerk Office
PO Box 47879
Olympia, WA 98504-7879

cc: Janis Sigman, Program Manager

Enclosure

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE SERVICE UNIT

In Re:	)	
	)	Master Case No. M2014-1290
Certificate of Need #1538 concerning	)	
PROVIDENCE MEDICAL PARK	)	DECLARATION OF SERVICE
	)	BY MAIL
ROCKWOOD HEALTH SYSTEM, d/b/a	)	
VALLEY HOSPITAL	)	
Petitioner	)	
	)	
	)	

I declare under penalty of perjury, under the laws of the state of Washington, that the following is true and correct:

On August 24, 2016, I served a true and correct copy of the Findings of Fact, Conclusions of Law, and Final Order, signed by the Presiding Officer on August 23, 2016, by placing same in the U.S. mail by 5:00 p.m., postage prepaid, on the following parties to this case:

John F. Sullivan
Attorney at Law
1420 NW Gilman Blvd Suite #2-2206
Issaquah, WA 98027

Brian Grimm
Matthew Gordon
Perkins Coie LLP
1201 Third Ave Suite 4900
Seattle, WA 98101-3099

Richard McCartan, AAG
Office of the Attorney General
PO Box 40109
Olympia, WA 98504-0109

DATED: This 24th day of August, 2016

Michelle Singer, Lead Adjudicative Clerk Office
Adjudicative Clerk

cc: Janis Sigman, Program Manager

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
OFFICE OF THE SECRETARY

In the Matter of: CERTIFICATE OF NEED #1538 concerning PROVIDENCE MEDICAL PARK, ROCKWOOD HEALTH SYSTEM d/b/a VALLEY HOSPITAL, Petitioner.	Master Case No. M2014-1290 FINDINGS OF FACT, CONCLUSIONS OF LAW, AND FINAL ORDER

APPEARANCES:

Petitioner, Rockwood Health System d/b/a Valley Hospital, by
Law Offices of John F. Sullivan, per
John F. Sullivan, Attorney at Law

Department of Health, Certificate of Need Program, by
Robert W. Ferguson, Attorney General, per
Richard A. McCartan, Assistant Attorney General

Intervenor, Providence Health Services – Washington, by
Perkins Coie, LLP, per
Brian Grimm and Anastasia K. Anderson, Attorneys at Law

PROCEDURAL HISTORY ON REVIEW

This matter comes before the Review Officer for administrative review of the Findings of Fact, Conclusions of Law and Initial Order (Initial Order) dated February 22, 2016, of the Presiding Officer, John F. Kuntz. The Presiding Officer issued the Initial Order after a contested administrative hearing held September 28 and 29, 2015, regarding the issuance of a certificate of need (CN) application to Providence Health Services –

ORIGINAL

Washington (Providence) to establish a four-operating room ambulatory surgical facility (ASF) in Spokane Valley, Washington over the objections of Rockwood Health System.

The Initial Order granted the CN to Providence. The Initial Order was served on the parties on February 23, 2016. Rockwood filed a Petition for Administrative Review (Petition) on March 15, 2016. The Program filed a response on April 4, 2016. Providence filed a response on April 6, 2016.

The Review Officer reviewed the administrative record including, but not limited to, the Petition, responses thereto, transcripts, application record and clerk's file.

ROCKWOOD'S PETITION FOR REVIEW

Rockwood claims the findings of fact and conclusions of law in the Initial Order are erroneous. Specifically, the Initial Order fails to follow the need criteria in WAC 246-310-210(1) and 270(9). Further, the Initial Order is arbitrary, capricious and contrary to law because it grants Providence an impermissible and unwarranted exception to the need criteria. Rockwood argues that the exception in WAC 246-310-270(4) is invalid because it fails to provide guidelines or standards for applying the exception, thus creating "rulemaking on the fly." Even if such an exception were allowed, it was unwarranted in this case.

PROVIDENCE'S RESPONSE

Providence opposes Rockwood's Petition and provides extensive argument in support of the Initial Order. It contends the Initial Order properly found that circumstances warranted granting the CN without a determination of numeric need under WAC 246-310-270(9). However, even if a finding of numeric need is required, there is a showing of need

for the ASF if certain dedicated specialized rooms are appropriately removed from the total capacity of the planning area.

THE PROGRAM'S RESPONSE

The Program also opposes the Petition. It contends that although the methodology in WAC 246-310-270(9) does not show need, WAC 236-310-270(4) allows an exception to be made in the absence of numerical need. The Initial Order properly considered "non-ordinary" circumstances that justified Providence's proposed ASF. The Program disputes Rockwood's contention that WAC 246-310-270(4) is invalid and argues an agency rule is not required to identify all possible applicable situations in order to be valid.

REVIEW OFFICER'S ANALYSIS

Numeric Need

Before discussing the primary issue briefed by the parties (whether the CN can be granted in the absence of numeric need), it is important to first assess whether numeric need does, in fact, exist as is argued by Providence. The Review Officer finds that the appropriate number of available operating rooms is 71. Therefore, no numeric need exists for additional operating rooms.

Exception When Numeric Need Does Not Exist

WAC 246-310-270 states:

> (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.

If the meaning of a rule is plain and unambiguous on its face, the court should give effect to that plain meaning. *Overlake Hosp. Ass'n v. Dept. of Health*, 170 Wash.2d 43, 52, 239 P.3d 1095 (2010). The rule clearly allows the addition of outpatient operating rooms in the absence of numeric need, as evidenced by use of the phrase "should ordinarily not be approved". The word "ordinarily" has meaning. If something is not ordinarily approved, it stands to reason that it may be approved in extraordinary circumstances. As with all other aspects of a CN application, the applicant bears the burden of proving extraordinary circumstances by a preponderance of the evidence.

Rockwood contends that in the absence of any guidelines, standards, or criteria for evaluating an exception situation, a case-by case evaluation is "rulemaking on the fly." The Review Officer disagrees. As cited by the Program, the rulemaking requirements in chapter 34.05 RCW are not intended to "straightjacket" administrative decision-making. *Budget Rent A Car Corp. v. Dept. of Licensing*, 144 Wash.2d 889, 898, 31 P.3d 1174 (2001).

The fact that many CN rules are detailed and formulaic does not require every rule to adhere to such a model. WAC 246-310-270(4) allows the addition of outpatient operating rooms in non-ordinary or extraordinary circumstances. The commonly accepted definition of extraordinary is "very unusual or very different from what is normal or ordinary."[1] The very nature of an extraordinary event makes it unlikely to fit into rule language. In other words, if it were common enough to anticipate in rule, it would probably not be extraordinary.

[1] Merriam-Webster online dictionary, accessed August 12, 2106.

Evidence of Extraordinary Circumstances

Rockwood denies the existence of an exception in (4), but argues if it does exist, its application in this case is arbitrary and capricious. Again, the Review Officer disagrees. Arbitrary and capricious action is "willful and unreasoning action, without consideration and in disregard of facts and circumstances. Where there is room for two opinions, action is not arbitrary and capricious even though one may believe an erroneous conclusion has been reached. Action taken after giving respondent ample opportunity to be heard, exercised honestly and upon due consideration, even though it may be believed an erroneous decision has been reached, is not arbitrary or capricious." *Regan v. State Dept. of Licensing*, 130 Wash.App. 39, 58-59, 121 P.3d 731 (2005) quoting *Heinmiller v. Dept. of Health*, 127 Wash.2d 595, 609, 903 P2d 1294 (1995), *cert. denied,* 518 U.S. 1006, 116 S.Ct. 2526, 135 L.Ed. 1051 (1996). In this case, Rockwood had full opportunity to argue its position and did so zealously. Although Rockwood does not agree with the outcome, evidence does exist to support a finding of extraordinary circumstances including, but not limited to, the complete absence of mixed-use freestanding operating rooms and the lower costs of procedures performed in ambulatory surgical facilities compared to hospitals.

ISSUES

1) Does the Providence application for a four-operating room ambulatory surgical facility satisfy the applicable certificate of need criteria?
2) What is the proper interpretation of WAC 246-310-270(4)?

I. PROCEDURAL HISTORY AND SUMMARY OF PROCEEDINGS

1.1 On November 14, 2013, Providence applied for a CN to establish a four-operating room (ASF) in Spokane Valley, Washington.[2] Providence's proposal included the expense of purchasing land and building the facility at an estimated capital expenditure of $8,441,110.00.

1.2 On October 29, 2014, the Program issued an evaluation granting Providence's CN to establish a four-operating room ASF in Spokane Valley, Washington. The Program concluded that Providence's project qualified for a CN even though the Program's need calculations did not show the necessity for any additional operating rooms in the Spokane planning area.

1.3 Rockwood did not file a CN application for an ASF in this matter. On November 17, 2014, Rockwood did file a timely petition for an adjudicative proceeding to contest the Program's decision. The parties submitted a Stipulation and Order allowing Providence to intervene in the matter and intervention was granted on December 16, 2014.[3]

1.4 Prior to the hearing, the Presiding Officer ruled that other than the need criterion, the Providence application satisfied all other CN criteria under WAC 246-310-220, WAC 246-310-230, and WAC 246-310-240.[4] The Presiding Officer also deemed it

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[2] The Program issued Determination of Reviewability #13-03, which originally determined Providence's project was not subject to CN review. Rockwood appealed the Program's determination and prevailed on summary judgment. *See* Corrected Order on Summary Judgment, master case no. M2013-614. Application Record (AR) 858-63. Providence subsequently filed the current CN application.

[3] *See* Stipulation and Order for Intervention by Providence Health and Services – Washington, dated December 16, 2014.

[4] *See* Prehearing Order No. 9.

established that outpatient surgery in an ambulatory facility is less expensive than the same procedure performed in a hospital.[5]

1.5 At the hearing held on September 28-29, 2015, Rockwood presented the testimony of Greg Repetti, CEO of Valley Hospital CEO; and Jody Carona, owner/president of Health Facilities Planning and Development. Providence presented the testimony of Elaine Couture, Providence's Regional Chief Executive; Scott O'Brien, Providence's Chief Strategy officer; Karen Nidermayer, CN Program Analyst; and Dr. Frank Fox, Ph.D. The Program listed Karen Nidermayer as a witness but chose not to recall her.

1.6 The Presiding Officer admitted the following exhibits at hearing:

Program

- Exhibit P-1: The complete 1,380 page Application Record.

Rockwood

- Exhibit R-1: The complete 1,380 page Application Record.

Providence

- Exhibit PR-1: The complete 1,380 page Application Record.
- Exhibit PR-2: Curriculum Vitae of Frank G. Fox, Jr.
- Exhibit PR-3: Department of Health Spokane Planning Area ASF Need Methodology and Forecast with Providence Sacred Heart Medical Center OR Count Reduced;
- Exhibit PR-4: Department of Health's Spokane Planning Area ASF Need Methodology and Forecast with Deaconess Hospital Surgery Volumes at its Quarterly Report Figures;
- Exhibit PR-5: Population map of Washington counties;
- Exhibit PR-6: Photograph of Providence Medical Park east entrance (exterior A);

[5] *Id.*

- Exhibit PR-7: Photograph of Providence Medical Park west entrance (exterior A);
- Exhibit PR-8: Photograph of Providence Medical Park (interior A);
- Exhibit PF-9: Photograph of Providence Medical Park (interior B);
- Exhibit PR-10: Photograph of Providence Medical Park (interior C);
- Exhibit PR-11: Photograph of Providence Medical Park (interior D);
- Exhibit PR-12: Photograph of Providence Medical Park (interior E);
- Exhibit PR-13: Photograph of hallway of Providence Medical Park (interior F).

1.7 The parties submitted briefs in lieu of closing arguments. *See* RCW 34.05.461(7). Initial closing briefs were due by October 26, 2015. Responsive closing briefs were due by November 2, 2015. The hearing record closed on November 2, 2015. Pursuant to RCW 34.05.461(8), the date for the issuance of the Initial Order was extended to February 26, 2016.[6]

1.8 On February 22, 2016, the Presiding Officer issued an Initial Order granting the CN to Providence. The Initial Order was served on the parties on February 23, 2016.

1.9 On March 15, 2016, Rockwood filed a Petition for Administrative Review.

1.10 On April 4, 2016, the Program filed a Response to the Petition.

1.11 On April 6, 2016, Providence filed a Response to the Petition.

II. FINDINGS OF FACT

2.1 In order to qualify for a certificate of need (CN), an applicant must show that its application meets all of the relevant criteria in chapter 246-310 WAC. These criteria include a showing by the applicant that the CN project: (a) is needed; (b) is

[6] *See* Post-hearing Order No. 1.

financially feasible; (c) will meet certain criteria for structure and process of care; and (d) will foster cost containment of health care costs and charges.

WAC 246-310-210 "Determination of Need"

2.2 WAC 246-310-210(1) states in relevant part:

> The population served or to be served has a 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.

An "ambulatory surgical facility" means any free-standing entity that operates primarily for the purpose of performing surgical procedures to treat patients not requiring hospitalization. WAC 246-310-010(4). Need for an ambulatory surgical facility is calculated using the WAC 246-310-270(9) formula, which provides:

> (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.

In simpler terms, the need calculation counts the number of available outpatient and inpatient or mixed use[7] operating rooms, surgeries, and surgery minutes in the secondary health services planning area (planning area). Here the planning area is Spokane County. WAC 246-310-270(3); *see also* Exhibit PR-5 (map of 2015 residential population by county). The figure is obtained from taking the last calendar year for which the information is available (here 2012) and using that information to project the number of operating rooms needed to accommodate the increase of the planning area's population by the third year of the project period (here 2017). The planning area facilities report the information annually to the Department of Health regarding the total number of available operating rooms in its facility, the total number of surgeries performed in its operating rooms, and total number of surgery minutes. The facilities report the information by completing survey forms and filing the surveys with the Department of Health. *See* AR 373 through AR 416. The number of surgical cases is important to determine the "use rate." The term "use rate" is not defined but is understood to represent a figure to project

[7] Mixed use operating rooms are operating rooms that can accommodate both inpatient surgeries (surgeries where a patient will need care more than 24 hours) and outpatient surgeries (surgeries where a patient will need care less than 24 hours).

how many surgeries will be needed for each 1,000 individuals of the population in the planning area in the future. The use rate figure is determined by dividing the number of surgical cases in 2012 by the population in 2012. *See* AR 676. The accuracy of the need calculation is therefore dependent on the accuracy of the information reported by the facilities in the planning area regarding available operating rooms, surgeries, and surgery minutes.

Providence proposed four new operating rooms to be located at its Providence Medical Park Spokane Valley facility, 16528 East Desmit Court, Spokane Valley, Washington. In support of its CN application, Providence calculated need using the WAC 246-310-270(9) formula. Providence's calculations used information based on its count of five dedicated outpatient operating rooms and 69 remaining mixed use operating rooms in the Spokane planning area. Based on the number of surgeries and surgical minutes resulting from those operating rooms, Providence calculated that there was a need for 19.57 outpatient operating rooms by 2017 (the third year of the project). *See* AR 151-152. Providence therefore found that numeric need existed in support of its CN application.

2.3 Rockwood opposed the Providence CN application. Rockwood was unable to verify the accuracy of the Providence numeric need calculations. *See* AR 676; transcript (TR) 337-338 (J. Carona). The Program was also unable to verify the accuracy of Providence's numeric need calculations. *See* AR 676. The Program therefore performed its own numeric need calculations using information obtained from the ambulatory surgery facility utilization survey data and the Department of Health Integrated Licensing & Regulatory System (ILRS). *See* AR 676 and 694. The Program

determined that there were three dedicated outpatient operating rooms and 71 mixed use rooms available in the Spokane planning area. The 71 mixed use rooms included:

Hospital	**Number of Operating Rooms**
Deaconess Medical Center	18
Providence Holy Family	11
Providence Sacred Heart	34
Valley Hospital and Medical Center	6
Shriner's Hospital for Children	2
Total Operating Room Count	**71**

AR 675. The Program's numeric need calculations found a surplus of 3.08 operating rooms in the planning area in 2017 (the third year of the project). *See* AR 694. This surplus of operating rooms would ordinarily argue against awarding a CN to Providence for its proposed ambulatory surgery facility.

2.4 At the hearing, Providence disputed the Program's need calculations and attempted to clarify information in the Application Record.[8] Providence argued that the correct number of total mixed use operating rooms should be 67[9] and not 71 because four of the identified 71 operating rooms were dedicated and should be excluded pursuant to WAC 246-310-270(9)(a)(iv). *See* Providence's Post-Hearing

[8] A CN decision is based on a snapshot of facts that is data that existed during the application time frame. *See University of Washington Medical Center v. Washington State Department of Health*, 164 Wash.2d 95, 103-104 (2008).

[9] Contrary to its application which excluded the two operating rooms at Shriner's, Providence later argued that an additional two operating rooms should be excluded.

Brief, pages 19-25. Decreasing the number of mixed use operating rooms would increase the likelihood that need existed. Providence reached this number by:

A. Excluding two operating rooms from the total of 34 operating rooms identified at the Sacred Heart hospital; this reduced the total mixed operating room number from 71 to 69. Providence's Post-Hearing Brief, pages 21-22. Elaine Couture performed a physical count of the Sacred Heart hospital operating rooms, and two of the 34 operating rooms were dedicated to open heart surgery. *See* TR 68-70. Providence argues that this reduces the total number of operating rooms from 34 to 32.[10] Rockwood argues that Sacred Heart had already accounted for the dedicated open heart rooms and so the correct operating room count was 34 and not 32, based on Sacred Heart's reported information on its 2013 Survey form. *See* AR 449.

However, the Sacred Heart survey data indicates that the two dedicated open heart operating rooms were previously accounted for. *See* AR 377-378. In other words, Providence's surveys previously reported that Sacred Heart hospital had 34 "available" operating rooms and not 32 "available" operating rooms with two that were dedicated open heart operating rooms and thus "unavailable." *See* AR 377-378.

B. Providence further argued that the need calculation required a deduction of an additional two dedicated pediatric operating rooms at the Shriners Hospital for Children, which would reduce the total mixed operating room number from 69 to 67.

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[10] In past CN decisions, need calculations have consistently excluded dedicated open heart operating rooms from the available number of operating rooms in the planning area. TR 160 (K. Nidermayer); TR 225 (F. Fox); and TR 383 (J. Carona).

See Providence Post-Hearing Brief, pages 22-23. Shriners Hospital is an independent non-profit Spokane pediatric hospital with two operating rooms. These two operating rooms are used exclusively for pediatric patients and cannot be used for adult surgeries.

C. If the WAC 246-310-270(9) formula is calculated using 67 mixed use operating rooms instead of 71, Providence calculates there is a need for 18.68 additional operating rooms. *See* Exhibit PR-3.[11]

2.5 Assuming for the sake of argument that these four operating rooms could be excluded from the need calculation formula, Providence's need calculations contains the following calculation errors:

A. Providence excluded its two open heart dedicated operating rooms from the 34 total operating rooms at Sacred Heart hospital but failed to exclude the surgeries and surgery minutes for the two excluded operating rooms. This is inconsistent with the Department of Health's decade-long interpretation of WAC 246-310-270(9)(iv), which is contained in the survey form instructions. *See* AR 377; TR 194 (K. Nidermayer) and TR 404 (J. Carona). It is also inconsistent with Providence's own approach in its CN application calculation, where Providence excluded the minutes associated with excluded special purpose rooms. *See* TR 277 (F. Fox). Using the

[11] Providence also submitted another need calculation using cases from Deaconess Quarterly Reports rather than from its Provider Survey, which calculated a need for 18.68 operating rooms. PR-4. Providence's own expert admitted that there is nothing in the CN regulations to permit such an adjustment. TR 263 (F. Fox). The Presiding Officer does not give weight to these calculations given the absence of any CN regulations permitting such an adjustment.

surgical minutes associated with the cases will overstate the use rate, which will overstate the need for additional operating rooms. *See* TR 165 (K. Nidermayer).

B. Providence also excluded the two operating rooms from the Shriners Hospital in its need calculations because it believed that the Shriners operating rooms are special purpose rooms that can be excluded under WAC 246-310-270(9)(a)(iv). *See* TR 226 (F. Fox). Providence relies on an earlier CN order in support of this position, which ruled that dedicated pediatric operating rooms which could not be used for adult procedures were considered special purpose rooms under WAC 246-310-270(9)(a)(iv). *See Findings of Fact, Conclusions of Law, and Order on Remand, In Re Eastside Medical Group CN to Establish an Ambulatory Surgical Facility in Issaquah*, Master Case No. M2012-102 (March 27, 2013), at page 12; and *Findings of Fact, Conclusions of Law and Final Order, In Re Eastside Medical Group CN to Establish an Ambulatory Surgical Facility in Issaquah*, Master Case No. 2012-102 (July 23, 2013), at page 9.

2.6 The two Shriners operating rooms are not special purpose rooms that can be excluded from the calculation of the need formula. The operating rooms are not automatically special purpose rooms just because they only serve children. A room is not a special purpose room if it is used for different types of surgeries.[12]

[12] For example, an operating room that is used for open heart surgeries and other types of surgeries is not a special purpose room. Here the Eastside decision can be distinguished on the facts of the case. There the CN applicant did not propose to serve children or perform surgeries on children. *See* AR 15 and AR 673. Following the same logic, it is reasonable to include the two Shriner's operating rooms, and the surgeries performed in those operating rooms, in calculating numeric need here. Even if excluding the Shriner's operating rooms was the correct decision, Providence's numeric need calculations included the same error discussed above, namely that it excluded the two operating rooms but kept the surgeries and surgical minutes in the calculation.

2.7 The Review Officer finds there are three outpatient rooms and 71 mixed use rooms in the Spokane planning area. There is a surplus of 3.08 operating rooms using the WAC 246-310-210(9) numeric need formula. *See* AR 694-695 (attached as Appendix A to this decision). No numerical need exists in the Spokane planning district. Rockwood argues this should be the end of the need analysis.[13]

2.8 WAC 246-310-270(4) provides that outpatient operating rooms should *ordinarily* not be approved in the planning area where the total number of operating rooms available for both inpatient and outpatient operating rooms exceeds the area need. (Emphasis added). In other words, there may be circumstances where an applicant for an ambulatory surgical facility may still be approved despite the absence of numerical need. The applicant must then make the case why an exception should be made for its application.[14]

2.9 Spokane County is Washington's fourth largest populated county. *See* Exhibit PR-5. Other large counties (King, Pierce, and Snohomish) are divided into sub-county planning areas. Spokane County is a single planning area. *See* WAC 246-310-270(3). Of the largest nine counties in Washington, Spokane County is the only one without a CN-approved outpatient multi-specialty ambulatory surgical facility.[15] *See* TR 246-47 (Fox). One of the primary purposes of the certificate of need law is to reduce or control costs.[16] Performing surgeries in ambulatory surgical facilities is less expensive

[13] *See* Rockwood Reply Post-Hearing Brief, page 2.
[14] In all cases involving an application for a license the burden shall be on the applicant to establish that the application meets all applicable criteria. WAC 246-10-606(2).
[15] There is one CN approved ambulatory surgical facility (Rockwood Eye Surgery) in Spokane County but it is limited to eye surgery. AR 676, footnote 12.
[16] *See generally* RCW 70.38.015.

than performing surgeries in hospital or mixed use operating rooms. *See* Prehearing Order No. 9; *see also* AR 678. Staffing costs are higher in hospitals because hospitals operate on the 24-hours-a-day/seven-days-a-week schedule. *See* TR 74-75 (E. Couture) and TR 130-131 (S. O'Brien). These hospital fixed operating costs are therefore significantly higher than those in an outpatient ambulatory surgical setting. The planning area had no CN approved, multi-specialty ambulatory surgical facilities. *See* TR 163 (K. Nidermayer). This means individuals do not have the opportunity to obtain surgery in the less costly ambulatory surgical facility setting.

2.10 Additionally, the Center for Medicare and Medicaid Services reimbursement rates for surgeries performed at an ambulatory surgical facility are lower than the reimbursement rates for hospital-based surgeries. The reimbursement rate for outpatient surgeries in a free-standing ambulatory surgical facility was 56 percent of the hospital outpatient reimbursement rate for the same service. *See* AR 934; TR 75 (E. Couture).[17]

2.11 "Available and accessible" normally means the existence of numeric need, which means there are more individuals requiring surgery in operating rooms than there are operating rooms in which to complete the surgeries. Where there is need in a planning area for additional outpatient room capacity, preference shall be given to

[17] A comparison of the 2014 Medicare/Medicaid reimbursement rates demonstrates that the freestanding ambulatory surgical facility rate for every single outpatient procedure is lower than the corresponding hospital outpatient department rate. Many procedures are reimbursed at significantly lower rates when a procedure is performed in a freestanding ambulatory surgical facility. AR 1323-1224; AR 678. Finally, the Application Record contains public comments from payers that emphasize the cost advantages of surgeries performed at ambulatory surgical facilities over surgeries performed at hospitals. AR 341, 342, and 347. Patients can pay significantly less out-of-pocket expenses when their care is provided at a lower cost setting. TR 80-81 (E. Couture). At least one study provides that patient-borne costs may be $363 to $1,000 less per procedure when surgeries are performed in a freestanding setting rather than a hospital setting. AR 1264-1266.

outpatient operating rooms. *See* WAC 246-310-270(5). If WAC 246-310-270(4) is to mean anything, it must be read that even when there are a sufficient number of operating rooms in the planning area, circumstances may exist which justify the approval of additional operating rooms despite the sufficient number of operating rooms.[18] Thus, there are circumstances where it is appropriate to grant an application for a multi-specialty ambulatory surgical facility even though there are hospital operating rooms available. Given the size of the Spokane planning area, the total absence of a multi-specialty ambulatory surgical facility and the opportunity to provide a lower cost surgical alternative, such extraordinary circumstances exist here. That is especially true given that lower costs promote and maintain access to healthcare services for all citizens, including underserved groups, the elderly, and others identified in WAC 246-310-210(2). *See Overlake Hospital Association v. Department of Health*, 170 Wash. 2d 43, 55 (2010); *see also* TR 19 (K. Nidermayer) (Access to services is something that is seen throughout the numeric need methodology). Evidence shows the situation in the Spokane planning area is not "ordinary" and Providence meets the WAC 246-310-210(1) need requirement.

2.12 The WAC 246-310-210(2) criterion focuses on whether all residents of the service area, including low-income, racial and ethnic minorities, women, handicapped persons, other underserved groups, and the elderly will have adequate access to the proposed project. A review of Providence's admission policies, charity care policies, and Medicare eligibility certifications and policies shows that Providence will accept patients

[18] In any event, the Review Officer cannot declare any rule invalid. WAC 246-10-602(3)(c).

for outpatient surgeries without regard for age, race, color, ethnicity, sex or sexual orientation, religious or political beliefs, medical diseases, disorders or disability.

2.13 Based on the evidence in this matter, Providence's application meets the need criteria under WAC 246-310-210.

WAC 246-310-220 "Financial Feasibility"

2.14 Pursuant to WAC 246-310-220, an applicant for a CN must demonstrate that the proposed project is financially feasible. The CN applicant must show that: the capital and operating costs can be met under WAC 246-310-220(1); the costs of the project will probably not result in an unreasonable impact on the costs for health services under WAC 246-310-220); and that the applicant can appropriately finance the proposed project under WAC 246-310-220(3).

2.15 To prove that its application meets the WAC 246-310-220(1) criteria, Providence is required to show that its project meets the immediate and long-range capital costs. Providence provided information showing its assumptions regarding the number of surgical cases by type. *See* AR 28, and 681-682. Providence also provided the assumptions it used to project revenue, expenses, and net income for the ambulatory surgical facility. *See* AR 682-683. Providence anticipated it would experience a net profit in 2015, 2016, and 2017 (the third year of operation). *See* AR 683. According to the balance sheet it provided, Providence's proposed ambulatory surgical facility would be operated with little liabilities and financial stability. *See* AR

684. The Providence project can meet its immediate and long-range operating costs as required under WAC 246-310-220(1).

2.16 To prove that its application meets the WAC 246-310-220(2) criteria, Providence is required to show that its project, including any construction costs, will probably not result in an unreasonable impact on the costs and charges for health services. Providence provided that its ambulatory surgical facility will be located within a larger building known as the Providence Medical Park. The ambulatory surgical facility project will occupy approximately 10 percent of the building. Groundbreaking for the Providence Medical Park took place in 2012, and was constructed at a cost of $44,000,000. The ambulatory surgical facility will occupy approximately 20 percent of the Medical Park, so the apportioned cost will be $8,400,000. The apportioned cost for the project includes such items as construction cost; fixed equipment; moveable equipment; land purchase and improvements; and fees, taxes, and interim interest. *See* AR 34 and 685.

2.17 Providence also provided a projected payer mix for the ambulatory surgical facility. The proposed payer mix:

Table 9
Projected Payer Mix

Payer Source	Percentages
Medicare	23.7%
Medicaid	27.3%
Commercial	35.1%
Other Insurance	13.9%
Total	**100.0%**

See AR 685. Based on the information provided by Providence in its application, its project (including construction costs) meets the WAC 246-310-220(2) criteria and will probably not result in an unreasonable impact on the costs and charges for health services.[19]

2.18 To prove that its application meets the WAC 246-310-220(3) criteria, Providence is required to show that the project can be appropriately financed. In 2012, Providence purchased the land for the larger Providence Medical Park project using unrestricted cash reserves. The remaining costs for the ambulatory surgical facility ($7,987,670) were financed through taxable bonds in 2012. *See* AR 686. Providence supplied copies of its consolidated financial statements (including the independent auditors' reports for 2010, 2011, and 2012) in support of its application. *See* AR 213-255. Based on the information provided, Providence can appropriately finance its project as required under WAC 246-310-220(3).

WAC 246-310-230 "Structure and Process of Care"

2.19 There are five criteria that an applicant must meet for the project to qualify under WAC 246-310-230. These criteria include: adequate staffing; appropriate organizational structure and support; conformity with licensing requirements; continuity of healthcare; and the provision of safe and adequate care.

2.20 WAC 246-310-230(1) requires a sufficient supply of qualified staff (both management and health personnel) are available or can be recruited. Providence

[19] Rockwood argues that Providence does not meet the financial feasibility and cost containment criteria. *See* Rockwood's Post-Hearing Brief, pages 23-24. Given the Presiding Officer's ruling in Prehearing Order No. 9, the Review Officer will disregard this portion of the Post-Hearing Brief.

has a very large presence in Spokane County and employs a large number of general and specialty care providers. *See* AR 687. Because of its presence in the community, Providence has the ability to float selected administrative, clerical, and technical staff as needed. It can offer an attractive work environment and hours, which will attract qualified candidates. *See* AR 687. Based on the information provided, Providence can recruit or obtain a sufficient supply of qualified staff for its ambulatory surgical facility and meet the WAC 246-310-230(1) criteria.

2.21 WAC 246-310-230(2) requires that the proposed services will have an appropriate relationship to ancillary and support services. As an existing provider in the Spokane planning area, Providence has an existing relationship with ancillary and support services for its healthcare facility. As the ambulatory surgical facility will be located on the second floor of the Providence Medical Park, patients will have access to a variety of services. The services include urgent care, primary and specialty care physician offices, an imaging center, laboratory services, and a pharmacy. Based on the information provided in its application, Providence will have an appropriate relationship to ancillary and support services as required under WAC 246-310-230(2).

2.22 WAC 246-310-230(3) requires that there is reasonable assurance that the project will conform with applicable state licensing requirements and, if the applicant is or plans to be certified under the Medicare or Medicaid programs, that the applicant will meet the applicable conditions of participation related to those programs. Providence is a long-time provider of healthcare services in the state of Washington. It also owns or manages a total of 26 acute care or critical access

hospitals in Alaska, California, Montana, Oregon, and Washington. *See* AR 688. A review of the Joint Commission[20] website reveals that 24 of Providence's 26 hospitals received a score demonstrating a performance similar to, or above, the Joint Commission target range. *See* AR 689. Given the compliance history of the majority of Providence's healthcare facilities, there is a reasonable assurance that Providence's ambulatory surgical facility will conform with the applicable state licensing requirements and will conform with Medicare or Medicaid program requirements as required under WAC 246-310-230(3).

2.23 WAC 246-310-230(4) requires that the proposed project will: promote continuity of care; not result in the unwarranted fragmentation of services; and have an appropriate relationship to the service area's existing healthcare system. Providence's ambulatory surgical facility project will be a part of Providence Medical Park. As stated above, the Medical Park contains a variety of services, including urgent care, primary and specialty care physician offices, an imaging center, laboratory services, and a pharmacy on site, which will reduce patient travel time and costs. As a part of the larger facility, Providence's ambulatory surgical facility will be part of the electronic health record system. This will allow for an expedient system of communicating relevant medical information among providers, which will allow for coordination of care and improved clinical outcomes. Based on the information provided, Providence's proposed project will promote continuity of care and have an

[20] The Joint Commission's accreditation and certificate is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. AR 689, footnote 21.

appropriate relationship to the Spokane planning area's existing health care system. Providence meets the WAC 246-310-230(4) criteria.

2.24 WAC 246-310-230(5) requires that an applicant provide reasonable assurances that the services provided will be done in a manner that ensures safe and adequate care to the public, and in accordance with federal and state laws, rules, and regulations. As the evidence shows that Providence's application complies with the criteria under WAC 246-310-230(3) above, the same evidence supports a finding showing that Providence meets the WAC 246-310-230(5) criterion.

WAC 246-310-240 "Cost Containment"

2.25 The final criteria for CN applications are set forth in WAC 246-310-240. There are three sub-criteria: are there superior alternatives in terms of cost, efficiency, or effectiveness (WAC 246-310-240(1); what are the costs of projects involving construction (WAC 246-310-240(2); and does the project involve improvements or innovations in the financing or delivery of health services (WAC 246-310-240(3).[21]

2.26 WAC 246-310-240(1) addresses the superiority analysis criteria. However, a word needs to be said about "superiority." In order to make CN decisions in a logical and consistent manner, the law allows the use of certain legal fictions.[22] Legal Fiction No. 1: a CN decision is only based on a snapshot of facts, which is information and data that are available within a specified time period. *See University*

[21] Rockwood argues that Providence's application fails to satisfy the cost contain criteria in WAC 246-310-240. *See* Rockwood's Post-Hearing Brief, page 24. Given the Presiding Officer's ruling in Prehearing Order No. 9, the Review Officer will disregard this portion of Rockwood's Post-Hearing Brief.

[22] As used here, "legal fiction" is simply an assumption of facts used as a basis for deciding a legal question necessary to dispose of the matter.

of Washington Medical Center v. Department of Health, 164 Wash. 2d 95, 103-104 (2008). The relevant time period includes the timeframe of the application period, through the public comment period, to when the application is closed. This rule is absolutely vital to the managing of the CN process. There is always more up-to-date data. If the application record remained open to capture the most up-to-date data, there would never be a CN application decision because there is always more recent data available. There must therefore be a cutoff date or endpoint beyond which more data will not be considered.

2.27 Legal Fiction No. 2: Each planning area is an island unto itself. In order to make a CN decision on the available data, one must assume that no prospective patient who resides in the planning area will leave the planning area to seek treatment in a different planning area. Likewise, it is assumed that no prospective patient from another planning area will come into this planning area to seek treatment.

2.28 As counterintuitive as these two legal fictions appear to be, they actually create a more statistically reliable result. The alternative would be to speculate on patient migration, on a mile-by-mile basis, radiating out from every proposed location or facility. There is no detailed or accurate data to support such a speculation.

2.29 The above legal fictions are counterbalanced by the "superiority alternative" test of RCW 34.05.240(1), which provides a framework to apply practical human discernment to the analysis. As an example, while geographical location does not matter in the legal fiction, a proposed project that is extremely difficult to reach

would not be superior in terms of travel, cost, or efficiency of the delivery of treatment. Similarly, a proposed project that was extremely easy to reach but could not provide cost-effective or efficient delivery of treatment might lose the superiority test to a project that was slightly more inconvenient to reach, but provided cost-effective or efficient healthcare. A superiority determination under WAC 246-310-240(1) examines the totality of factors for each application. This includes a consideration of the WAC 246-310-240(2) and (3) criteria to determine if any factor regarding construction costs or innovations in healthcare delivery might cause one project to be superior to the other.

2.30 In addition to establishing an ambulatory surgical facility, Providence considered two other options: do nothing; and expand hospital-based operating room capacity at a site off campus. *See* AR 691.

A. Providence disregarded the "do nothing" option, given that it found that numeric need existed for additional operating rooms as a part of its application. Doing nothing would not address their belief there is a shortage of outpatient operating rooms in the Spokane planning area.

B. Providence also disregarded the option of expansion by establishing the hospital-based operating room off site. This option would address the need for additional operating rooms but at a higher cost. This is because the facility would be licensed under the hospital license, which would require building the facility in compliance with hospital licensure codes. Using this option required the submission of a CN application.

2.31 As discussed in Paragraph 2.12 above, allowing Providence to establish an ambulatory surgical facility meets two goals sought in CN applications, specifically decreased healthcare costs and increased access to individuals in the Spokane planning area. Providence's project will meet the first goal by providing less costly outpatient surgery. It meets the second goal by increasing access to individuals in the Spokane planning area. Providence meets the criteria under WAC 246-310-240(1).

2.32 WAC 246-310-240(2) states:

> In the case of a project involving construction: (a) the costs, scope, and methods of construction and energy are reasonable; and (b) the project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.

The WAC 246-310-240(2)(a) sub-criterion can be evaluated using the WAC 246-310-220(2) criteria. By meeting the WAC 246-310-220(2) criteria, Providence's ambulatory surgical facility project also meets the WAC 246-310-240(2)(a) sub-criterion here. *See* AR 691. Meeting the WAC 246-310-220(2) criterion shows that Providence's project will also meet the WAC 246-310-240(2)(b) sub-criterion as well.

2.33 WAC 246-310-240(3) states:

> The project will involve appropriate improvements or innovations in the financing and delivery of health services which foster cost containment and which promote quality assurance and cost effectiveness.

Providence's ambulatory surgical facility project has the potential to improve the delivery of outpatient services. *See* AR 692. It does so by providing the opportunity for decreased healthcare costs by delivering outpatient surgeries at a lower cost than the same procedures offered in a hospital setting. It promotes quality assurance by

improving patient access to surgeries. Providence meets the WAC 246-310-240(3) criteria.

III. CONCLUSIONS OF LAW

3.1 The Department of Health is authorized and directed to implement the Certificate of Need Program. RCW 70.38.105.

3.2 The Secretary is authorized to designate a Review Officer to review initial orders and to enter final orders. RCW 43.70.740.

3.3 Rockwood's Petition for Administrative Review was timely filed. WAC 246-10-701.

3.4 In acting as the Department's final decision maker, the Review Officer reviewed the entire file including the application record, hearing transcripts and closing briefs submitted by the parties pursuant to RCW 34.05.461(7). The Review Officer also reviewed the Petition and responses thereto. The Review Office applied the standards found in WAC 246-310-200 through 246-310-240 in evaluating Providence's application.

3.5 An applicant for a CN must show or establish that its application meets all of the applicable criteria. *See* WAC 246-10-606. The Program issues a written analysis which grants or denies the CN application. The written analysis must contain sufficient evidence to support the Program's decision. *See* WAC 246-310-200(2)(a). Admissible evidence in CN hearings is the kind of evidence on which

reasonably prudent persons are accustomed to rely in the conduct of their affairs. *See* RCW 34.05.452(1). The standard of proof is preponderance of the evidence. *See* WAC 246-10-606.

3.6 WAC 246-310-200 sets forth the "bases for findings and actions" in evaluating a CN application, to wit:

> (1) The findings of the department's review of certificate of need applications and the action of the secretary's designee on such applications shall, with the exceptions provided for in WAC 246-310-470 and 246-310-480 be based on determinations as to:
>
> (a) Whether the proposed project is needed;
>
> (b) Whether the proposed project will foster containment of the costs of health care;
>
> (c) Whether the proposed project is financially feasible; and
>
> (d) Whether the proposed project will meet the criteria for structure and process of care identified in WAC 246-310-230.
>
> (2) Criteria contained in this section and in WAC 246-310-210, 246-310-220, 246-310-230, and 246-310-240 shall be used by the department in making the required determinations.

3.7 WAC 246-310-210[23] defines the "determination of need" in evaluating a CN application, to wit:

> The determination of need for any project shall be based on the following criteria, except these criteria will not justify exceeding the limitation on increases of nursing home beds provided in WAC 246-310-810.

[23] WAC 246-310-210 (3), (4), (5), and (6) were not relevant to the Providence project and were not considered for that reason.

(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 assessment of the conformance of a project with this criterion shall include, but need not be limited to, consideration of the following:

(b) In the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities similar to those proposed;

(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. The assessment of the conformance of a project with this criterion shall include, but not be limited to, consideration as to whether the proposed services makes a contribution toward meeting the health-related needs of members of medically underserved groups which have traditionally experienced difficulties in obtaining equal access to health services, particularly those needs identified in the applicable regional health plan, annual implementation plan, and state health plan as deserving of priority. Such consideration shall include an assessment of the following:

(a) The extent to which medically underserved populations currently use the applicant's services in comparison to the percentage of the population in the applicant's service area which is medically underserved, and the extent to which medically underserved populations are expected to use the proposed services if approved;

(b) The past performance of the applicant in meeting obligations, if any, under any applicable federal regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal financial assistance including the existence of any unresolved civil rights access complaints against the applicant);

(c) The extent to which Medicare, Medicaid, and medically indigent patients are served by the applicant; and

(d) The extent to which the applicant offers a range of means by which a person will have access to its services (e.g., outpatient services, admission by house staff, admission

3.8 Rockwood argues that another criterion of WAC 246-310-210(1) requires a determination whether other providers are not sufficiently available or accessible to meet the need for surgical services.[24]

3.9 Since the numeric need methodology shows no numeric need, Rockwood argues this must mean the existing providers are sufficiently available and accessible to meet Spokane planning area surgical services.[25] The Program did not analyze whether existing providers were sufficiently available or accessible to meet the need for surgical services. *See* TR 198 (K. Nidermayer). Neither did Providence. *See* TR 351-352 (J. Carona).[26] There appears to be some amount of idle operating room capacity in the Spokane planning area, given the utilization rate (the amount of time the operating rooms are being used) is 73 percent. *See* TR 349 (J. Carona).

3.10 "Available and accessible" normally means the existence of numeric need, which means there are more individuals requiring surgery in operating rooms than there are operating rooms in which to complete the surgeries. Where there is need in a planning area for additional outpatient room capacity, preference shall be given to outpatient operating rooms. WAC 246-310-270(5). The plain meaning of

[24] *See* Rockwood's Post-Hearing Brief, pages 17-19.
[25] *See* Rockwood's Post-Hearing Brief, page 18, footnote 21.
[26] Providence did address this issue in its reply brief. *See* Providence's Post-Hearing Reply Brief, pages 13-15.

WAC 246-310-270(4) is that even when there are a sufficient number of operating rooms in the planning area, circumstances may exist which allow for the approval of additional operating rooms despite a sufficient number of existing operating rooms.[27] Thus, there may be circumstances where it is appropriate to grant an application for a multi-specialty ambulatory surgical facility even though there are hospital operating rooms available. Given the size of the Spokane planning area, the total absence of a multi-specialty ambulatory surgical facility and the opportunity to provide a lower cost surgical alternative, such need exists here. That is especially true given that lower costs improve access for individuals of the type identified in WAC 246-310-210(2). *See Overlake Hospital Association v. Department of Health*, 170 Wash. 2d 43, 55 (2010); *see also* TR 19 (K. Nidermayer) (Access to services is something that is seen throughout the numeric need methodology). There is sufficient evidence to show the situation in the Spokane planning area is not "ordinary" and Providence meets the WAC 246-310-210(1) need requirement.

3.11 WAC 246-310-220 sets forth the "determination of financial feasibility" criteria to be considered in evaluating a CN application, to wit:

> The determination of financial feasibility of a project shall be based on the following criteria.
>
> (1) The immediate and long-range capital and operating costs of the project can be met.
>
> (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.

[27] The Review Officer may not declare any rule invalid. WAC 246-10-602(3) (c).

(3) The project can be appropriately financed.

3.12 WAC 246-310-230 sets forth the "criteria for structure and process of care" to be used in evaluating a CN application, to wit:

> A determination that a project fosters an acceptable or improved quality of healthcare shall be based on the following criteria.
>
> (1) A sufficient supply of qualified staff for the project, including both health personnel and management personnel, are available or can be recruited.
>
> (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.
>
> (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.
>
> (4) The proposed project will promote continuity in the provision of healthcare, not result in an unwarranted fragmentation of services, and have an appropriate relationship to the service area's existing healthcare system.
>
> (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. The assessment of the conformance of a project to this criterion shall include but not be limited to consideration as to whether:
>
> (a) The applicant or licensee has no history, in this state or elsewhere, of a criminal conviction which is reasonably related to the applicant's competency to exercise responsibility for the ownership or operation of a healthcare facility, a denial or revocation of a license to operate a healthcare facility, a revocation of a license to practice a health profession, or a decertification as a provider of services in the Medicare or Medicaid program because of failure to comply with applicable federal conditions of participation; or

(b) If the applicant or licensee has such a history, whether the applicant has affirmatively established to the department's satisfaction by clear, cogent and convincing evidence that the applicant can and will operate the proposed project for which the certificate of need is sought in a manner that ensures safe and adequate care to the public to be served and conforms to applicable federal and state requirements.

3.13 WAC 246-310-240 sets forth the "determination of cost containment" criteria to be used in evaluating a CN application, to wit:

A determination that a proposed project will foster cost containment shall be based on the following criteria:

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

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

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

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

(3) The project will involve appropriate improvements or innovations in the financing and delivery of health services which foster cost containment and which promote quality assurance and cost effectiveness.

3.14 Based on the above Findings of Fact and Conclusions of Law, the Review Officer determines that Providence has met its burden of proof and grants Providence's CN application.

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IV. FINAL ORDER

Based on the foregoing, IT IS HEREBY ORDERED Providence's CN application to establish an ambulatory surgical facility in the Spokane planning area is GRANTED.

Dated this 23rd day of August, 2016

JOHN WIESMAN, DrPH, MPH
SECRETARY OF HEALTH

By KRISTI WEEKS
REVIEW OFFICER

NOTICE TO PARTIES

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

Adjudicative Clerk Office
Adjudicative Service Unit
PO Box 47879
Olympia, WA 98504-7879

A copy must be sent to the other parties. If sending a copy to the Assistant Attorney General in this case, the mailing address is:

Agriculture and Health Division
Office of the Attorney General
P.O. Box 40109
Olympia, WA 98504-0109

The petition must state the specific grounds upon which reconsideration is requested and the relief requested. WAC 246-10-704. The petition for reconsideration is considered denied twenty (20) days after the petition is filed if the Adjudicative Clerk Office has not responded to the petition or served written notice of the date by which action will be taken on the petition.

A petition for judicial review must be filed and served within thirty (30) days after service of this Order. RCW 34.05.542. The procedures are identified in chapter 34.05 RCW, Part V, Judicial Review and Civil Enforcement. A petition for reconsideration is not required before seeking judicial review. If a petition for reconsideration is filed, the thirty (30) day period for requesting judicial review does not start until the petition is resolved. RCW 34.05.470(3).

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

Final orders are public documents, and may be placed on the Department of Health's website and otherwise released as required by the Public Records Act, chapter 42.56 RCW.