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SUPREME COURT OF THE STATE OF WASHINGTON

WASHINGTON STATE HOSPITAL ASSOCIATION,

Respondent,

v.

WASHINGTON STATE DEPARTMENT OF HEALTH,

Appellant.

**CORRECTED BRIEF OF AMICI CURIAE WASHINGTON STATE
NURSES ASSOCIATION, UFCW 21, AND SEIU HEALTHCARE
1199NW**

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ORIGINAL

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IDENTITIES AND INTERESTS OF AMICI

Amici are three health care unions whose familiarity with the issues presented by this case arises from representing thousands of registered nurses (“RNs”) and other hospital workers in Washington State.

Founded in 1908, the Washington State Nurses Association (“WSNA”) is a statewide professional association and labor organization which seeks to provide leadership for the nursing profession and promotes quality health care for consumers through education, advocacy, and influencing health care policy in Washington, while advancing nurses’ economic and general welfare.¹ WSNA represents 16,000 RNs at Washington hospitals and health care facilities for collective bargaining, and all Washington RNs as a professional advancement association.²

SEIU Healthcare 1199NW, founded in 1983, represents 26,000 nurses, hospital staff, and behavioral health workers across Washington.³ SEIU Healthcare 1199NW’s mission is to unite health care workers to improve health care jobs and the care workers can provide to their patients. It has a history of advocating for improvements in quality care,

¹ See WASHINGTON STATE NURSES ASSOCIATION, Vision, Mission & Goals, <http://www.wsna.org/About/Vision-Mission-Goals/> (last visited May 6, 2015)

² See WASHINGTON STATE NURSES ASSOCIATION, About WSNA, <http://www.wsna.org/About/> (last visited May 6, 2015).

³ See SEIU HEALTHCARE 1199NW, Who is SEIU Healthcare 1199NW? <http://www.seiu1199nw.org/about/> (last visited May 6, 2015).

including the safe lifting law, Medicaid expansion, and funding for behavioral health programs and services.

UFCW 21 is the largest private-sector labor union in Washington, with 45,000 members.⁴ All UFCW 21 members use health care, but 17,000 are employed in the health care industry including many in hospitals impacted by current or proposed mergers and affiliations.

Like the members of WSNA and SEIU Healthcare 1199NW, the members of UFCW 21 value the certificate of need process as an important tool for maintaining accountability of health care institutions to the communities in which they are located, and believe that market consolidation has significant, potentially negative effects meriting scrutiny by the public, health care providers, and government regulators. Further, UFCW 21, WSNA, and SEIU Healthcare 1199NW have each, separately and in coalition with others, submitted comments regarding the certificate of need regulations at issue in this case and proposed and pending change of control transactions.⁵

⁴ See UFCW 21, Who We Are, <http://www.ufcw21.org/who-we-are/> (last visited May 6, 2015).

⁵ See, e.g., Letter from Sarah Cherin, Political and Policy Director, UFCW 21 to Janis Sigman, Program Manager, Washington State Department of Health (July 30, 2013); Letter from Sarah Cherin, Political and Policy Director, UFCW 21 to Janis Sigman, Program Manager, Washington State Department of Health (August 8, 2013); Sofia Aragon, "Challenges Ahead for the 2015 Legislative Session," 44 THE WASHINGTON NURSE, at 8 (2014), available at <http://www.wsna.org/washington-nurse/documents/wn1404.pdf>.

Amici submit this memorandum because the superior court's ruling below interferes with the Washington State Department of Health ("DOH")'s statutory duty to implement a statewide health care resources strategy. The decision does so by permitting hospitals to shield certain change of control transactions from the State's certificate of need process—a primary tool in the development of a statewide health care strategy—merely by using labels for the transactions that are inconsistent with the ones in the certificate of need statute, RCW 70.38.105(b).

Amici support statewide health planning because an informed and comprehensive plan helps ensure health care services are available in every community. By permitting hospitals seeking consolidation to avoid the certificate of need process, nurses, technicians, and other health care workers are harmed because they and the public cannot provide information to state regulators regarding the impact of a proposed consolidation. When adequate services are not available in a community, it is the nurses and providers on the frontline of health care service who continue to be responsible to their patients.

An effective certificate of need process helps ensure Washington's health care resources are available when and where they are needed, and that the community and providers have a voice in how health care resources are managed. As the DOH's new rule furthers this statutory

purpose, the decision below invalidating that rule should be overruled.

STATEMENT OF THE CASE

Amici adopt the assignments of error, issues related to the assignments of error, and the statement of the case as set forth on pages 3–12 of the DOH’s Brief of Appellant.

ARGUMENT

I. THE SUPERIOR COURT DECISION THREATENS THE ABILITY OF THE DOH TO REGULATE HOSPITALS AT A TIME WHEN HOSPITALS ARE RAPIDLY CHANGING HANDS AND A FEW SYSTEMS ARE TAKING CONTROL.

A. Hospitals Play An Important Role In Washington Communities.

Washington is home to more than 100 hospitals. Many were created by a public hospital district, authorized by RCW 70.44. Nearly all of Washington’s hospitals are controlled by a government or a non-profit and operate in the public’s interest, receiving help in the form of donations, tax breaks, government grants, and loans.⁶

In 1945, the Washington legislature created a statutory procedure for communities to establish public hospital districts. RCW 70.44. At the same time, the federal government had begun to subsidize the construction

⁶ See Holly Herman and Lissa Bell, Northwest Federation of Community Organizations, *A Debt Unpaid: Nonprofit Hospitals Fail in Their Community Benefits Mission* (1999), available at http://allianceforajustsociety.org/wp-content/uploads/2010/04/1999-1201_A-Debt-Unpaid.pdf.

of hospitals with the passage of the Hill Burton Act. 42 U.S.C. §§ 291 *et seq.* (1946). Later, the expansion of the private insurance market, followed by the Medicare and Medicaid programs in the sixties, lead to an increase of patients with the ability to pay and bed capacity soon began to expand. Furthermore, improvements in nineteenth-century health care advancements like anesthesia, aseptic surgery, and new drug therapies intensified the trend towards a greater role of hospitals and professional nursing care in people's lives.⁷

Escalating health care costs, due in part to new life-saving technologies, the third-party payer system, and an increased investment in health care, led to regulatory and reform efforts. Academics observed that hospitals were unique when compared with other service providers in that the more patient beds built, the more patients that would fill them.⁸ *See also, St. Joseph Hosp. & Health Care Ctr.*, 125 Wn.2d 733, 741, 887 P.2d 891 (1995) (noting that “the United States Congress and our Legislature made the judgment that competition had a tendency to drive health care costs up rather than down”). As explained in greater detail at pages 14-15,

⁷ *See generally* Barbara Mann Wall, Ph.D, *History of Hospitals*, available at <http://www.nursing.upenn.edu/nhhc/Pages/History%20of%20Hospitals.aspx>.

⁸ *See* Paul L. Delameter, et al., *Do More Hospital Beds Lead to Higher Hospitalization Rates? A Spatial Examination of Roemer's Law*, PLOS ONE 8(2) (2013), available at <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0054900> (“Roemer's Law defines a positive relationship between the availability of hospital beds and the use of hospital services.”).

Washington implemented a statewide health resource planning strategy to address these concerns in 1979. *Id* at 735. Now, “[u]nder Washington law, certain medical services can be offered only by holders of a certificate of need issued by the Washington State Department of Health.” *Univ. of Washington Med. Ctr. v. Washington State Dep’t. of Health*, 164 Wn.2d 95, 99, 187 P.3d 243 (2008) (internal quotation omitted).

Today, Washington hospitals are often among the largest employers in their communities, employing more than 100,000 workers across the state—with many earning middle class wages and protected by union contracts—and generating significant economic benefit through “ripple effects” in other health care-related businesses.⁹ Decisions made by hospital administrators impact the attraction and retention of health care providers, the specialized services the hospital will provide, the equipment to be purchased, whether teaching opportunities will be available, which local community activities receive support, to what degree the hospital will fulfill its charity care obligations, and many other decisions. A change of control transaction potentially affects all of these decisions to some degree, often with substantial economic impact.

B. A Change In Control Of A Hospital Can Result In

⁹ See American Hospital Association, *Economic Contribution of Hospitals Often Overlooked* (2011), available at <http://www.aha.org/research/reports/13econimpact.shtml>.

Significant Changes In Employment, Health Care Services, And The Cost Of Health Care.

1. Changes in working conditions.

Washington communities have faced major impacts when hospitals change control. For example, during the time when CHI Franciscan Health was transitioning into control of Harrison Medical Center in Bremerton in 2013, the employer's bargaining committee sought to undermine the contract rights earned over several decades by the UFCW 21-represented workers there.¹⁰ They demanded a one-year, rather than the traditional three-year, collective bargaining agreement; a new policy limiting how workers could collectively address disputes with management; and an end to the health plan covering the UFCW 21 workers. These demands prompted the workers to overwhelmingly authorize a one-day strike.¹¹

While UFCW 21 and CHI Franciscan Health were eventually able to reach an agreement, the once cooperative relationship between union and management was damaged due to the hospital's newly "aggressive and combative approach in bargaining."¹² Although the change of control had major impact on the working conditions of the health care providers,

¹⁰ Kevan Moore, "Harrison workers authorize one-day strike," Bremerton Patriot, available at <http://www.bremertonpatriot.com/news/262735411.html#>.

¹¹ *Id.*

¹² *Id.*

there was no certificate of need review or opportunity for public comment because CHI Franciscan labeled the transaction an “affiliation.”¹³

2. Changes in services provided.

Similarly, when CHI Franciscan Health assumed control of Highline Medical Center in 2013, an approximately 269-bed hospital in King County, this new operator imposed new restrictions on patient care. However, because CHI Franciscan described the consolidation as an “affiliation,” the DOH determined on December 28, 2012, that the takeover was not subject to certificate need review or approval.

Specific procedures and treatments are now prohibited at both Highline and Harrison, including artificial fertilization for infertile women, abortion, prenatal diagnosis in certain cases, contraception, sterilization, and euthanasia.¹⁴ However, there was no public review of the consolidation or any opportunity for nurses, other health care providers, patients, or members of the affected communities to comment on these changes. Nurses are now prohibited from discussing certain end-of-life and reproductive health care procedures unless first prompted by the

¹³ Letter from Sarah Cherin, Political and Policy Director, UFCW 21 to Janis Sigman, Program Manager, Washington State Department of Health (July 30, 2013).

¹⁴ See United States Conference of Catholic Bishops, *Ethical Religious Directives Catholic Health Care Services*, 5th ed. (2009), available at <http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf>.

patient, who may not even be aware of the medical options.¹⁵

3. Increased prices for health care.

In addition to impacting the services available for the community and working conditions of health care providers, consolidations can also result in higher prices for patients. In a meta-analysis of hospital consolidation studies conducted by the Robert Wood Johnson Foundation, report authors found that “hospital mergers in concentrated markets generally lead to significant price increases.”¹⁶ Where hospitals mergers result in a concentrated market, the “magnitude of price increases...is typically quite large, most exceeding 20 percent.”¹⁷ A 2014 study confirmed the connection between consolidations and higher prices.¹⁸

As Washington’s Attorney General explained in an amicus brief filed along with other states in support of the Federal Trade Commission challenge of an Idaho hospital consolidation:

¹⁵ See, e.g., “Overview: Restrictions On Health Care At Religiously Affiliated Medical Facilities,” ACLU of Washington State, *available at* <https://aclu-wa.org/overview-restrictions-health-care-religiously-affiliated-medical-facilities>.

¹⁶ See Martin Gaynor, Ph.D and Robert Town, Ph.D, Robert Wood Johnson Foundation, *The Impact of Hospital Consolidation-Update* at 2 (2012), *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261.

¹⁷ *Id.*

¹⁸ See Paul B. Ginsburg and L. Gregory Pawlson, *Seeking Lower Prices Where Providers Are Consolidated: An Examination Of Market And Policy Strategies*, 33 HEALTH AFFAIRS 1067 (2014), *available at* <http://content.healthaffairs.org/content/early/2014/05/13/hlthaff.2013.0810.full.html> (“The ongoing consolidation between and among hospitals and physicians tends to raise prices for health care services, which poses increasing challenges for private purchasers and payers”).

We have seen the growth of large health care systems through the systematic acquisition of hospitals and physician groups, and experienced the effects of the systems' increased bargaining power in negotiations with insurers on the terms of their inclusion in the insurance plan networks offered to employers in our States...These developments have all led to higher prices for insurers, resulting in consumers paying higher premiums, deductible and co-pays.

Although the vast majority of health care provider acquisitions have gone unchallenged to date for various reasons, we have come to see how large health care providers can acquire market power and successfully impose price increases on payors without risking significant patient defection to markets located farther away...

A key component of this escalation of costs has been the growth of large health care provider systems with market power, leading to higher prices...

Brief of *Amicus Curiae* the States of California, et al., at 2, 5–6, 10–11, *St. Luke's Health Care Sys. v. FTC*, (No. 14-35173) (9th Cir. 2014).¹⁹

All of these impacts—new working conditions for a major workforce, changes in health care services available for patients, higher prices, and potential changes in the hospitals' prior commitment to community support and charity care—are possible when a hospital changes hands. The certificate of need regulatory process allows the DOH

¹⁹ On February 10, 2015, the Ninth Circuit upheld the U.S. District Court in the District of Idaho's decision that St. Luke's Health System acquisition violated Section 7 of the Clayton Act and ordered St. Luke's, which operates Boise, Idaho's main hospital, to fully divest itself of the physician group it had acquired. *St. Alphonsus Med. Ctr. v. St. Luke's Health Sys. Ltd.*, 778 F.3d 775 (2015).

to examine these potential impacts and take public comment from community members and health care providers before allowing a change. If the process is not triggered because a hospital re-labels a change of control transaction, there is no way to evaluate the impact of the consolidation. Without the certificate of need process, transfer of control to an out-of-state interest or for-profit corporation leaves the affected community with no opportunity to comment on the possible impact.

C. Transactions Resulting In A Change In Control Of A Hospital Are On The Rise, Making Public Oversight More Important Than Ever.

While the push towards consolidations has been strong since the nineties, the incentives in the Affordable Care Act have resulted in a dramatic uptick of consolidations of hospitals as they try to improve their bargaining leverage with insurers.²⁰ Nationally, in 2012, 105 hospitals reported consolidations, up from the approximately 50-60 per year reported in 2005-2007.²¹ Nationwide, 60 percent of hospitals are now part of a larger system and are no longer independent. The percentage is higher in Washington, where more than half of Washington's hospitals are

²⁰ Nationwide, health care economists estimate that hospital mergers increased by 25 percent in 2010-12 as compared to 2007-09, and this trend is expected to continue due to incentives in the Affordable Care Act. *See, e.g.,* Ginsburg et. al, *supra* at n. 18.

²¹ *See* Leemore Dafny, PhD, *Hospital Industry Consolidation – Still More to Come?*, 370 NEW ENG. J. MED. 198 (2014), available at <http://www.nejm.org/doi/ref/10.1056/NEJMp1313948#t=article#t=references>.

now affiliated. The hospitals themselves are also bigger and more powerful, offering a greater range of services; more than 60 percent of hospitals now offer home health services, while 37 percent have skilled nursing facilities, 62 percent own hospice services, and 15 percent provide assisted living options.²²

In Washington, hospitals are increasingly engaging in consolidation arrangements in which terms such as “partnership” or “network” are substituted for “merger” or “acquisition” to avoid potential regulatory oversight or barriers. The historical chronology by the Washington State Hospital Association (“WSHA”) shows that in the last ten years, hospitals report that they are affiliating, creating strategic partnerships, or integrating systems rather than simply engaging in an acquisition or merger. CP 286-293. Between 2001 and 2008, there were seven acquisitions. By contrast, between 2009 and 2012, seven hospitals finalized a contract to “affiliate” with other hospitals, three have “pending affiliations;” one established a “strategic partnership” and another announced “system integration.” *Id.* In that same period, there was only one arrangement labeled an “acquisition.” *Id.* Since 2012, at least two additional major consolidations have occurred in Washington State: the

²² See David M. Cutler, PhD and Fiona Scott Morton, PhD, *Hospitals, Market Share, and Consolidation*, 310 JAMA 1964 (2013), available at <http://jama.jamanetwork.com/article.aspx?articleid=1769891>.

establishment of a new health care facility called Confluence Health in Wenatchee from the consolidation of Central Washington Hospital and Wenatchee Valley Hospital, and Harrison and Highline Medical Centers' affiliations with CHI Franciscan Health.

As a result of these consolidations, more than half of Washington's approximately 15,000 hospital beds are now controlled by the four largest health systems in the state: Providence Health & Services, CHI Franciscan Health, PeaceHealth, and MultiCare Health System. Where all hospitals in Washington State were once non-profit or religiously affiliated, now there are eight for-profit hospitals, all with out-of-state owners.

The state certificate of need law allows for public input and consideration *before* a hospital makes changes that impact the community, and also enables the DOH to stop or change a hospital's change of control transaction that may not benefit the community. However, the process cannot work if hospitals can evade accountability merely by using a different label for their transactions.

II. THE SUPERIOR COURT'S DECISION INVALIDATING THE DOH RULE CLARIFYING WHICH HOSPITAL TRANSACTIONS ARE SUBJECT TO REGULATION WILL LIMIT THE STATE'S ABILITY TO "PROMOTE, MAINTAIN, AND ASSURE" PUBLIC HEALTH.

The purpose of Washington's statewide health care regulation is to "promote, maintain, and assure the health of all citizens in the state."

RCW 70.38.015(1). *See also, King Cnty. Pub. Hosp. Dist. No. 2 v. Wash. State Dep't of Health*, 178 Wn.2d 363, 366, 309 P.3d 416 (2013) (intent of RCW 70.38 is to “provide accessible health services and assure the health of all citizens in the state while controlling costs”).

The Washington Legislature originally enacted RCW 70.38 in 1979 in response to a federal law that required every state to adopt a statewide health care resource regulation strategy.²³ Pub. L. 93-641, 88 Stat. 2225, §§ 1-3 (1975) (formerly codified at 42 U.S.C. § 300k-300n-5) (repealed by Pub. L. 99-660, title VII, § 701(a), 100 Stat. 3743, 3799 (1986)). “Congress was concerned ‘that marketplace forces in this industry failed to produce efficient investment in facilities and to minimize the costs of health care.’” *St. Joseph Hosp.*, 125 Wn.2d at 735 (citing *Nat'l Geromedical Hosp. & Gerontology Ctr. v. Blue Cross of Kansas City*, 452 U.S. 378, 386, 101 S.Ct. 2415, 2420, 69 L.Ed.2d 89 (1981)).

Washington State responded to the federal mandate with one of the strongest certificate of need laws in the nation. Laws of 1979, ch. 161, §§ 1-22. Although the federal law made no mention of the importance of

²³ The requirement that every state adopt statewide health care resource regulation was eliminated in 1986. Today, 36 states have some form of statewide health care regulation, such as a certificate of need process. National Conference of State Legislatures, *Certificate of Need: State Health Laws and Programs* (July 2014), <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>, last visited March 27, 2015.

public participation in state health care planning and regulation, the Washington legislature tasked the DOH with holding public hearings in order to obtain specific information about the potential impact of a hospital change of control transaction. RCW 70.38.115(9)-(10). The legislature further directed that “[i]nvolvement in health planning from both consumers and providers throughout the state *should be encouraged.*” RCW 70.38.015(1) (emphasis added).²⁴

In further contrast to the federal law, controlling costs is not the primary focus of Washington’s certificate of need program. Instead, assuring the health of all Washington citizens and providing accessible care “is the overriding purpose of the [certificate of need] program.” *Overlake Hosp. Ass’n v. Dep’t of Health of State of Wash.*, 170 Wn.2d 43, 55, 239 P.3d 1095, 1101 (2010) (agreeing that “controlling the costs of medical care and promoting prevention are also priorities,” but holding that “these goals are of secondary significance because, to a large extent, they would be realized by promotion and maintenance of access to health care services for all citizens”).

²⁴ The original federal certificate of need law also recognized that important role of health care providers in developing health policy, noting, “since the health care provider is one of the most important participants in any health care delivery system, health policy must address the legitimate needs and concerns of the provider if it is to achieve meaningful results; and, thus, it is imperative that the provider be encouraged to play an active role in developing health policy at all levels.” Pub. L. 93-641, 88 Stat. 2225, § 2(A)(5) (1975).

In order to achieve the goals of RCW 70.38, the legislature charged the DOH with gathering information before approving certain expansions or changes in health care facilities. Upon receipt of an application for a certificate of need, the DOH is to examine, *inter alia*:

- 1) whether there is “need for the project”;
- 2) 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”;
- 3) whether “[t]he extent to which medicare, medicaid, and medically indigent patients are served by the applicant”;
- and
- 4) whether the project will “have an adverse effect on health professional schools and training program...”

WAC 246-310-210.

In 2005, the legislature created a task force to make recommendations to improve and strengthen the certificate of need law, finding that the “certificate of need statute plays a vital role and should be reexamined and strengthened to reflect changes in health care delivery and financing since its enactment.” H.R. E2SHB 1688, 59th Leg., Reg. Sess. (2005). Recognizing that “market forces alone” cannot control rising health care costs, “increase access,” or “significantly improve quality of care,” the Task Force recommended, *inter alia*, adherence to timelines; coordination between certificate of need regulation and hospital licensure; more scrutiny of the charity care obligations of hospitals; more

transparency; more information gathering; and continued regulation.²⁵

Yet evasion on the part of some health care systems engaged in consolidation activities has diminished the ability of the DOH to administer the certificate of need program. In many instances, the certificate of need process is the sole opportunity the community, patients and providers have to provide information to regulators about the impacts of change-of-control transactions. “The certificate of need law provides community groups an opportunity to ensure that hospitals meet their community benefits obligations.”²⁶ If consolidating hospitals can merely label their transactions as “affiliations” in order to avoid review, all the benefits of the certificate of need program are lost and its primary objective—assuring the health of all in Washington, pursuant to RCW 70.38.015(1)—cannot be achieved.

When change-of-control transactions are allowed to occur without transparency and without public consideration of the consequences, the DOH cannot fulfill its legislative charge to assure the health of the citizenry, thwarting the purpose of the statute.

III. THE SUPERIOR COURT’S DECISION SHOULD BE OVERRULED BECAUSE THE DOH’S PROMULGATION

²⁵ See “Executive Summary,” *Washington State Certificate of Need Program Task Force Report* at 1 (2006), available at <http://www.hca.wa.gov/documents/CONFfinalreporta.pdf>; H.R. E2SHB 1688, 59th Leg., Reg. Sess. (2005).

²⁶ See Herman and Bell, *supra* at n. 6.

OF WAC 246-310-010(54) WAS BOTH WITHIN ITS AUTHORITY AND NECESSARY TO ACHIEVE THE LEGISLATURE'S GOAL TO ASSURE HEALTH CARE ACCESS FOR ALL IN WASHINGTON.

RCW 70.38.135(3)(c) provides the DOH with broad authority to promulgate rules to implement the statute. Washington courts have repeatedly interpreted RCW 70.38.135(3)(c) as giving the DOH "authority to promulgate rules setting up the process for obtaining a [certificate of need]." *St. Joseph Hosp.*, 125 Wn.2d at 736; *Children's Hosp. & Med Ctr. v. Wash. State Dep't of Health*, 95 Wn. App. 858, 866 (1999) (same); *Overlake Hosp. Ass'n.*, 170 Wn.2d at 50 (same).

Here, hospitals began to label their consolidations as affiliation or mergers or anything *other than* the three words used in the statute triggering certificate of need review. Recognizing that the entire statewide regulatory process would be undermined if major change of control transactions were not reviewed under the certificate of need program, the DOH clarified that major transactions required a certificate by promulgating WAC 246-310-010(54).

The DOH's clarification is entirely consistent with the legislation. Courts have "never held that [the legislature] must repeat itself or use extraneous words before [courts] acknowledge its unambiguous intent." *Friends of Earth, Inc. v. E.P.A.*, 446 F.3d 140, 144 (D.C. Cir. 2006). The

legislature mandated a public process and the DOH's revision of WAC 246-310-010(54) furthers the legislative intent of RCW 70.38.105. The rule benefits patients, nurses, and health care providers across the state by bringing all change-of-control transactions within the regulatory oversight of the certificate of need process.

IV. WSHA'S PLEAS OF ECONOMIC BURDEN SHOULD BE GIVEN NO WEIGHT BY THIS COURT GIVEN THE IMMENSE FINANCIAL RESOURCES OF THE HEALTH CARE SYSTEMS DRIVING THE CONSOLIDATIONS.

WSHA argues that the certificate of need process "imposes substantial cost burdens," pointing to a survey of hospitals in which they self-reported that the certificate of need process cost "well over \$100,000, and often over \$500,000." Answering Brief, p. 5-6. However, these costs represent a tiny fraction of a percent of the revenues and value of the health care systems driving the mergers in Washington State.

For example, the largest health care system in Washington, Providence Health System, maintained cash reserves of \$5.4 billion as of December 2013.²⁷ Providence reported \$4.5 million in compensation to

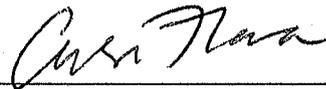
²⁷ See Consolidated Financial Performance Fiscal Year 2013, Providence Health & Services, prepared by KPMG, LLP (2013), available at <http://www2.providence.org/phs/Documents/financials/PHS%20Mar%202013.pdf>.

its president in 2012 and also paid millions to its other executives.²⁸ PeaceHealth's revenues exceed \$1 billion annually.²⁹ CHI Franciscan Health is part of the Catholic Health Initiatives based in Colorado which have annual revenues of more than \$10.7 billion.³⁰

CONCLUSION

Without the certificate of need process, there is no way for the DOH to determine if a proposed consolidation provides any benefits to the community. The DOH has appropriately clarified that change-of-control transactions fall within the certificate of need process, and by doing so, has furthered the purpose of the statewide health care regulation statute. For the foregoing reasons, *Amici* respectfully requests that the Court uphold the DOH's lawful amendment to WAC 246-310(54).

Respectfully submitted this 28th day of April, 2015.



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²⁸ See Compensation of Hospital Employees, Washington State Department of Health (2012), available at <http://www.doh.wa.gov/Portals/1/Documents/5300/Comp2012-Providence.pdf>.

²⁹ See Erin Middlewood, *Digging Into Clark County Non Profits' Top Earners*, The Columbian, December 8, 2013, <http://www.columbian.com/news/2013/dec/08/clark-county-nonprofits-top-earners-what-is-fair-s/>.

³⁰ See *Franciscan Medical Center Opens in Bonney Lake*, CHI Franciscan Health, June 11, 2013, available at <http://www.chifranciscan.org/news/Franciscan-Medical-Pavilion-Opens-in-Bonney-Lake/>.

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DECLARATION OF SERVICE

I declare, under penalty of perjury under the laws of the state of Washington, that on this date I caused a true and correct copy of the Corrected Brief of *Amici Curiae* Washington State Nurses Association, UFCW 21, and SEIU Healthcare 1199NW to be placed in the UPS Overnight mail, addressed to:

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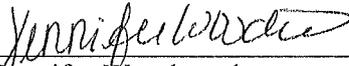
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DATED this 6th day of May, 2015, at Seattle, Washington.


Jennifer Woodward
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OFFICE RECEPTIONIST, CLERK

To: Jennifer Woodward
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Subject: RE: WSHA v. Washington State Dept. of Health (No. 90486-3): Corrected Brief of Amici and letter

Received 5-6-2015

Supreme Court Clerk's Office

Please note that any pleading filed as an attachment to e-mail will be treated as the original. Therefore, if a filing is by e-mail attachment, it is not necessary to mail to the court the original of the document.

From: Jennifer Woodward [mailto:woodward@workerlaw.com]
Sent: Wednesday, May 06, 2015 4:16 PM
To: OFFICE RECEPTIONIST, CLERK
Cc: Laura Ewan; Carson Flora; Jennifer Schnarr
Subject: WSHA v. Washington State Dept. of Health (No. 90486-3): Corrected Brief of Amici and letter

Good Afternoon,

Please find the attached Corrected Brief of Amici Curiae Washington State Nurses Association, UFCW 21 and SEIU Healthcare 1199NW, submitted per the Court's April 30, 2015 Order in this case. Also submitted is a copy of the letter to the Washington State Law Library which addresses materials cited in the parties' brief.

Case Name: Washington State Hospital Assoc. v. Washington State Dept. of Health

Case No.: 90486-3

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Please let me know if you have any trouble with the attachments.

Sincerely,

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