STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE SERVICE UNIT

In Re: EVALUATIONS DATED FEBRUARY 9, 2012 FOR THE FOLLOWING CERTIFICATE OF NEED APPLICATION PROPOSING TO ADD DIALYSIS STATION CAPACITY TO KING COUNTY PLANNING AREA #4: (1) NORTHWEST KIDNEY CENTERS PROPOSING TO ADD FIVE STATIONS TO SEATAC KIDNEY CENTER; AND (2) DAVITA, INC, PROPOSING TO ESTABLISH A FIVE STATION DIALYSIS CENTER IN DES MOINES, NORTHWEST KIDNEY CENTERS, a Washington nonprofit corporation, Petitioner.	Master Case No. M2012-360 FINDINGS OF FACT, CONCLUSIONS OF LAW, AND FINAL ORDER

APPEARANCES:

Petitioner, Northwest Kidney Centers (NWKC), by
Davis Wright Tremaine, LLP, per
Douglas C. Ross and Lisa Rediger Hayward, Attorneys at Law, and by
Riddell Williams, P.S., per
Barbara Allan Shickrich, Attorney at Law

Intervenor, DaVita, Inc. (Davita), by
Law Office of James M. Beaulaurier, per
James M. Beaulaurier, Attorney at Law, and by
Terrell Marshall Daudt & Willie, PLLC, per
Kimberlee L. Gunning, Attorney at Law

Department of Health (DOH) Certificate of Need Program (Program), by
Office of the Attorney General, per
Richard A. McCartan, Assistant Attorney General

PRESIDING OFFICER: Frank Lockhart, Health Law Judge

The Presiding Officer conducted a hearing on December 5-6, 2012, regarding two Certificate of Need (CN) Applications to each establish dialysis stations in the same planning area, to wit: DaVita's application to establish a five-station dialysis center in Des Moines and NWKC's application to add five stations to its dialysis center in SeaTac.

ISSUES

A. Does DaVita's application to establish a five-station dialysis center in the King County Planning Area #4 meet the relevant CN criteria in WAC 246-310-210, WAC 246-310-220, WAC 246-310-230, and WAC 246-310-240?

B. Does NWKC's application to add five stations to its dialysis center in the King County Planning Area #4 meet the relevant CN criteria in WAC 246-310-210, WAC 246-310-220, WAC 246-310-230, and WAC 246-310-240?

C. If both DaVita's and NWKC's applications meet the above-listed criteria, which application better meets the tie-breaker criteria set forth in WAC 246-310-288?

PROCEDURAL HISTORY

In May 2011, NWKC applied for a CN to add five dialysis stations at its SeaTac facility, which would increase its capacity from 25 dialysis stations to 30 stations. The initial estimated capital expenditure of this project was $100,969.

That same month, DaVita applied for a CN to build a new five-station dialysis facility in Des Moines, Washington. The initial capital expenditure of DaVita's project was $1,824,465. DaVita amended their application in June 2011, and revised their capital expenditure to $1,992,705.

Franciscan Health Systems also applied for a CN in May 2011, to establish a new five-station dialysis facility in the same King County planning area, but subsequently withdrew its application, and thus will not be considered herein.

On February 9, 2012, after an extensive evaluation, the Program awarded the CN to DaVita. NWKC timely filed a petition for an adjudicative hearing.

SUMMARY OF PROCEEDINGS

At the hearing, the Program presented the testimony of Karen Nidermayer, CN Analyst. NWKC presented testimony of: Palmer Pollock, Director of Support Services for NWKC; Scott Strandjord, Chief Financial Officer for NWKC; and Helen Wattley-Ames, Joshua Green Corporation. DaVita presented testimony of Jason Bosh, Group Regional Operations Director for DaVita. Closing arguments were filed by brief pursuant to RCW 34.05.461(7).

The Presiding Officer admitted the following exhibits at hearing:

Program Exhibits:

Exhibit P-1: The Application Record.

DaVita Exhibits:

Exhibit D-2: NWKC Rebuttal documents;

Exhibit D-6: Map of Planning Area (demonstrative exhibit);

Exhibit D-8: Comparison of Revenue per Treatment of DaVita and NWKC (demonstrative exhibit);

Exhibit D-9: Third Year Profit using Average Revenue per Treatment (demonstrative exhibit); and

Exhibit D-10: DaVita Corporate Resources 2010 (demonstrative exhibit).

NWKC Exhibits:

Exhibit N-11: Map of Planning Area (demonstrative exhibit); and

Exhibit N-12: Chart of Distances from DaVita to other facilities (demonstrative exhibit).

Supplemental Exhibits (see Post-Hearing Order No. 2):

Supplemental Exhibit 1: Declaration of Jason Bosh.

(Note: All citations to the Application Record herein are in footnote form, citing to the Bates Stamp number, as in "AR 343." All citations to the transcript of the administrative hearing are likewise cited, as in "TR 99.")

I. FINDINGS OF FACT

1.1 NWKC is a private, not-for-profit corporation that provides dialysis services in King and Clallam counties. NWKC owns and operates 14 dialysis facilities in Washington, of which 13 are in King County, including their SeaTac Kidney Center.[1] DaVita is a publicly held, for-profit corporation that provides dialysis services in multiple states including Washington.[2] DaVita owns or operates 24 kidney dialysis centers in Washington, of which four are in King County.[3]

1.2 In order to qualify for a CN, an applicant must show compliance with WAC 246-310 and demonstrate that the proposed project (a) is needed; (b) is financially feasible; (c) will meet certain criteria for structure and process of care; and (d) will foster containment of costs of health care. Both DaVita's and NWKC's applications were reviewed under these criteria in the adjudicative process.

[1] AR 747, TR 136.

[2] AR 147.

[3] AR 7.

WAC 246-310-210 "Determination of Need"

1.3 Pursuant to WAC 246-310-210, applicants for a CN must demonstrate a need for the proposed services. For kidney disease treatment facilities, the method for projecting the numeric need for dialysis stations is described in WAC 246-310-284.

1.4 In this case, there was no dispute about the need for additional dialysis stations. Using verified population and patient information from the Northwest Renal Network, the Program projected a need for five additional dialysis stations by the year 2014.[4] DaVita's calculation came to the same result.[5] NWKC's calculations showed the slightly reduced figure of 4.4 stations needed by the year 2014.[6] However, WAC 246-310-284(4)(c) requires such calculations to be rounded up to the nearest whole number. Thus, all the parties demonstrated a need for five dialysis stations.

1.5 One of the sub-criterion of WAC 246-310-210 is whether all residents of the service area, including low-income, racial and ethnic minorities, women, handicapped persons, other underserved groups, and the elderly have adequate access to the proposed projects. Because the majority of dialysis patients are Medicare patients,[7] the Program examined both parties' access policies and their Medicare contracts in this analysis. The Program found, and there is no data in the Application Record to dispute this, that both parties met this sub-criterion.[8]

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4 AR 664-669.

5 AR 666.

6 AR 666.

7 As much as 73% of dialysis patients are Medicare patients. TR 185.

8 AR 668-9.

1.6 Based on the Application Record, the reliability of the underlying population and patient data used by all parties, the application of the proper methodology in projecting need used by all parties, the consistent result in the prediction of a need for five additional dialysis stations by the year 2014, and the accessibility of care available with both DaVita's and NWKC's proposals, the Presiding Officer finds that Need was properly determined.

WAC 246-310-220 "Financial Feasibility"

1.7 Pursuant to WAC 246-310-220, an applicant for a CN must demonstrate that the project is financially feasible. Specifically, an applicant must demonstrate that the capital and operating costs can be met; that the costs of the project will probably not result in an unreasonable impact on the costs for health services; and that the project can be appropriately financed. This is the area where the differences between the two projects become more distinct.

1.8 NWKC proposes to add five dialysis stations to its already existing 25 station SeaTac facility. The project's estimated capital expenditure is $100,969.[9] DaVita, on the other hand, proposes to establish a new facility with an estimated capital expenditure of $1,992,705.[10] In other words, DaVita's capital expenditure would be 19 times that of NWKC's capital expenditure. Both applicants have sufficient cash assets and board approval to finance their respective projects.[11] However, two criteria remain: (1) Can the operating costs be met; and (2) will either project have an

[9] AR 717.

[10] AR 13.

[11] AR 675-6.

unreasonable impact on the costs of health services?

Can operating costs be met?

1.9 WAC 246-310-220 sets forth the criteria that the determination of financial feasibility be based in part on whether "the immediate and long-range capital and operating costs of the project can be met." However, the rule does not lay out a single method of evaluating whether capital and operating costs can be met. Therefore the Program has adopted a practice of looking at income and expenses for the 3rd year of operation as an indicator of financial feasibility.

> "[U]sing its experience and expertise the department evaluates if the applicant's pro forma income statements reasonably project that the proposed project is meeting its immediate and long-range capital and operating costs by the end of the third complete year of operation."[12]

This practice is not codified in RCW or WAC.[13] It is simply a method for examining financial feasibility.

1.10 By the third year of operation, NWKC projects net revenue for the five dialysis stations[14] of $1,350,063; total expenses at $1,273,598; with a net revenue of $76,465. Although DaVita challenged the validity of NWKC's figures, the Presiding

[12] AR 670.

[13] The closest codification is WAC 246-310-284(6) which requires that by the third full year of operation, new kidney dialysis stations be reasonably projected to be operating at 4.8 patients per station. However, both DaVita and NWKC projected that they would achieve this goal, and there was nothing in the application record or at hearing to dispute the reasonableness of this projection.

[14] The figures for the five station project are based on NWKC figures in AR 670 which show income, expense, and net revenue for the 30 stations in the whole facility.

Officer finds they are valid estimates.[15]

1.11 DaVita's third year forecasts, however, are problematic. Because of the depreciated higher capital costs, DaVita's expenses are higher. But oddly, their income is higher.[16] In addition, DaVita's forecasts changed. In their original forecast, DaVita estimated a net loss for the first three years of operation.[17] The original pro forma estimated a net loss of $22,717 for the third year of operation.[18] However in August 2011, in Response to the Program's screening questions, DaVita revised their pro forma to show a net gain of $21,841 by the third full year of operation.[19] This $44,558 change was accomplished by removing landlord operating expenses (landlord taxes, common area maintenance charges, and insurance charges) from the pro forma. DaVita justified the removal of these operating expenses on the basis that such charges "are based upon landlord obligations and arrangements with which an applicant/lessee would have no experience."[20] The Program accepted this revised pro forma.

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[15] DaVita challenged the method whereby NWKC excluded from their rent expense the offices at the facility that were administrative offices for other NWKC facilities and not the SeaTac facility at issue. The Program's evaluation found this exclusion acceptable. The Presiding Officer has examined the figures and also finds it acceptable. DaVita also challenged the validity of NWKC's using a one-year renewable medical director contract as a predictor of multiple year medical director costs. The Presiding Officer finds no merit in DaVita's argument. DaVita also claimed that NWKC lease figures could not be deemed accurate because the property had changed legal owners. There is likewise no merit in this argument since the leases are valid and enforceable against new owners.

[16] This is odd because the vast majority of clients for both facilities would be Medicare/ Medicaid clients, and Medicare/Medicaid payment of charges is at a fixed rate. This issue is discussed further below.

[17] TR 81.

[18] AR 528.

[19] AR 534, TR 83.

[20] AR 534. Despite the Program's acquiescence, the omission of the landlord's operating expenses for the reasons DaVita offered is problematic. Both the landlord and DaVita are sophisticated professionals with experience in budgeting fluctuating expenses. The lease included annual operating expense at $6.00 a foot or $42,000 annually with a maximum of 3% annual adjustments of 3%, (AR 533) so it is reasonable that the parties did foresee expenses that would require annual upward adjustments.

1.12 The following chart is derived from the parties' respective pro forma statements and shows DaVita's original third year projections, its revised third year projections, and NWKC's third year projections.

THIRD FULL YEAR OF OPERATION[21]

	DaVita (Original)	DaVita (Revised)	NWKC
Net Revenue	1,716,696	1,716,696	1,350,063
Total Expense	1,739,414	1,694,856	1,273,598
Net Profit or (Loss)	-22,718	21,840	76,465

1.13 Charts as the one above serve two purposes: Under the WAC 246-310-220 analysis, they are used to answer the question: "Is each proposal, viewed independently, financially feasible?" (Under the WAC 246-310-240 "superiority" analysis - to be discussed below - they are used to answer a different question: "Which proposal is more financially feasible?") Thus, under the WAC 246-310-220 analysis, the Program reviewed DaVita's revised figures and NWKC's figures and determined that each project was able to meet its operating expenses by the third year.

1.14 However, one is struck by the difference in net revenue from both projects which, as indicated, appears odd since they both have the same number of dialysis stations and both have a high percentage of Medicare clients that would provide the same fixed reimbursement for services to both facilities.

1.15 The majority of patients who seek dialysis treatment are Medicare/Medicaid patients. The rest either have other insurance (commercial payors)

[21] This chart is derived from DaVita's pro forma (AR 705), DaVita's revision of its operating costs (AR 534) and NWKC's pro forma (AR 883). NWKC's pro forma figures (for 30 stations) were adjusted to show the dollar amounts for 5 stations. Because of rounding, some of the figures are a dollar off from the figures in the previous page.

or some type of private funds. Some eventually become charity cases. One would naturally assume that since the geographical area is the same, the projected need for dialysis is the same, and the number of dialysis stations (five) is the same for both projects, that the ratio of Medicare/Medicaid to commercial payor reimbursement (the payor mix) would be the same, and thus the income would be the same for both facilities. But the projected income is not the same. DaVita's projected income for their third year is $366,633 higher than NWKC. Even using the lower expenses in their revised pro forma, it is clear that DaVita would not be able to meet its third year operating expenses but for this higher income. There are two factors involved in determining why DaVita's income would be higher: (a) the payor mix, and (b) the rate charged to commercial payors. DaVita refused to divulge this information during the discovery process, claiming it was proprietary information containing trade secrets. At the hearing, DaVita testified that the payor mix it used to calculate income for their project was their national payor mix rather than any local ratio.[22] More importantly, however, DaVita admitted that it charges (and receives) a higher rate to its commercial payors than NWKC does.[23] In other words, insurance companies are paying DaVita more for non-Medicare patients treated at DaVita than non-Medicare patients treated at NWKC. While DaVita claims that insurers recognize the higher value of the service DaVita pays and thereby rewards it with higher reimbursement,[24] the fact is, basic dialysis procedures are standardized and similar.

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[22] TR 303.

[23] TR 299, 356, and 359.

[24] TR 248.

1.16 Even assuming that third year profitability is simply a method of examining financial feasibility and not a litmus test, one is still left with the following dialectic: Either DaVita's original figures or its revised figures are more accurate (accurate meaning realistic). If the original figures are more accurate, DaVita is not meeting its operating expenses by the third year. If DaVita's revised figures are more accurate, DaVita is only meeting its operational expenses by the third year by charging commercial carriers more. This brings us to the third prong of WAC 246-310-220:

Will either project have an unreasonable impact on the costs of health services?

1.17 DaVita's estimated capital expenditure is $1,992,705 versus NWKC's capital expenditure of $100,969. Both parties are able to finance their respective projects from their own reserves. NWKC expenses for the expansion of five dialysis stations are reasonable, and their budgeted income is in line with their current experience with managing 25 dialysis stations at the same site. DaVita expenses are 19 times that of NWKC. As a viable for-profit, publicly held company, DaVita has an obligation to shareholders to provide a return on their investment, i.e., in laymen's terms, to turn their nearly two million dollar investment into a profit. Since the dollar amount of Medicare reimbursements are fixed by the federal government, the only area where profit can be increased is by increased billing to those non-Medicare patients who have insurance or other funding. This, by definition, has an impact on the costs of health services. Insurance companies must adjust premiums to cover increased health costs. The only question is: is the impact on the costs of health services

"unreasonable"? And the answer is, it depends. It depends on the alternatives.[25] This is why the CN statutes provide for an analysis of alternatives, i.e., the "superior alternative analysis" of WAC 246-310-240. In many CN cases where there are competing applications, the question of whether an applicant meets the criteria of WAC 246-310-220 (financial feasibility) will depend on applying a WAC 246-310-240 analysis.

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

1.18 The criteria for structure and process of care, spelled out in WAC 246-310-230, includes five areas that must be considered when reviewing a CN Application, to wit: adequate staffing, appropriate organizational structure and support, conformity with licensing requirements, continuity of health care, and the provision of safe and adequate care.

1.19 Both applicants certainly have experience in building, staffing, and operating dialysis facilities. Because NWKC is already operating 25 dialysis stations at its SeaTac facility, the underlying structure, staffing, agreements, and transfer agreements are already in place. As part of its application, NWKC submitted an executed medical director's agreement, transfer agreements, and documentation of compliance with regulations.

1.20 Although DaVita's project would be a new facility, DaVita likewise has many years experience in building, staffing, and operating dialysis facilities. As part of

[25] For example, if there was only one dialysis facility in an entire county, but it charged more for its service than dialysis facilities in other counties, it would have an impact on health care costs but that impact might be justifiable (reasonable) because it would be providing service to patients who could not get to other facilities. Whether something is reasonable always depends on the alternatives.

its application, DaVita identified a medical director, and submitted a draft medical director's agreement, sample transfer agreements, and quality of care compliance histories from its other facilities.

1.21 Based on Paragraphs 1.18 through 1.20 above, both applicants meet all the criteria in WAC 246-310-230. There is nothing in the Application Record to suggest otherwise.

WAC 246-310-240 "Cost Containment"

1.22 The final criteria for analyzing the viability of a CN Application is a determination of cost containment, as described in WAC 246-310-240, which includes an analysis of whether there are superior alternatives to the proposed project in terms of cost, efficiency, or effectiveness. An indicated, this brings the analysis back to an examination of the factors involved in the "financial feasibility" analysis under WAC 246-310-220.

1.23 However, in this case, the Program did not do an analysis under WAC 246-310-240. The Program's method of concurrent review is to analyze the two applications under WAC 246-310-210, 220, and 230. If both applications meet the criteria in those three WACs, then the Program jumps to a "tie-breaker" contest as described in WAC 246-310-288.[26] This is an incorrect method of determining CNs. An application for CN must be analyzed under WAC 246-310-240 equally as thoroughly as the other WACs, and the analysis under WAC 246-310-240(1) requires a comparison of

[26] AR 683-4, TR 65-69. The only "superior alternative" analysis that the Program does is to ask each applicant to list what alternatives it considered. This is not a rational reading of WAC 246-310-240 and leads to such absurd results as DaVita (AR 685) simply listing that it considered "doing nothing" as an alternative and that response being deemed as meeting the criteria of WAC 246-310-240.

the two applications with each other. This is not new information. In a 2009 CN Order, a health law judge wrote the following:

> WAC 246-310-240(1) requires a comparison and determination whether concurrent applications may be superior to each other. To substitute the WAC 246-310-288 tie-breaker analysis for the required comparison of applications under WAC 246-310-200 and WAC 246-310-240(1) is to stand the review process on its head and nullify the importance of judging applications on the four basic review criteria established by the rule.[27]

1.24 In the instant case, there is one applicant that wants to add five stations to its already existing 25-station facility at a cost of $100,969. The other applicant wants to establish a brand new five-station facility at a cost of $1,992,705. Because of the enormous costs of the new facility (DaVita's), it is unclear whether it can be profitable by the third year of operation. If DaVita can become profitable by the third year of operation,[28] it is only because it is charging (and receiving) more from commercial carriers than NWKC would be charging for the same service.

1.25 As indicated earlier, in many CN cases where there are competing applications, the question of whether an applicant meets the criteria of WAC 246-310-220 (financial feasibility) will depend on applying a WAC 246-310-240 analysis. The Presiding Officer finds that, given the alternative (NWKC), the project

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[27] Prehearing Order No 4, (Order Granting Part Motion for Summary Judgment), In Re Certificate of Need on the Applications of Puget Sound Kidney Centers and DaVita, Inc., to Establish Dialysis Centers in the Snohomish County Planning Area No. 1, Master Case No. 2008-118573, pg 21. Theodora Mace, Presiding Officer. *See also*, Prehearing Order No. 6, (Order on Motion for Summary Judgment), In Re Evaluation of Two Certificate of Need Applications Submitted by Central Washington Health Services Association d/b/a/ Central Washington Hospital and DaVita, Inc., Proposing to Establish New Dialysis Facilities in Douglas County, Master Case M2008-118469, pgs. 11-12, John Kuntz, Presiding Officer.

[28] For purposes of this sentence, it does not matter whether DaVita's original pro forma or their revised pro forma was more correct, nor does it matter whether the Program's practice of examining whether a facility is profitable by the third year is a requirement or simply a method of testing financial feasibility – the sentence is still true.

proposed by DaVita has an unreasonable impact on health care costs (i.e., it does not meet the criteria in WAC 246-310-220). Either patients would be paying more, or insurance companies would be paying more (and passing those costs onto their insured.) In comparing the two applications, NWKC is the superior alternative.

1.26 There are three prongs in WAC 246-310-240. The first prong is the above-discussed "superior alternative" comparison. The second prong is a separate analysis for CN applications that involve construction. Not only does this second prong analyze the reasonableness of construction costs but it also asks whether the construction costs would have an "unreasonable impact on the costs and charges to the public of providing health services by other persons." This is a slightly different inquiry than the WAC 246-310-220 question (of whether a project would in general have a unreasonable impact on the cost of health services). Applied to this case, the WAC 246-310-240 question is whether DaVita's construction cost would unreasonably cause some other party to increase the cost of health services. To the extent that a commercial payor is a provider of health services (insurance), the answer is yes. The increased charges to commercial payors would contribute to those commercial payors recouping those costs through consumers.

1.27 The third prong in WAC 246-310-240 involves a balancing test with the first two prongs. WAC 246-310-240(3) asks, in essence, if there is anything in a project (e.g. improvements or innovations in the delivery of health services) which would "foster cost containment and which promote quality assurance and cost effectiveness." This is the only place in WAC 246-310-220 through 240 that the issue of promoting competition

in the same planning area can be analyzed as a value. The issue of valuing competition (presumably on the theory that competition keeps health care costs down) is seen in the "tie-breaker" tests of WAC 246-310-288. However, one never gets to the tie-breaker in a concurrent evaluation if one applicant is found to be superior to the other. However, under this third prong of WAC 246-310-240, it would be possible for an applicant to offset an increased impact on the cost of health services by offering services that increased the quality of the health services in a planning area. However, there is nothing in the Application Record in this case to demonstrate that DaVita's project would do that.[29] In fact, in the context of the purpose of CN authority (to control health care costs) and the unique nature of kidney dialysis facilities (whereby the majority of patients are Medicare/Medicaid and the reimbursements levels are determined by the federal government), market competition is not a valuable factor unless it significantly improves the quality of care.

1.28 The Presiding Officer finds that NWKC's application meets the criteria for CN set forth in WAC 246-310-210, WAC 246-310-220, WAC 246-310-230, and WAC 246-310-240, but that DaVita's application only meets the criteria set forth in WAC 246-310-210 and WAC 246-310-230. For this reason, the CN is awarded to NWKC.

[29] Although the Program determined that both applicants would provide safe and adequate care to the public, the Program did note that since 2008 NWKC only had four minor non-compliance issues in their facilities that required plans of correction whereas DaVita had significant non-compliance deficiencies in their facilities in other states over the past three years. AR 681-2.

II. CONCLUSIONS OF LAW

2.1 The Department of Health is authorized and directed to implement the CN program. RCW 70.38.105(1). Kidney dialysis treatment centers are health care facilities that require a CN. WAC 246-310-284. See also, WAC 246-310-010(26). The applicant must show or establish that its application meets all of the applicable criteria. WAC 246-10-606. The Program issues a written analysis which grants or denies the CN application. The written analysis must contain sufficient evidence to support the Program's decision. WAC 246-310-200(2)(a). Admissible evidence in CN hearings is the kind of evidence on which reasonably prudent persons are accustomed to rely in the conduct of their affairs. RCW 34.05.452(1). The standard of proof is preponderance of the evidence. WAC 246-10-606.

2.2 The Presiding Officer (on delegated authority from the Secretary of Health) is the agency's fact-finder and final decision maker. *DaVita v. Department of Health*, 137 Wn. App. 174, 182 (2007) (*DaVita*). The Presiding Officer engages in a de novo review of the record. *See, University of Washington Medical Center v. Department of Health,* 164 Wn.2d 95 (2008) (citing to *DaVita).* The Presiding Officer may consider the Program's written analysis in reaching his decision but is not required to defer to the Program analyst's decision or expertise. *DaVita*, 137 Wn. App. at 182-183.

2.3 In acting as the Department's final decision maker, the Presiding Officer reviewed the application record. The Presiding Officer also reviewed the hearing transcripts and the closing briefs submitted by the parties pursuant to

RCW 34.05.461(7). The Presiding Office applied the standards found in WACs 246-310-200 through 246-310-240 in evaluating both parties' applications.

2.4 WAC 246-310-200 sets forth the "bases for findings and actions" on CN Applications, to wit:

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

2.5 WAC 246-310-210 defines the "determination of need" in evaluating CN Applications, to wit:

> The determination of need for any project shall be based on the following criteria, except these criteria will not justify exceeding the limitation on increases of nursing home beds provided in WAC 246-310-810.
>
> (1) The population served or to be served has need for the project and other services and facilities of the type proposed are not or will not be sufficiently available or accessible to meet that need. The assessment of the conformance of a project with this criterion shall include, but need not be limited to, consideration of the following:

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

(2) All residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly are likely to have adequate access to the proposed health service or services. The assessment of the conformance of a project with this criterion shall include, but not be limited to, consideration as to whether the proposed services makes a contribution toward meeting the health-related needs of members of medically underserved groups which have traditionally experienced difficulties in obtaining equal access to health services, particularly those needs identified in the applicable regional health plan, annual implementation plan, and state health plan as deserving of priority. Such consideration shall include an assessment of the following:

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

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

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

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

2.6 WAC 246-310-220 sets forth the "determination of financial feasibility" criteria to be considered in reviewing CN Applications, to wit:

> The determination of financial feasibility of a project shall be based on the following criteria.
>
> (1) The immediate and long-range capital and operating costs of the project can be met.
>
> (2) The costs of the project, including any construction costs, will probably not result in an unreasonable impact on the costs and charges for health services.
>
> (3) The project can be appropriately financed.

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

> A determination that a project fosters an acceptable or improved quality of health care shall be based on the following criteria.
>
> (1) A sufficient supply of qualified staff for the project, including both health personnel and management personnel, are available or can be recruited.
>
> (2) The proposed service(s) will have an appropriate relationship, including organizational relationship, to ancillary and support services, and ancillary and support services will be sufficient to support any health services included in the proposed project.
>
> (3) There is reasonable assurance that the project will be in conformance with applicable state licensing requirements and, if the applicant is or plans to be certified under the medicaid or medicare program, with the applicable conditions of participation related to those programs.
>
> (4) The proposed project will promote continuity in the provision of health care, not result in an unwarranted fragmentation of services, and have an appropriate relationship to the service area's existing health care system.

(5) There is reasonable assurance that the services to be provided through the proposed project will be provided in a manner that ensures safe and adequate care to the public to be served and in accord with applicable federal and state laws, rules, and regulations. The assessment of the conformance of a project to this criterion shall include but not be limited to consideration as to whether:

2.8 WAC 246-310-240 sets forth the "determination of cost containment" criteria to be used in evaluation a CN Application, to wit:

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

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

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

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

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

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

2.9 Based on the above Findings of Fact and Conclusions of Law, the Presiding Officer determines that NWKC's application meets the criteria for CN set forth in WAC 246-310-210, WAC 246-310-220, WAC 246-310-230, and WAC 246-310-240, but that DaVita's application only meets the criteria set forth in WAC 246-310-210 and WAC 246-310-230. Therefore, the CN should be awarded to NWKC.

ORDER

A Certificate of Need is approved for Northwest Kidney Centers to add five dialysis stations to its SeaTac Center pursuant to its application and in conformity with requirements set by the Program.

Dated this __22__ day of March, 2013.

_____/s/_____
FRANK LOCKHART, Health Law Judge
Presiding Officer

NOTICE TO PARTIES

This Order is subject to the reporting requirements of RCW 18.130.110, Section 1128E of the Social Security Act, and any other applicable interstate or national reporting requirements. If discipline is taken, it must be reported to the Healthcare Integrity Protection Data Bank.

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

Adjudicative Service Unit
P.O. Box 47879
Olympia, WA 98504-7879

and a copy must be sent to:

Certificate of Need Program
P.O. Box 47852
Olympia, WA 98504-7852

The petition must state the specific grounds for reconsideration and what relief is requested. WAC 246-10-704. The petition is denied if the Presiding Officer does not respond in writing within 20 days of the filing of the petition.

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

The order is in effect while a petition for reconsideration or review is filed. "Filing" means actual receipt of the document by the Adjudicative Service Unit. RCW 34.05.010(6). This order is "served" the day it is deposited in the United States mail. RCW 34.05.010(19).

For more information, visit our website at:
http://www.doh.wa.gov/PublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/Hearings.aspx