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SUPREME COURT OF THE STATE OF WASHINGTON

WASHINGTON STATE HOSPITAL ASSOCIATION,

Respondent,

v.

WASHINGTON STATE DEPARTMENT OF HEALTH,

Appellant.

**APPELLANT'S ANSWER TO AMICI CURIAE BRIEFS OF
ASSOCIATION OF WASHINGTON PUBLIC HOSPITAL
DISTRICTS, WASHINGTON RURAL HEALTH ASSOCIATION,
AND WASHINGTON STATE MEDICAL ASSOCIATION**

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I. INTRODUCTION

The Legislature directed the Department of Health to review certificate of need applications for any “sale, purchase, or lease of part or all of any existing hospital.” RCW 70.38.105(4)(b). The Department promulgated WAC 246-310-010(54) to define the undefined statutory terms “sale, purchase, or lease.” The Department’s rule is consistent with the statute’s plain language and with common definitions of these terms.

Some health care industry groups have filed amicus briefs attacking the rule. *See* Amicus Briefs of Washington Rural Health Association, Washington State Medical Association, and Association of Washington Public Hospital Districts (collectively “industry amici”). These groups never argue that the Department lacks authority to define undefined terms, nor that “purchase” and “sale” have only one meaning. Instead, they argue that the Department has impermissibly changed its regulatory approach and that this new approach is unwise because it hinders hospitals’ ability to adapt in a rapidly changing health care environment. But this rapidly changing environment is what prompted the rule in the first place, and the industry amici fail to show that the Department’s new approach is impermissible or will actually cause the harms they claim.

In recent years, the Affordable Care Act has resulted in a surge of transactions between hospitals, and hospitals in Washington have carefully avoided calling such transactions a “sale, purchase, or lease,” in order to circumvent certificate of need review. But these transactions affect what

services a hospital offers, prompting legitimate concern that communities will lose certain services. The certificate of need process is aimed at avoiding exactly such harms, a goal that is being undermined by these recent trends. The Department's rule—permissibly interpreting statutory terms it is charged with enforcing—helps achieve the statute's goals.

Moreover, the industry amici have not shown that the rule will cause the harms they allege. They argue that certificate of need review is costly, unnecessary, and outdated. But those overblown claims are attacks on the underlying certificate of need statute, not this rule. The industry amici also contend that this rule will hinder crucial change, but their own briefs show this to be untrue. For example, the Medical Association says the rule will require every new "Accountable Care Organization" to obtain a certificate of need. Medical Ass'n Br. at 12–13. But the Rural Health Association disagrees, saying that "ACO arrangements do not necessitate a change of control" requiring review. Rural Ass'n Br. at 12.

In short, the industry amici's legal arguments fail and their policy arguments are speculative and irrelevant. The Department's rule is consistent with the statute it implements and a necessary and reasonable reaction to new circumstances. The Court should uphold the rule.

II. ARGUMENT

A. **The Legislature Gave the Department Broad Authority to Implement the Certificate of Need Program, Which Includes the Authority to Define Undefined Statutory Terms**

The Legislature directed the Department to implement the state's certificate of need program and granted the Department broad rulemaking

authority to accomplish this. RCW 70.38.105(1), .135(3)(c). The Department adopted its definitional rule, WAC 246-310-010(54), under this authority.

The industry amici never argue that the Department lacks authority to define undefined statutory terms, nor do they dispute that the terms “sale, purchase, or lease” are subject to more than one interpretation. Instead, they argue that the Department’s rule conflicts with its prior application of these terms and the rule therefore deserves no deference. They are wrong.

1. Under Long-Standing Principles of Administrative Law, the Department’s Rule Is Entitled to Deference

This Court gives substantial deference to the Department’s interpretation of the certificate of need law because the law is within the Department’s specialized knowledge and expertise. *Overlake Hosp. Ass’n v. Dep’t of Health*, 170 Wn.2d 43, 56, 239 P.3d 1095 (2010). Such deference is consistent with the long-standing rule that courts grant great weight to an agency’s definition of an undefined statutory term when the agency is charged with administering the statute. *See Phillips v. City of Seattle*, 111 Wn.2d 903, 908, 766 P.2d 1099 (1989). An agency rule that is “reasonably consistent” with the statute being implemented should be upheld. *See Wash. Pub. Ports Ass’n v. Dep’t of Revenue*, 148 Wn.2d 637, 646, 62 P.3d 462 (2003); *see also Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 845, 104 S. Ct. 2778, 81 L. Ed. 2d

694 (1984) (interpretation should be upheld if it is a “reasonable policy choice for the agency to make”).

The Rural Health Association argues that this Court should reject *Chevron*-style deference to the Department’s rule. Rural Ass’n Br. at 14–15. But as the above cases demonstrate, Washington courts have long deferred to agency expertise when interpreting statutory provisions that are susceptible to more than one meaning. Although our courts have recognized that this is akin to *Chevron* deference, it is the principle rather than the label that matters.¹

The Rural Health Association would nix this long-standing principle in favor of a lower deference standard commonly referred to as *Skidmore* deference. Rural Ass’n Br. at 15 (citing *Skidmore v. Swift & Co.*, 323 U.S. 134, 140, 65 S. Ct. 161, 89 L. Ed. 124 (1944)). But *Skidmore* only applies to informal agency interpretations, not to interpretations that are adopted through notice-and-comment rulemaking. *United States v. Mead Corp.*, 533 U.S. 218, 226–35, 121 S. Ct. 2164, 150 L. Ed. 2d 292 (2001). When an agency does promulgate a formal rule to interpret ambiguous statutory language, a reviewing court “is obliged to accept the agency’s position if [the Legislature] has not previously spoken to the point at issue and the agency’s interpretation is reasonable.” *Id.* at 229.

¹ Cases that recognize the equivalence of the *Chevron* standard with our state’s deference standard include *Sebastian v. Dep’t of Labor & Ind.*, 142 Wn.2d 280, 292–93, 12 P.3d 594 (2000) (dissenting opinion); *Puget Soundkeeper Alliance v. Dep’t of Ecology*, 102 Wn. App. 783, 787 n.4, 9 P.3d 892 (2000); and *Seatoma Convalescent Ctr. v. Dep’t of Soc. & Health Servs.*, 82 Wn. App. 495, 518, 919 P.2d 602 (1996).

The couple of cases cited by the Rural Health Association that apply *Skidmore* deference are therefore inapplicable. *See Western Telepage, Inc. v. City of Tacoma*, 95 Wn. App. 140, 146, 974 P.2d 1270 (1999) (review of agency interpretation contained in an article rather than a rule); *Young v. United Parcel Serv., Inc.*, ___ U.S. ___, 135 S. Ct. 1338, ___ L. Ed. 2d ___ (2015) (no deference to guideline adopted after the onset of litigation).

2. Traditional Rules of Deference Apply Even When an Agency Adopts a Rule That Differs From Its Prior Interpretation of a Statute

The Rural Health Association fights against deference based on the factually incorrect premise that the Department has interpreted “sale, purchase, or lease” in only one way since the statute’s inception. The Rural Health Association also starts from the legally incorrect premise that the Department must stay wedded to any prior interpretation of the statute no matter how much the health care industry has changed over the years. Both lines of argument are flawed.

On the facts, the Rural Health Association repeats the same false allegations included in the Washington State Hospital Association’s brief. First, the Rural Health Association argues that “for over 20 years” the Department unambiguously excluded hospital mergers from certificate of need review. Rural Ass’n Br. at 2. In fact, the Department has required a certificate of need for about half of the mergers that took place over the years. CP at 232. The Rural Health Association then, without citation, states that the Department “first announced” its interpretation of the

statutory terms in 1985. The Department is unaware of any such “announcement.” At any rate, as the Department acknowledged in its reply brief, the Department has been inconsistent in its application of the terms “sale, purchase, or lease” over the years. What this demonstrates “if anything, is that there was good reason for the [Department] to promulgate the new regulation, in order to eliminate uncertainty and confusion.” *Smiley v. Citibank (S.D.), N.A.*, 517 U.S. 735, 743, 116 S. Ct. 1730, 135 L. Ed. 2d 25 (1996).

The Department’s inconsistency over the years also defeats the Rural Health Association’s unsupported argument that there is a “presumption of legislative acquiescence” based on the Legislature’s failure to amend the definition of “sale, purchase, or lease.” Rural Ass’n Br. at 2. Did the Legislature acquiesce in the Department’s decisions *not* to review mergers and certain other transactions, or in the decisions where the Department *did* review those transactions? Setting that aside, the Rural Health Association presents no evidence that the Legislature was aware of any of the Department’s prior decisions, which are fact-specific and not subject to a public process. *See* WAC 246-310-050. In contrast, the Department went through a very public process before promulgating WAC 246-310-010(54) in 2013, and the Legislature did not amend the definition of “sale, purchase, or lease” in the 2014 or 2015 legislative sessions. Thus, if it is possible to conclude anything from legislative inaction, it may be that the Legislature has acquiesced in the Department’s

rule rather than in the non-public and fact-specific decisions that the Department has rendered over the years.

On its legal arguments, the Rural Health Association fares no better. A change in agency interpretation does not eliminate the deference usually given to the agency. *Smiley*, 517 U.S. at 742. Rather, an agency “must be given ample latitude to adapt [its] rules and policies to the demands of changing circumstances.” *Rust v. Sullivan*, 500 U.S. 173, 187, 111 S. Ct. 1759, 114 L. Ed. 2d 233 (1991) (alteration in original) (internal quotation marks omitted). Courts grant substantial deference to a changed interpretation if there is a valid reason for the change. *Robertson v. Methow Valley Citizens Council*, 490 U.S. 332, 355–56, 109 S. Ct. 1835, 104 L. Ed. 2d 351 (1989). Changed factual circumstances are one such valid reason. *Nat’l Cable & Telecomms. Ass’n v. Brand X Internet Servs.*, 545 U.S. 967, 981, 125 S. Ct. 2688, 162 L. Ed. 2d 820 (2005) (internal quotation marks omitted) (quoting *Chevron*, 467 U.S. at 863–64).

Here, the Department promulgated its rule in response to rapidly changing circumstances in the health care industry brought about by the Affordable Care Act. The industry amici briefs help describe the scope of these changes and the resulting proliferation of hospital consolidations. Rural Ass’n Br. at 9–13; Medical Ass’n Br. at 10–12. But rather than allow the certificate of need regulations to evolve as the industry evolves, the industry amici’s unfortunate solution appears to be to dump the certificate of need program altogether and just let hospitals continue their massive restructuring of the health care marketplace without any

regulatory oversight. *See* Medical Ass’n Br. at 6 (complaining about certificate of need program). As the other amici point out, however, the certificate of need program is often the only mechanism for ensuring that vital hospital services are preserved within a community. *See* Northwest Health Law Advocates (NoHLA) Br. at 15–19; American Civil Liberties Union (ACLU) Br. at 5–12; Nurses Ass’n Br. at 17. It is in response to this reality that the Department took a fresh look at the statute and decided to adopt a comprehensive definition of “sale, purchase, or lease.” Doing so was well within the Department’s authority. Indeed, an agency should “consider varying interpretations and the wisdom of its policy on a continuing basis.” *Nat’l Cable*, 545 U.S. at 981. The industry amici are wrong that the Department’s rule deserves no deference.

B. The Industry Amici’s Arguments Are Largely an Attack on the Certificate of Need Statute Itself, Not This Rule

The industry amici complain that the rule is too broad because it applies to “part or all of any existing hospital” and because it applies to public hospital districts. They also complain that the certificate of need process is too burdensome and too costly. These complaints, however, are about the statute itself, not the rule. And, at any rate, the amici’s complaints are factually and legally unfounded.

1. The Statute Itself Requires Certificate of Need Review for Transactions Involving “Part or All of Any Existing Hospital”

The industry amici argue that a large number of transactions will get swept into certificate of need review because the rule applies to “part

or all” of any existing hospital. Medical Ass’n Br. at 13–14; Rural Ass’n Br. at 13. But this language exactly mirrors the statute, which directs the Department to conduct certificate of need review on “[t]he sale, purchase, or lease of *part or all* of any existing hospital.” RCW 70.38.105(4)(b) (emphasis added). Certainly the Department didn’t exceed its statutory authority by including language that exactly tracks the statutory language.

The amici’s suggestion that the rule could apply to acquisitions of non-hospitals is also unsupported. *See* Rural Ass’n Br. at 6–7, 12; Medical Ass’n Br. at 15–16. By its plain language, the rule applies only to a transaction in which control *of the hospital* changes to a different person. WAC 246-310-010(54). If control of the hospital does not change, then the rule does not apply. Indeed, even the amici don’t agree among themselves what the scope of the rule will be, with the Medical Association arguing that Accountable Care Organizations will fall under the rule and the Rural Health Association arguing that formation of such organizations do *not* result in a change in control. Medical Ass’n Br. at 12–13; Rural Ass’n Br. at 12. The language of the rule itself dictates when it will apply—when there is a change in control of part or all of a hospital. Transactions that do not fall within this language will not be affected. *See, e.g.*, CP at 194–96 (Department declining to review transaction because it did not involve acquisition of a *hospital*).

2. The Statute Itself Covers Public Hospital Districts

The Public Hospital Districts argue that the rule is invalid as applied to the Districts themselves. *See, e.g.*, Districts Br. at 1 (rule is

irrelevant for hospitals governed by elected district commissioners);
3 (Department's concern over lack of public involvement in public hospital district transactions is unfounded). In essence, the Districts seek an exemption from the rule. However, the Legislature did not see fit to exempt the Districts from the certificate of need statute, and the Department is charged with implementing the statute. Therefore, the Department did not exceed its statutory authority by failing to exempt Public Hospital Districts from the rule.

The Districts seek an exemption because they argue that any affiliation or partnership involving a public hospital district will likely undergo a public review and approval process such that certificate of need review would be redundant. That is not factually accurate. Between 1998 and 2012, there were seven affiliations involving public hospital districts, but only two of them were required to undergo the review and approval process for acquisitions of public district hospitals. Sigman Reply Decl. to Stay Mot. ¶ 3, Ex. A. Involvement of a public hospital district, therefore, does not guarantee public involvement prior to a transfer of control to a new entity. For example, in a recent affiliation between the King County Public Hospital District No. 1 and the University of Washington, the District subsequently tried to back out of its contract with the University by arguing that the District had improperly ceded the powers of its elected commissioners to the University. *Pub. Hosp. Dist. No. 1 of King Cnty. v. Univ. of Wash.*, 182 Wn. App. 34, 41, 327 P.3d 1281 (2014). Prior to the lawsuit, many had criticized the District's deal with the University for

giving the University majority control of the hospital's operations without any public input or accountability to the District's voters.² In that instance, the mere involvement of a public hospital district did not result in public participation. However, if WAC 246-310-010(54) had been in effect, that transaction would have likely undergone public scrutiny before being approved.

In sum, the Department agrees with the Districts' argument that public involvement is critically important before a community hospital transfers control of its operations to a new entity. The Department disagrees that the public is already involved in all transactions involving public district hospitals, and the Department certainly disagrees that the public is involved in the majority of transactions that don't involve public district hospitals. The Districts' request for an exemption is misplaced and should be disregarded.

3. Industry Amici's Claims About the Costs and Burdens of Certificate of Need Review Are Overblown and an Attack on the Statute Itself, Not the Rule

The industry amici repeat the Washington State Hospital Association's complaint that certificate of need review is too burdensome and too costly. The Medical Association, for example, complains about how "expanded [certificate of need] review and litigation . . . increases the 'transaction cost' of the [certificate of need] process (application fees plus

² See, e.g., Bruce Ramsey, Op-Ed., *Alliance of UW Medicine, Valley Medical a Hard Pill to Swallow for Some*, Seattle Times, Dec. 4, 2006, available at <http://www.seattletimes.com/opinion/op-ed-alliance-of-uw-medicine-valley-medical-a-hard-pill-to-swallow-for-some/>.

cost of litigation).” Medical Ass’n Br. at 15. But certificate of need reviews for sales, purchases, and leases are not lengthy nor are they usually litigated. In fact, only one certificate issued for a sale, purchase, or lease was ever appealed—back in 1989. Sigman Stay Decl. ¶ 3. And these transactions are subject to expedited review under WAC 246-310-110(2)(b).

The industry amici also exaggerate the cost of review by claiming that costs range from \$100,000 to over \$500,000. Districts Br. at 16 n.42. Actually, when hospitals self-reported their costs to the Department, the costs ranged from \$10,000 to \$200,000. AR at 92–96. Also, a certificate of need is a one-time cost paid from the hundreds of millions or even billions of dollars in patient revenues that hospitals bring in annually. *See* Dep’t Reply Br. at 16.

In truth, it is the certificate of need statute itself that the industry amici are opposed to. The Medical Association irrelevantly refers to the fact that other states have repealed their certificate of need laws, suggesting that our Legislature should perhaps follow suit. Medical Ass’n Br. at 6. These arguments are properly made to the Legislature, not to this Court. The issue before this Court is whether the Department exceeded its statutory authority in promulgating WAC 246-310-010(54). The Department did not, so the rule should be upheld.

C. The Industry Amici Fail to Show That the Rule Will Prevent Beneficial Changes in the Health Care Marketplace

The industry amici argue that the rule will hinder their ability to engage in transactions that are envisioned by the Affordable Care Act. *See, e.g.*, Medical Ass’n Br. at 2 (“expanded” certificate of need program will “prevent” agreements to coordinate and integrate patient care and other key functions); Rural Ass’n Br. at 9 (rule “interferes with necessary market-based responses” to the Affordable Care Act). Those arguments are incorrect. As noted above, the rule applies only to a change in control of a hospital. Many of the transactions that the amici identify do not involve a change in control of a hospital, so the rule would not apply.

Also, the certificate of need process does not press a stop button on all transactions, as the amici allege. Rather, the process presses a pause button to ensure that there is adequate public and regulatory deliberation before major hospital transactions are consummated. The benefits of this careful and deliberative process far outweigh the relatively short delay involved in the review process for the sale, purchase, or lease of a hospital. *See Sigman Stay Decl.* ¶ 3 (length of time to review “sale, purchase, or lease” transaction is usually four to six months).

The industry amici also assume that unfettered affiliations and consolidations are necessarily a good thing and that the Department simply needs to get out of the way. The Medical Association, for example, extols the virtues of greater consolidation and warns that the alternative would impede innovation and raise patient costs. Medical Ass’n Br. at 10–14. Other amicus briefs, however, chronicle the many ways in which

consolidations and affiliations have actually increased patient costs, sometimes in excess of 20 percent. NoHLA Br. at 10–12; Nurses Ass’n Br. at 9–10.

In the end, the industry amici present nothing other than fear mongering and speculation when they argue that certain beneficial transactions will be prevented by the Department’s rule. In contrast, the Department is aware of several instances where health care services have already been reduced or eliminated because of an affiliation.³ Without the rule, this troubling trend will continue. The Department’s rule addresses a real threat to health care access, whereas the industry amici have failed to show any of the harms that they claim this rule creates.

D. The Department’s Rule Advances the Primary Purpose of the Certificate of Need Program by Ensuring That Major Hospital Transactions Do Not Decrease or Eliminate Access to Health Care Services

The promotion and maintenance of health care for all citizens is the “overriding purpose of the [certificate of need] program.” *Overlake Hosp. Ass’n*, 170 Wn.2d at 55. WAC 246-310-010(54) advances that purpose by ensuring that major hospital transactions involving a change in

³ See, e.g., AR at 163 (affiliation of Highline Medical Center with Franciscan Health System resulting in prohibition on information about and referrals on aid-in-dying and restriction of broad range of reproductive services, including birth control and abortions); AR at 235 (Swedish Hospital discontinuing abortions after affiliating with Providence); AR at 250 (Harrison Medical Center affiliation with Franciscan resulting in ban on abortions and aid-in-dying); AR at 265 (PeaceHealth threatening to discontinue lab services for Planned Parenthood based on Bishop’s directive); Tr. at 11 (decrease in on-site pediatric services); Tr. at 16 (Everett General Hospital eliminating emergency services after affiliation with Providence, and Valley Regional Hospital eliminating mammography machine after affiliation).

control are publicly vetted and subject to regulatory oversight. Prior to approving a change in control, the Department evaluates whether the transaction will eliminate a health care service and, if so, whether that service is available elsewhere in the community. WAC 246-310-210(1)(a). If the service is not available elsewhere, the Department can condition its approval by requiring the hospital to maintain the service that would otherwise be lost to the community. WAC 246-310-490(3). This ensures that patients do not lose access to needed health care services.

Several amicus briefs point out services that could be jeopardized if major hospital transactions slip through without any public or regulatory oversight. For example, a decrease in a hospital's level of charity care would create significant hardship for low-income patients. NoHLA Br. at 16–18; WAC 246-310-210(1)(a) (requiring Department to review transaction's likely effects on low-income and other underserved groups like racial and ethnic minorities). Consolidations between secular and religious institutions can decrease or eliminate access to certain reproductive health services such as contraception, vasectomies, fertility treatments, and all abortions, including in instances of ectopic pregnancy, rape, and danger to the mother's life. ACLU Br. at 7–8; Nurses Ass'n Br. at 8. Such consolidations can also impact end-of-life care by, for example, prohibiting compliance with the terms of a patient's living will. ACLU Br. at 7–8; Nurses Ass'n Br. at 8.

The industry amici dismiss these concerns by fixating on the same OFM report that the Washington State Hospital Association cited. Rural

Ass'n Br. at 3, 16–17; Medical Ass'n Br. at 8. Again, the superior court excluded that report from the record because it didn't exist at the time that the Department finalized its rule. CP at 347–48. The Washington State Hospital Association did not cross appeal, so the OFM report is not part of the record and cannot be considered. *See, e.g., Kailin v. Clallam Cnty.*, 152 Wn. App. 974, 990, 220 P.3d 222 (2009) (cross appeal is essential if respondent seeks affirmative relief by the appellate court). But even if the report was in the record, it would shed little if any light on whether major hospital transactions involving a change in control can impair access to health care services. The report only evaluated three procedures, none of which are typically performed in a hospital setting. Thus, the OFM report tells us next to nothing about how hospital consolidations and affiliations might impact patients' access to care.

The industry's desire for the narrowest possible definition would defeat the statutory purpose by excluding newly titled transactions having the same outcomes as "sales, purchases, and leases" from certificate of need review. In contrast, the Department's definition of "sale, purchase, or lease" advances the statutory purpose of preserving access to health care services. If a statute can be interpreted in more than one way, "the interpretation which better advances the overall legislative purpose should be adopted." *Weyerhaeuser Co. v. Dep't of Ecology*, 86 Wn.2d 310, 321, 545 P.2d 5 (1976). WAC 246-310-010(54) is, at a minimum, "reasonably consistent" with the statute being implemented and should be upheld. *See Wash. Pub. Ports Ass'n*, 148 Wn.2d at 646.

E. Public Involvement Is an Integral Part of Certificate of Need Review

Another important purpose of the certificate of need statute is to involve citizens in health care planning. RCW 70.38.015(1). Yet, with the exception of the Public Hospital Districts, the industry amici completely disregard this public interest. For example, as the Medical Association makes clear, it would prefer doing away with certificates of need altogether, creating a world where affiliations and consolidations continue to proliferate without the interference of pesky regulators and citizens. Medical Ass'n Br. at 6, 12–17. But the brave new world envisioned by industry would undermine rather than advance the statutory goal of including the public in health care planning.

Public involvement is ensured by allowing citizens and health care providers to comment on materials submitted by the certificate of need applicant and to participate in public hearings on the application. RCW 70.38.115(9); WAC 246-310-180. As shown by the recent affiliation between King County Hospital District No. 1 and the University of Washington, depriving citizens of a chance to weigh in on health care planning within their communities can result in public outrage, resentment, and backroom deals that can't be unwound. *See generally Pub. Hosp. Dist. No. 1*, 182 Wn. App. 34.

As stated in the Districts' amicus brief, “[Public Hospital Districts] and the community-minded commissioners that govern them support public awareness and involvement in change of control transactions.” Districts Br. at 20. So do the many members of the public that weighed in

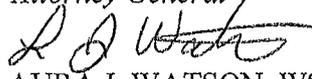
on the Department's rule, and so does the Department. Unfortunately, most of these transactions, whether they involve public, non-profit, or for-profit hospitals, are completely evading certificate of need review. WAC 246-310-010(54) will ensure that these major hospital transactions receive public and regulatory oversight before the deals are signed. The Department's rule is a reasonable interpretation of the statute and best satisfies the statutory purposes. It should therefore be upheld.

III. CONCLUSION

Like the Washington State Hospital Association, the industry amici fail to show that WAC 246-310-010(54) is invalid. To the contrary, the rule properly interprets undefined statutory terms in a way that is consistent with the statutory language. Without the rule, the health care marketplace in Washington could completely transform without any public involvement or regulatory input. As a result, access to community care could be severely compromised. The certificate of need statute aims to prevent this result, and WAC 246-310-010(54) helps accomplish this legislative purpose. The rule is a valid exercise of the Department's rulemaking authority and should be upheld.

RESPECTFULLY SUBMITTED this 12th day of May 2015.

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CERTIFICATE OF SERVICE

I certify, under penalty of perjury under the laws of the state of Washington, that on this date I have caused a true and correct copy of Appellant's Answer to Amici Curiae Briefs of Association of Washington Public Hospital Districts, Washington Rural Health Association, and Washington State Medical Association to be served on the following via e-mail:

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Case Name: *Washington State Hospital Association v. Washington State Department of Health*
Case No.: 90486-3

Attached for filing in the above matter please find Appellant's Answer to Amici Curiae Briefs of Association of Washington Public Hospital Districts, Washington Rural Health Association, and Washington State Medical Association.

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