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SUPREME COURT OF THE STATE OF WASHINGTON

WASHINGTON STATE HOSPITAL ASSOCIATION,

Respondent,

v.

WASHINGTON STATE DEPARTMENT OF HEALTH,

Appellant

ON APPEAL FROM THURSTON COUNTY SUPERIOR COURT

BRIEF OF *AMICI CURIAE*
WASHINGTON STATE MEDICAL ASSOCIATION AND
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS,
WASHINGTON CHAPTER, AND WASHINGTON STATE
RADIOLOGICAL SOCIETY

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Radiological Society



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I. IDENTITY AND INTEREST OF *AMICI CURIAE*

The Washington State Medical Association (“WSMA”) is a 125-year old, statewide association of over 9800 medical and osteopathic physicians, surgeons, and physician assistant members. WSMA is thoroughly familiar with medical practice and the health care system in Washington, especially matters impacting the provision of health care to all Washington patients. This includes issues like Certificate of Need (“CN”) which directly affect the cost, availability, and quality of health care for Washington State patients.

WSMA has historically been committed to promoting the greatest access of health services to all patients in Washington and examines potential restrictions on the availability of health care. WSMA is participating here because it believes, if allowed, the rule adopted by the Department of Health (“Department”) would restrict new methods of providing the best health services to the most patients and ultimately restrict access to care while increasing costs.

The American College of Emergency Physicians, Washington Chapter (“WA-ACEP” or “Emergency Physicians”) represents over 620 emergency physicians and is widely recognized as the voice of emergency medicine. WA-ACEP knows emergency departments need flexibility in operational arrangements to care for the most patients at the least cost in our changing health care system.

The Washington State Radiological Society (“WSRS”), a chapter of the American College of Radiology, has approximately

850 members and is Washington's primary association representing diagnostic radiologists, radiation oncologists, interventional radiologists and medical physicists. WSRS is concerned the rule adopted by the Department will delay or preclude innovative contractual arrangements between physician groups and hospitals, limiting patient access to comprehensive, quality care.

II. ISSUES OF CONCERN TO *AMICI CURIAE*

The WSMA, WA-ACEP and WSRS (collectively "Physician Amici") will address the following issues:

- **First:** That an expanded CN program will restrict hospitals and physicians from implementing innovative methods of health care delivery by preventing agreements to coordinate and integrate patient care and other key functions. If not restricted by CN review, physicians could increase the availability of health care services to more patients while helping reduce costs paid by patients, insurers, and the State.
- **Second:** That the new CN rule does not promote the best interests of the patients because it reduces access to health care by preventing and discouraging clinical integration that allows for better coordinated care, reduced health care costs, and standardized quality measures. The expanded CN rule is the wrong tool to try to preserve access to care.
- **Third:** That the separation of powers doctrine controls the outcome here because the executive lacks the power to legislate. It also provides the process for resolution – legislation by the legislature. The legislature must determine in which part of the CN statutes to implement an express policy assuring access to health services in appropriate, least costly facilities, **and** how to balance implementing that policy with the stifling effects of expanded CN review that increase health costs.

III. DISCUSSION

A. The Certificate of Need Statute And Regulation At Issue.

When the legislature addressed “change of control” for CN purposes in 1984, it passed a simple statute. It requires review for the “sale, purchase, or lease of all or any part of any existing hospital.” RCW 70.38.105(4)(b).¹ The Department applied the statute as written for over 30 years. But in December 2013, in response to the Governor’s June 2013 directive, the Department adopted a rule “defining” those provisions, which states:

‘Sale, purchase, or lease’ means any transaction in which the control, either directly or indirectly, of part or all of any existing hospital changes to a different person including, but not limited to, by contract, affiliation, corporate membership restructuring, or any other transaction.

WAC 246-310-010(54) (“New Control Rule”).

By its terms, the New Control Rule requires CN review for “any transaction in which the control, either directly or indirectly, of part or all of an existing hospital changes.” *Id.* It thus does not merely define the terms “sale, purchase or lease.” As stated in the Department’s documents associated with its promulgation, it expressly expands the scope and reach of the law by allowing the

¹ The full provision of RCW 70.38.105(4)(b) states:

(4) The following shall be subject to certificate of need review under this chapter:

(b) The sale, purchase, or lease of part or all of any existing hospital as defined in RCW 70.38.025 including, but not limited to, a hospital sold, purchased, or leased by a health maintenance organization or by a combination of health maintenance organizations;

Department to regulate events and occurrences that indirectly result in the change of control of *any part* of a hospital. This is at odds with the history and purpose of the statute.

B. The Executive’s Effort To Expand CN Review Runs Counter To Modern Trends In Health Care.

1. CN legislation was adopted over 35 years ago to address issues in that health care market, and the statute has not materially changed since.

Washington’s current CN law, the State Health Planning and Resources Development Act (“State Health Planning Act”), was enacted in 1979 in response to federal laws passed in 1974.² In the 1970’s, both federal health care programs and private payers reimbursed health care facility charges on a “retrospective cost reimbursement” or “cost-plus” basis.³ Under this economic model, health care facilities could pass on the fixed costs of capital improvements via higher charges for care delivered, regardless of whether the improvements were necessary to provide that care, or to serve the existing patient population.⁴ That model encouraged

² Laws of 1979, 1st Ex.Sess., ch. 161. Washington’s first CN law in 1971 was based on earlier certificate of need laws passed in the 1960s. New York was the first state to implement a CN program in 1964. *Certificate of Need: State Health Laws and Programs*, National Conference of State Legislatures (3/30/2015), available at: <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx> (“NCSL: Certificate of Need”).

³ *Improving Health Care: A Dose of Competition*, Federal Trade Commission & Department of Justice (2004), at <https://www.ftc.gov/reports/improving-health-care-dose-competition-report-federal-trade-commission-department-justice> (“A Dose of Competition”), Ch. 8 at 2.

⁴ *NCSL: Certificate of Need*. As a simplified example, hospitals with more beds than necessary could still pass on the fixed costs of the unused beds through higher charges for the beds that were being used.

health care facilities to expand unnecessarily, resulting in higher health care costs. That system encouraging higher costs was exacerbated by the fact that patients were generally not responsible for their own health care costs and thus lacked price-sensitivity.⁵

To address these concerns, Congress passed the National Health Planning and Resources Development Act of 1974 (“National Health Planning Act”).⁶ Based on the unique dynamics of health care economics in the 1970’s, its primary purpose was to control health care costs by restricting expansion of health care facilities and expensive equipment. The National Health Planning Act provided for increased federal funding for states which implemented CN programs.⁷ By 1980, 49 states including Washington had enacted CN programs in response to the National Health Planning Act.⁸

⁵ *A Dose of Competition*, Ch. 8 at 2.

⁶ Pub. L. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. §§ 300k-300n-5), *repealed*, Pub. L. 99-660, § 701, 100 Stat. 3799 (1986).

⁷ *St. Joseph Hosp. v. Dept. of Health*, 125 Wn.2d 733,736, 887 P.2d 891 (1995) (“Congress endeavored to control costs by encouraging state and local health planning. It offered grants to state agencies provided the agencies met certain standards and performed certain functions. Among the specified functions was the administration of a CN program.”) (emphasis added).

⁸ *A Dose of Competition*, Ch. 8 at 1; *St. Joseph Hosp.*, 125 Wn.2d at 735; *UW Med. Ctr. v. Dept. of Health*, 164 Wn.2d 95, 99, 187 P.3d 243 (2008).

Despite this primary focus on cost containment under both the federal and state laws establishing CN programs, this Court recently held that “provid[ing] accessible health services . . . is the overriding purpose of the CN program” while “controlling the cost of medical care” is only a goal “of secondary significance.” *Overlake Hosp. Ass’n v. Dept. of Health*, 170 Wn.2d 43, 55, 239 P.3d 1095 (2010). However, Justice Alexander also said in *Overlake* that the nominal demotion of the importance of cost containment (to achieve the result in that case) was because the cost containment goal, to a large extent, “would be realized by promotion and maintenance of access to health care for all citizens.” *Id.* In fact, reducing the cost of care will help ensure the greatest access since if

(Footnote continued next page)

As the federal government and private payers moved away from reimbursement on a “cost-plus” basis and towards fixed fees, the role of CN programs in controlling health care costs was called into question. In 1986 Congress repealed the National Health Planning Act after just 12 years, following which many states abandoned their respective CN programs.⁹ More recently in 2004, the Federal Trade Commission and the Department of Justice concluded that “CON programs are generally not successful in containing health care costs and that they can pose anticompetitive risks,” recommending that “states with CON programs...reconsider whether they are best serving their citizen’ health care needs by allowing these programs to continue.”¹⁰

Washington’s CN program is over thirty-five years old, dating to 1979.¹¹ Despite the dramatic changes in reimbursement

it costs less, health care can be afforded by more people, ensuring high quality care is provided in the least costly setting to maximize access to care.

⁹ *NCSL: Certificate of Need*. Thirty-six states still have some form of CN law.

¹⁰ *A Dose of Competition*, Ch. 8 at 6. More recently, the FTC and DOJ issued a Joint Statement before the Illinois Task Force on Health Planning Reform. In advocating for the repeal of the Illinois CN program, those agencies stated:

[I]t is important to note that CON laws were not adopted as a means of cross-subsidizing care; CON laws were not adopted to have centralized planning of health care markets as an end in itself; CON laws were not adopted to supplant or augment state-law licensing regulations designed to protect the health and safety of the population from poor-quality health care.

Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission Before the Illinois Task Force on Health Planning Reform, 4, (September 15, 2008), available at:

http://www.justice.gov/atr/public/press_releases/2008/237153a.pdf.

¹¹ The 1971 certificate of need statute was repealed and the 1979 statute was created to comply with the National Health Planning Act.

practices and the shift in both federal law and policy in the last forty years, Washington's CN program has not materially changed between 1979 and 2013.¹² Pertinent here, there has been no change to the statutory provision at issue since it was adopted in 1984, nor any expansion to the scope of CN review pursuant to it until now.

2. The Department promulgated an expansive New Control Rule to address an unsubstantiated problem that is unrelated to the purpose of CN review when the statute was passed in 1984.

The legislature amended the law in 1984 to require CN review for the "sale, purchase, or lease of all or any part of any existing hospital." *See* RCW 70.38.105(4)(b). The Department applied the statute as written for the next 30 years--only parties who sold, purchased, or leased a hospital facility had to get a CN.¹³

As described by the parties, in July 2013 the Department began the process to promulgate the New Control Rule at the behest of the Governor to address perceived changes in control of facilities in the rapidly-changing health care marketplace; primarily local hospitals which were merging or affiliating with religious health care systems.¹⁴ A primary basis for the directive was to ensure access to a

¹² Thirty-six other states also maintain some form of a CN program, although many programs are "often in a loosened form compared to their predecessors." *A Dose of Competition*, Ch. 8 at 1; *NCSL: Certificate of Need*.

¹³ *See, e.g.*, WSHA Answer To The Department's Motion For Accelerated Review, pp. 2-3 and WSHA RB, pp. 7-9 (relating over a dozen determinations involving change of control without sale of a hospital facility that did not require a CN, per the Department's determinations).

¹⁴ *See, e.g.*, CP 210-212 (DOH Response Brief below); WSHA RB, pp. 9-15.

full range of health care services for all Washington patients should philosophical concerns result in restricted services after a change of control.¹⁵ Due to the concern about potential future access for some services, the Governor directed the Office of Fiscal Management (“OFM”) to conduct a study on whether mergers or affiliations with religiously affiliated hospitals had, in fact, affected access to care in the state. The OFM report found (in December 2013 before the New Control Rule was adopted) that such affiliations had *not* adversely affected access to care and that they most likely improved access, particularly in rural areas. OFM Report, p. 3, CP 400.^{16 17}

Amicus WSMA has long been an advocate for access to all health services for patients in the state. It would not be participating

¹⁵ The governor’s directive was generated by concerns brought to him following the affiliation of Swedish Hospital with the Providence Health System in 2012. *See* CP 295 (Swedish chronology); 345-346 (governor’s letter to ACLU); DOH OB, pp. 5-6.

¹⁶ *See e.g.*, excerpts from the Executive Summary at CP 400:

Our findings suggest that communities predominately served by religious hospitals do not appear to be experiencing barriers to care. On the contrary, tubal ligation sterilization rates within communities served by religious hospitals are the same as- or higher than- the rates within communities served by secular hospitals. . . .

No differences associated with hospitals’ religious or secular status were detected in community’s [sic] abortion rates.

¹⁷ The focus on religious hospitals may be misplaced given the findings in the OFM report and the ACLU’s February, 2015 suit against the secular Skagit Valley Hospital, a public hospital district, over access to reproductive health services for women. *See* “ACLU Suing Skagit Hospital District Over Abortion Rights Law,” *Bellingham Herald* (Feb. 19, 2015), at <http://www.bellinghamherald.com/2015/02/19/4141865/aclu-suing-skagit-hospital-district.html> (last visited 4/7/15). Physician amici note that the religious health systems have brought, and continue to provide, basic health services to previously underserved rural areas, increasing access to needy populations.

in this case as an amicus in favor of affirmance if it believed there was an immediate threat to the availability of all health services throughout the state which the New Control Rule resolved. Rather, the WSMA is confident there is presently good access for basic health services in most of the state, while recognizing too many rural areas (and jails and prisons) have long been underserved populations where corrective efforts continue to be needed. Physician Amici believe that ensuring maximum flexibility for new and creative practice arrangements between physicians, hospitals and other health care providers, *without* the new CN restrictions, will best maintain the good access that exists and improve less than optimal access.

As noted, the New Control Rule requires CN review for “any transaction in which the control, either directly or indirectly, of part or all of an existing hospital changes.” WAC 246-310-010(54). WSHA contended below that regulating events and occurrences that indirectly result in the change of control of any part of a hospital, which had not been done under the statutory language in the 30 years before the rule, was an illegal expansion of the Department’s CN authority beyond that granted by the statute. Judge Carol Murphy agreed and invalidated the New Control Rule in June, 2014.¹⁸ After denying a stay, this Court granted direct review.

¹⁸ WSHA also challenged the rule as arbitrary and capricious for ignoring the OFM report which undercut the access to care rationale for the proposed rule. Judge Murphy did not reach that issue. CP 318, 358.

C. Clinical Integration, Which Is Necessary In Today's Health Care Economy to Coordinate Care and Reduce Costs While Maintaining Quality And Access, Would Be Compromised Or Foreclosed By The New Control Rule.

1. Clinical Integration – a new model that provides better health care to more people for less cost, thus increasing access to care.

Traditionally, both hospitals and physicians were reimbursed by private and public payers for the amount of services provided, not the quality of care or patient outcome. That fee-for-service model is one of the main drivers of increased health care costs. Fee-for-service tends to generate a high volume of discrete services without necessarily rewarding coordination of care or preventative health care management.¹⁹ As such, state and federal policymakers and the healthcare industry as a whole now recognize the need to develop alternative health care delivery models that emphasize coordinated care and reimbursement based on patient outcomes.²⁰

To effect this change, hospitals, physicians, and payers are now contracting with each other in new and innovative ways. In particular, physicians and hospitals are entering into agreements with each other to allow them to share patient data, coordinate patient

¹⁹ *Cracking The Code On Health Care Costs: A Report by the State Health Care Cost Containment Commission*, 36, (January 2014), at <http://web1.millercenter.org/commissions/healthcare/HealthcareCommission-Report.pdf>.

²⁰ *Id.*; Harold D. Miller, *Transitioning to Accountable Care: Incremental Payment Reforms To Support Higher Quality, More Affordable Health Care*, Center for Healthcare Quality and Payment Reform (January 2011), available at <http://www.chqpr.org/downloads/TransitioningtoAccountableCare.pdf>.

care, and implement the standardized quality measures necessary for outcomes-based reimbursement. The creation of these clinically integrated networks has the added benefit of decreasing the amount of redundant services and increasing operational efficiency.

The need for clinical integration is also reflected in federal health care policy. Naked price-fixing among competitors is *per se* illegal under federal anti-trust law. However, in 1996 the Department of Justice (“DOJ”) and the Federal Trade Commission (“FTC”) issued guidelines stating that the “rule of reason” analysis would be applied in evaluating health care provider networks that are financially and clinically integrated.²¹ That analysis assesses whether the integration of providers through a network is likely to 1) produce significant efficiencies in cost, quality, and access that benefit patients and payers; and 2) whether the agreements by the network physicians are reasonably necessary to realize those efficiencies. *Id.*

The goal of clinical integration was recently institutionalized in the Patient Protection and Affordable Care Act of 2010 (“Affordable Care Act”). It promotes the creation of Accountable Care Organizations (“ACOs”) through the Medicare Shared Savings Program. ACOs are a type of healthcare organization characterized by a payment and care delivery model that ties provider

²¹ *Statements of Antitrust Policy in Health Care*, DOJ & FTC, (1996), at <http://www.justice.gov/atr/public/guidelines/0000.pdf>.

reimbursements to quality metrics. That system reduces the total cost of care for a designated population of patients.²²

Indeed, Washington’s own State Health Care Innovation Plan, “Healthier Washington,” aims to reduce state government health care costs by contracting with local ACOs and clinically integrated networks, with the ultimate goal of reducing costs “through a statewide, high-value accountable network with common infrastructure that effectively integrates finance and delivery.”²³

2. Adoption of the New Control Rule subjects the formation of ACOs and clinically integrated networks to CN review. This impedes innovation, raises costs on patients, payors and the State, and reduces access--contrary to the CN goals of controlling costs and maximizing access.

A high degree of physician participation in the governance of clinically integrated networks and ACOs is required to achieve the desired clinical outcomes.²⁴ ACOs generally involve the creation of a new legal entity with governance to be shared by ACO hospital and physician participants.²⁵ In contrast, clinically integrated

²² Miller, *supra*, n. 20, pp.11-12.

²³ *Healthier Washington: Paying for Value*, (April 7, 2015), http://www.hca.wa.gov/hw/Pages/paying_for_value.aspx. Unlike the New Control Rule, the state Health Care Innovation Plan has been reviewed and adopted by the legislature. Laws of 2014, Reg.Sess., ch. 223.

²⁴ Dennis Butts, *et al.*, *The 7 Components of a Clinical Integration Network*, Becker’s Hospital Review (October 19, 2012), available at <http://www.beckershospitalreview.com/hospital-physician-relationships/the-7-components-of-a-clinical-integration-network.html>.

²⁵ In fact, Medicare ACO’s with two or more otherwise independent ACO participants are required to create a separate legal entity with independent governance. 42 CFR §§ 425.104- 425.106.

networks may take the form of joint ventures between a hospital and its medical staff, hospital acquisition of physician practices, contracts between a hospital and independent physician groups or associations, or other forms of contracting that allow for physician control over hospital functions.²⁶

By requiring CN review whenever the control of part of any existing hospital changes to a different person “including, but not limited to, by contract, affiliation, corporate membership restructuring, or any other transaction” (contrary to the statutory requirements and their interpretation for 30+ years), the New Control Rule subjects the formation of ACOs and clinically integrated networks to CN review for the first time. This is because the language of the New Control Rule describes the type of transactions and contracting that is necessary to form an ACO or clinically integrated network. If the New Control Rule is allowed to stand, there is nothing to prevent the Department from requiring CN review of new clinically integrated networks or ACOs.²⁷ At a minimum, hospitals would still need to apply for a determination of reviewability to confirm CN review is unnecessary, at considerable expense and delay, since the plain language of the New Control rule

²⁶ Butts, *et al.*, *supra*, n. 24.

²⁷ For example, the Department’s Motion to Stay to this Court states its intent to apply the New Control Rule, and subject to CN review, Deaconess Medical Center’s acquisition of a physician practice. *See, e.g.*, WSHA RB, pp. 45-46.

will likely encompass the transactions necessary for the creation of the ACO or clinically integrated network.

One active case of which Physician Amici are aware, now on appeal to this Court, gives a concrete illustration by legislative facts of the kind of unnecessary costs imposed on providers, patients and the health care system by expanded CN Review. It involves a cost-cutting joint venture between a physician group and hospital to expand ambulatory surgery rooms.²⁸ Among the major benefits to patients and payors from expanded ambulatory surgical centers (“ASCs”) is that surgeries performed in them do not incur the hospital “facility fee” charged by hospital outpatient departments (“OPDs”), which are dramatically higher.²⁹ As noted a 2013 report to Congress, “for 2013, the Medicare rates for most services are 78 percent higher in [hospital outpatient departments] than in [ambulatory surgical centers]”. REPORT TO CONGRESS, p. 125.

²⁸ In *The Polyclinic, et al. v. Dep’t of Health*, No. 91569-5, a physician-owned multi-specialty clinic, entered into an agreement with Swedish Medical Center to relocate the clinic’s ambulatory surgery facility, expand it from three to ten operating rooms, and operate it as a joint venture with Swedish. See Order Granting Petitioners’ Motion For Summary Judgment and Denying Respondent’s Cross-Motion For Summary Judgment (“MSJ Order”), pp. 1-2, public record available at Thurston County Superior Court No. 14-2-01413-6, sub no. 32 (also at clerk’s papers pp. 178-179 in Supreme Court No. 91569-5). The clinic and hospital brought a declaratory judgment action to determine if a certificate of need was required for the expansion. MSJ Order, pp. 1-2. The trial court ruled CN was not required and the project could proceed, *id.*, p. 12. The Department appealed, resulting in No. 91569-5.

²⁹ Medicare Payment Advisory Commission, REPORT TO CONGRESS: MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM (2013), Chapter 2, “Medicare Payment Differences Across Ambulatory Settings”, (“REPORT TO CONGRESS”), pp. 106, 125 as paginated on the copy on file at the Washington State Law Library in conjunction with this appeal.

Accord, p. 106: “Medicare currently pays 78 percent more in OPDs than in ASCs for the same procedure, and this gap has increased over time, . . .” *Id.* at 125.

Although the project was allowed to go forward by the trial court, the inherent uncertainties and timing of the appellate process makes imminent completion uncertain. As a result, thousands of patients and their payers may unnecessarily incur the higher facility fees for those surgeries done while the appeal proceeds before the ambulatory surgical facility is built, frustrating both the “overriding purpose of access” and its necessary corollary of cost containment as declared in *Overlake, supra*. This concretely illustrates the kind of problems Physician Amici believe will occur under the New Control Rule, problems that frustrate the goals of the CN program and ultimately hamper patient access to the best, most affordable care.

Such expanded CN review and litigation not only increases the “transaction cost” of the CN process (application fees plus cost of litigation), but shows how in such situations the extended CN process necessarily imposes higher costs on patients and payors for the surgeries that must be performed in the hospital, not in an ambulatory surgery center.

The expanded CN process would also have an adverse impact on other every-day affiliations between hospitals and clinics or medical groups. These include exclusive contracts with medical specialty groups for physician services and agreements to share

credentialing, human resources services, or any other services that might save both the hospitals and physicians money and therefore help to reduce the cost of health care. Surely this was not the genuine intent of the CN law when passed in 1979, or amended in 1984. And it is the intent of those statutes that the Department is to implement, not a statute of its own creation.

The increased costs and burden of expanded CN review will only impede further clinical integration amongst Washington's health care providers. Clinical integration is necessary to reduce ever-growing health care costs and to increase the availability of quality care. The decision to subject ACO and clinical integration network formation to CN review thus has far-reaching implications that were not contemplated by the legislature in the 1970's when the CN legislation was first adopted, nor in 1984 when the "purchase sale or lease" provision was added.

As discussed in Section D, *infra*, any decision to expand CN review – whether dramatically or incrementally – must be made by the legislature. It has both the authority and the opportunity to fully examine the potential repercussions of such a decision on health care access, cost, and quality in Washington, and then make the policy decision. It is the legislature that determines what expanded scope of CN review is appropriate (if any) in the health care economy of the second decade of the 21st century. As noted in the following separation of powers argument, there is no lawful basis for the

Department to make such an expansion of its authority, no matter how well-intentioned, or even if at the Governor's behest.

D. Basic Administrative Law and Separation Of Powers Principles Prohibit The New Control Rule.

Under well-settled principles of administrative law and the doctrine of separation of powers, the Department plainly exceeded its statutory authority. The separation of powers doctrine reflects the constitutional distribution of political authority among the legislative, executive, and judicial branches of government. *State v. Moreno*, 147 Wn.2d 500, 505, 58 P.3d 265 (2002). "Each branch of government wields only the power it is given." *Id.* While the legislature's role is "to set policy and to draft and enact laws," it is within the judicial branch's authority "to determine what a particular statute means." *Hale v. Wellpinit Sch. Dist. No. 49*, 165 Wn.2d 494, 506, 198 P.3d 1021 (2009).

"The purpose of the doctrine is to prevent one branch of government from aggrandizing itself or encroaching upon the 'fundamental functions' of another." *Moreno*, 147 Wn.2d at 505, quoting *Carrick v. Locke*, 125 Wn.2d 129, 135, 882 P.2d 173 (1994). A separation of powers violation occurs when one branch of government "invades the prerogatives" of another. *Id.* at 505-06 (quotations omitted). In this case the violation is by the executive branch through its agency for invading the legislature's province of

setting or re-defining policy and regulation as to health care cost containment and access.

It is axiomatic that “administrative agencies do not have the power to promulgate rules that would amend or change legislative enactment.”³⁰ Nor can they legislate, but agency rules “must be within its statutory framework.”³¹ Nor may “[a]dministrative rules or regulations . . . amend or change legislative enactments.”³² Rules that are not consistent with the statutes that they implement are invalid.³³

The Department of Health, an executive branch agency, overstepped its authority when, in responding to Governor Inslee’s directive to begin rulemaking on CN review, it promulgated a rule that expanded the Department’s regulatory authority. It is the prerogative of the legislature to decide whether and when to expand CN review, and if such expansion would, in fact, further the goals of the certificate of need statute in the current era, or whether the costs of increased regulation would prevent and discourage hospitals and

³⁰ *Washington Pub. Ports Ass’n v. State, Dep’t of Revenue*, 148 Wn.2d 637, 646, 62 P.3d 462, 466 (2003), citing *Green River Cmty. Coll. v. Higher Educ. Pers. Bd.*, 95 Wn.2d 108, 112, 622 P.2d 826 (1980), as modified on other grounds, 95 Wn.2d 962 (1981).

³¹ *Anderson, Leech & Morse, Inc. v. Washington State Liquor Control Bd.*, 89 Wn.2d 688, 694, 575 P.2d 221, 225 (1978), citing *Kitsap-Mason Dairymen’s Ass’n v. Wash. State Tax Comm’n*, 77 Wn.2d 812, 467 P.2d 312 (1970); *State ex rel. West v. Seattle*, 50 Wn.2d 94, 309 P.2d 751 (1957).

³² *Swinomish Indian Tribal Cmty. v. Dep’t of Ecology*, 178 Wn.2d 571, 580, 311 P.3d 6 (2013) (alteration and internal quotation marks omitted).”

³³ *Id.*, citing *Bostain v. Food Express, Inc.*, 159 Wn.2d 700, 715, 153 P.3d 846 (2007).

physicians from finding new ways to improve patient care and lower costs without any corresponding benefit in access to care.

It is telling that the Department makes only policy-based arguments for expanding CN review. This shows the proposed rules go beyond the framework provided by the legislature. The legislature never gave the Department the authority to determine whether changed conditions in the health care marketplace, as alleged by the Department, allow for expanded CN review. The fact the Department relies on policy-based arguments in favor of expanded review shows that the Department is acting outside its appropriate sphere. As seen by the information provided by Physician Amici, *supra*, increased regulation of change of control transactions related to hospitals comes at a cost to hospitals and physicians as they attempt to improve patient care through innovations in health care delivery, and thus at a high cost to patients and payers, including the State. Only the legislature, not the executive branch acting through the Department, is authorized to weigh those competing policy concerns. The legislature, not the executive, may either enact legislation to address those concerns or decide that current legislation strikes an adequate balance.

The trial court correctly ruled that the Department invaded the province of the legislature when it promulgated the New Control Rule because it expanded the reach of CN review beyond the statutory framework provided for in RCW 70.38.105(4) by allowing

the Department to regulate transactions the legislature never made subject to CN review. The trial court correctly invalidated the rule.

IV. CONCLUSION

Physician Amici respectfully suggest that this Court recognize that the trial court correctly ruled that the Department exceeded its authority by expanding the CN program beyond its statutory mandate and affirm the result below. The Court's decision should remind the Department that its administration of the CN program must remain true to *both* central goals of the CN program and that neither may be ignored: to control costs and thereby increase access to care. The Department needs to be reminded that it is by adhering to the statute and its two-part, interdependent mechanism, that the availability of health care services to all patients throughout Washington will in fact be maximized.

Respectfully Submitted this 30th day of April, 2015.

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By 

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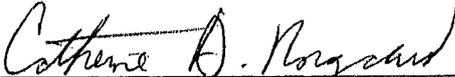
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1. Mr. Miller's April 30, 2015 letter addressed to the State Law Library/COS
2. (refiled per SCT's 4/23/15 instruction letter) Brief of *Amici Curiae* WSMA, ACEP, WSRS/COS

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