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November 26, 2013

**Hand-Delivered**

Janis Sigman

Department of Health

P.O. Box 47852

Olympia, WA 98504-7852

Dear Ms. Sigman,

Thank you for the opportunity to comment on the proposed rulemaking currently underway at the Department of Health for WAC 246-310-010, Certificate of Need and WAC 246-320-141, Hospital Licensing. We have significant concerns about both proposed rules, outlined below. In addition, our prior comments largely still apply.

WAC 246-310-010, Certificate of Need

**The proposed change to require CON review for transactions that involve a change of control other than a purchase, sale, or lease is contrary to law, and contrary to decades of precedent and clear interpretation by the Washington State Department of Health.**

State law and the existing rule require a Certificate of Need for a “sale, purchase, or lease of part or all of any existing hospital.”[[1]](#endnote-1) The phrase “sale, purchase, or lease” is well-defined in Washington law. A plain, clear, and unambiguous statute cannot be construed; its meaning is strictly interpreted from the words of the statute itself.[[2]](#endnote-2) This terminology does not include all changes of control. The Department of Health does not have the authority to amend or modify the statute.

The Department of Health has consistently found, over a period of more than 20 years, that mergers and affiliations do not require CON review. It has issued many determinations of non-reviewability in cases involving corporate reorganizations and changes in ownership interest and/or control of a hospital, ranging from changes in the entity that owns the hospital to changes that occur at levels above the hospital.[[3]](#endnote-3) The Department has explicitly acknowledged that a change in ownership and control of a hospital that occurs either through a corporate reorganization or through a transaction that falls short of a transfer of title to the assets of a licensed hospital does ***not*** result in the purchase or sale of a hospital and is ***not*** reviewable under the CON law. In the Department’s own words, “***had the CON law been intended to apply to mergers it would have specifically so stated.***”[[4]](#endnote-4)

If the legislature had intended the Certificate of Need law to apply to a change of ownership interest and/or control of a hospital, then the CON law would have included this language in defining what requires CON review.

Given this history, if the Department changes the rule now to encompass transactions which it previously clearly stated are not captured by the statute, it would be acting in an arbitrary and capricious manner.

**The proposed rule is so broad that it would require a multitude of arrangements to flow through Certificate of Need. The timing of the Certificate of Need process would stifle hospitals’ efforts to modernize and streamline.**

The proposed rule seeks to regulate a multitude of changes that happen in hospitals on an ongoing basis. The idea that “sale, purchase, or lease” would encompass a direct or indirect change in control of part or all of a hospital, by contract, affiliation, corporate membership restructuring, or any other transaction, is an enormously broad definition. It is far outside the scope of what the words “sale, purchase, or lease” mean. We expect if the rule were to be enacted, the Department would be inundated with Certificate of Need applications it is unprepared and understaffed to manage.

Hospitals are seeking ways to streamline their services and cut costs while maintaining quality. These decisions often lead to arrangements with outside groups who can perform the service more efficiently. Outsourcing Human Resources, joining a group to manage supply chain, or contracting with a provider group – all of these could be considered a change in control over part of the hospital. Even intra-company agreements could be swept up in this rule, which could impede a hospitals’ ability to manage efficiently.

The Certificate of Need process is a lengthy one, and legislative studies have pointed to its inefficiency and arbitrary nature.[[5]](#endnote-5) Requiring approval for so many different types of arrangements would be costly and significantly slow hospitals’ ability to make important changes.

Questions for the Department:

* What is the Department’s legal analysis of the statutory basis for expanding the scope of what is subject to Certificate of Need? How does the Department reconcile past agency precedent interpreting the law with the expanded scope of this proposed rule?
* Has the Department considered alternate ways to achieve its goals of increased public input and public process without subjecting health systems to a dramatic increase in regulatory process and resulting administrative burden and financial impact – a financial impact that is ultimately borne by patients?
* How will the Department staff the increased Certificate of Need applications?
* How will the Department process these increased applications in a timely manner, when the current process is already slow?
* If one of the Department’s goals is to improve access to end-of-life and reproductive services, how will subjecting more transactions to the Certificate of Need process improve this access?
* Will the Department condition the granting of Certificate of Need on the availability of abortion and Death with Dignity Act services? Under what statutory basis?
* Has the Department considered other avenues to address the goal of access to reproductive health services and end-of-life care that is not the Certificate of Need process, such as community health planning or community health needs assessments?
* If one of the Department’s goals is to improve access to end-of-life and reproductive health services, broadening the base of providers considered beyond those regulated under Certificate of Need would make sense. How will the Department assess the availability of other community resources for reproductive and end-of-life services and take these into account in the Certificate of Need process?
* How will the Department determine “need” for reproductive and end-of-life services?
* How will the Department take steps to ensure any unmet need is satisfied?

WAC 246-320-141, Hospital Licensing

We appreciate the changes the Department made between the concept rule and the formal rule proposal to partially address our concerns about the exceedingly broad nature of the concept rule. The rule would have required hospitals to create exhaustive, ever-changing, and probably unknowable lists about everything they do and do not offer, and every service they will and will not admit a patient to receive.

However, we still have concerns that the proposed requirement to submit policies has the potential to create extraordinary administrative burdens with very little value to the patient. Patients would have great difficulty wading through complicated hospital policies. We suggested an alternate approach of using the services inventory that would have provided easier-to-understand information to patients in a workable manner for hospitals. We are disappointed the Department did not adopt this suggestion.

We also believe that if the Department’s goal is to catalog where specific services are provided – in particular, abortions and Death with Dignity Act services – it should create a catalog that includes all relevant health care providers – physician offices, ambulatory surgical centers, health centers, and clinics. Hospital policies alone would provide a very limited inventory of available services.

Abortions and assisted suicides are largely provided outside hospital settings and patients often seek these services from other providers. Collecting policies from hospitals only and presenting them on the Department’s website as the list of places to get services would provide a very narrow view – and could have the unintended consequence of leading a patient to believe a service is not available in their community when it actually is available from a non-hospital provider.

In addition, hospital policies could be misleading to patients. Hospitals may have “permissive” policies related to abortion or Death with Dignity, but may not have doctors, nurses, anesthesiology providers, and technicians who are willing to perform the service or prescribe the medication – a situation that has been frustrating for patients.[[6]](#endnote-6) Hospitals as institutions cannot provide these services; there must be licensed personnel willing to do so. Hospitals are not allowed to compel any of their individual providers to provide abortion or end-of-life services if they are not comfortable doing so, nor can they require it as a condition of hiring or privileging.[[7]](#endnote-7)

Questions for the Department:

* Has the Department evaluated the ability of the policy collection process to provide meaningful information about what services are available at a particular hospital compared to a listing of services that could be gathered through a health services inventory?
* How will the Department provide potential patients information about other resources for abortion and Death with Dignity Act services, rather than the limited view hospital policies will provide?
* How will the Department evaluate what services may or may not be available at a particular hospital based on conscience clause opt-outs by providers?
* We have concerns about the time required and the cost of providing policies to the Department. We do not believe that 60 days is an adequate time frame, particularly for hospitals where policy development requires committee and governance approval. Has the Department considered a longer time period for compliance following the effective date?

Sincerely,

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Taya Briley Cassie Sauer

General Counsel Senior Vice President

Advocacy and Government Affairs

cc: **John Wiesman, DrPH, MPH, Secretary of Health**

**Steve Saxe, Director, Health Professions and Facilities**

1. RCW 70.38.105(4)(b). [↑](#endnote-ref-1)
2. *Bravo v. Dolmen Cos.*, 125 Wn.2d 745, 752, 888 P.2d 147 (1995). “Words in a statute are given their ordinary and common meaning absent a contrary statutory definition. Courts may resort to dictionaries to ascertain the common meaning of statutory language.” *Budget Rent-a-Car Corp. v. State*, 144 Wn.2d 889, 899 (2001) (internal citations omitted). *Webster’s* defines “purchase” as “to acquire real estate by means other than descent” or “to obtain by paying money or its equivalent: buy for a price.” *Webster’s Third New International Dictionary* 1844 (11th ed. 2004); *see also* *Black’s Law Dictionary* 1354 (9th ed. 2009) (“the act or instance of buying”). Similarly, “sale” is defined as “the act of selling: a contract transferring the absolute or general ownership of property from one person or corporate body to another for a price (as a sum of money or any other consideration).” *Webster’s Third New International Dictionary* at 2003; *see also* *Black’s* *Law* *Dictionary* at 1454 (9th ed. 2009) (“The transfer of property or title for a price.”). Both terms clearly incorporate the elements of transfer of title for consideration. [↑](#endnote-ref-2)
3. In August, 2013, the Department concluded that the affiliation between Franciscan Health System (“Franciscan”) and Harrison Medical Center was not subject to CON review. The affiliation involved the creation of a new corporation, Franciscan Health Ventures, consisting of a combined board from the two organizations. The Harrison board would still oversee the hospital’s day-to-day operations, but financial matters, appointments to the Harrison board and other major decisions would be decided by Franciscan Health Ventures.

In December 2012, the Department concluded that the affiliation of Franciscan with Highline Medical Center’s (“Highline”) main campus was not subject to CON review. Franciscan became the sole member of, and the parent entity to, Highline which previously had no members. Highline continued to exist as a separate Washington not-for-profit corporation.

In December 2011, the Department determined that the affiliation of Swedish Health Services (“Swedish”) with Providence Health and Services (“Providence”) was not subject to CON review. That transaction involved an intra-company transfer of the Western Washington hospital and health care assets of Providence Ministries to Providence Health and Services-Western Washington (“PH&S-WW”) and the formation of a new Washington nonprofit corporation which became the sole member of Swedish and a co-member, along with Providence Ministries, of PH&S-WW. The Department determined that neither Swedish obtaining a corporate member nor PH&S-WW obtaining another corporate member were subject to CON review.

In September, 2010, the Department determined that the affiliation of PeaceHealth and Southwest Washington Health System (“SWHS”), which was the sole corporate member of Southwest Washington Medical Center (“SWMC”), was not subject to CON review. The transaction involved PeaceHealth becoming the sole corporate member of SWHS. Pursuant to the affiliation agreement, on January 1, 2013, SWMC merged into PeaceHealth with the latter as the surviving entity.

In 2009, the Department concluded that the affiliation of Northwest Hospital Medical Center with UW Medicine did not require CON review. UW became the sole corporate member of NWHMC (which changed its name to “UW Medicine/Northwest”). The affiliation involved no transfer of title. The hospital continued to be owned, operated by, and licensed to Northwest Hospital Medical Center (albeit under the new name). UW Medicine made no payment as part of the transaction.

In March 2007, the Department determined that the affiliation between Franciscan and Enumclaw Regional Hospital did not require CON review. In that transaction, Franciscan became the sole corporate member of, and the parent entity to, ERH, replacing the all of the existing community members of ERH.

In August 2006, the Department determined that a transaction involving the affiliation of Good Samaritan Hospital in Puyallup, Washington into MultiCare Health System was not subject to CON review. That transaction was structured as a corporate affiliation in which MultiCare became the sole corporate member of Good Samaritan Community Healthcare (“GSCH”). GSCH was the sole corporate member of Good Samaritan Hospital, which owned and operated an acute care hospital in Puyallup, Washington. After the transaction, GSCH continued to operate Good Samaritan Hospital within the family of MultiCare affiliated organizations. The Department concluded that the corporate affiliation was not a purchase or sale of a hospital and was therefore not subject to CON review.

In September 2005, the Department determined that a transaction in which HCA, Inc. transferred to Capella Healthcare, Inc. its ownership interest in certain subsidiaries that owned and operated hospitals, including Capital Medical Center in Olympia, Washington, was not subject to CON review. That transaction involved a two-step process in which HCA first reorganized its subsidiaries’ holdings and then transferred ownership and control in its subsidiaries to Capella.

In a similar determination in June 2005, the Department concluded that a stock transaction in which Ardent Health Services, L.L.C. sold to Psychiatric Solutions, Inc. 100% of the stock of Ardent’s subsidiary, Ardent Health Services, Inc. (“AHS”), did not require CON review. AHS was the ultimate parent of an entity that owned and operated Fairfax Hospital in Kirkland, Washington. The Department then concluded that the entity subject to the stock sale, AHS, was not a hospital under state law and, therefore, the stock purchase between Psychiatric Solutions, Inc. and Ardent and resulting change of control of Fairfax Hospital was not subject to CON review.

In 1997, Tenet Healthcare Corporation acquired OrNda Healthcorp by issuing over 81 million shares of its common stock in a tax-free exchange for all of OrNda’s outstanding common stock such that OrNda became the wholly-owned subsidiary of Tenet. OrNda was the parent organization of Puget Sound Hospital (“PSH”) in Tacoma. The Department determined that the Tenet-OrNda transaction did not require prior CON review and approval.

In 1992, the Department concluded that the statutory merger of Ballard Community Hospital (“Ballard”) with Swedish Hospital Medical Center did not require CON review because it was not the sale, purchase or lease of part or all of an existing hospital. Swedish Hospital Medical Center acquired the assets of Ballard through the merger without paying or providing Ballard with any other compensation. Swedish Hospital Medical Center was the sole surviving corporation operating under a single hospital license.

Also in 1992, as a part of a corporate restructure, American Healthcare Management, Inc. (“AHM”) sought to transfer the shares of PSH, Inc., the owner and licensed operator of Puget Sound Hospital, to AHM Capital Management, Inc., another wholly-owned subsidiary of AHM. The Department found that the transaction did not constitute the sale, purchase or lease of all or part of a hospital because PSH remained the owner and operator of Puget Sound Hospital and the transaction did not involve the exchange of compensation for the corporate stock shares of PSH.

In 1989, AHM, the parent organization of PSH, Inc. (the owner and licensed operator of PSH), filed a petition for reorganization in bankruptcy.  Under the plan of reorganization, AHM’s senior secured creditors were to receive a majority (50.5%) of the total outstanding new common stock in AHM.  AHM took the position that the change of control in the shareholders of AHM did not constitute the sale, purchase or lease of all or part of a hospital.  AHM reasoned that PSH, Inc. would continue to be the owner and the licensed operator of PSH and AHM would continue to own and control 100% of the outstanding shares of PSH, Inc.  The Department agreed and determined that CON review was not required.

Also in 1989, the Department determined that a proposed acquisition of AHM by Merrill Lynch and Bain Venture Capital did not amount to the purchase or sale of a hospital and did not require Certificate of Need review.  In the proposed AHM-Merrill Lynch/Bain transaction, a new entity was to purchase all of the outstanding shares of common stock of AHM for a total acquisition price of $200 million.  [↑](#endnote-ref-3)
4. In 2000, a transaction between Swedish and Providence resulted in a change of ownership in and control of Providence Seattle Medical Center. The transaction also involved a corporate reorganization by Providence Health System-Washington and a subsequent merger of a newly formed holding company, PSMC, LLC, into Swedish Health System. The Department recognized clearly that this resulted in a “transfer [of] ownership and control” of Providence Seattle. *See* Department determination of non-applicability letter, at page 2, dated June 26, 2000. [↑](#endnote-ref-4)
5. Joint Legislative Audit and Review Committee, Performance Audit of the Certificate of Need Program, Final Report, June 2006 <http://www.leg.wa.gov/JLARC/AuditAndStudyReports/2006/Pages/06-6.aspx>. [↑](#endnote-ref-5)
6. “Man’s final wish for death with dignity unfulfilled,” Wenatchee World, April 9, 2009, *available at* <http://www.wenatcheeworld.com/news/2009/apr/09/mans-final-wish-for-death-with-dignity-unfulfilled/>. [↑](#endnote-ref-6)
7. RCW 9.02.150 states: “No person or private medical facility may be required by law or contract in any circumstances to participate in the performance of an abortion if such person or private medical facility objects to so doing. No person may be discriminated against in employment or professional privileges because of the person's participation or refusal to participate in the termination of a pregnancy.” [↑](#endnote-ref-7)