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DaVita submits the following comments in response to the Department's invitation to comment on the identified topics.

***Please submit comments on selecting a threshold number, between 4.8 and 6.0, whereby existing providers, having been at this level for at least two consecutive quarters, would qualify for an automatic capacity expansion ("plus two" proposal).***

DaVita is in favor of an automatic approval process for a maximum of 2 stations based upon a request that would not be tied to the concurrent review schedule. The process would be available for any facility operating at or above 5.0 patients per station ("pps") for 2 consecutive quarters, regardless of whether the methodology shows need.

Such automatic approval could happen once per facility each calendar year with at least 6 months between approvals for the facility. The stations would need to fit into the existing space (no additional floor area can be added to the facility without a full application). If no additional floor area can be added to the facility, and the maximum allowed is 2 stations per year, then we are not concerned with a limit on construction costs. If a provider wants to do a \$200,000 renovation to an existing floor area to potentially accommodate 6 expansion stations over a 3 year time period, we are okay with that-provided there's no additional floor area required.

***Please submit comments regarding larger facilities (say 40 stations and up) that qualify for an automatic capacity expansion using a percentage to add new stations to get below 4.8 (or the new agreed threshold #). One proposal suggested adding up to 20%. Others also suggested 20% with a cap.***

We believe anything over 2 stations starts to block providers from entering the planning area. The automatic +2 is meant give immediate relief for patient over-crowding. It would allow 12-16 additional patients per year per facility, and only in very extreme situations would a facility or planning area need more than that. We think approval for more than 2 stations should require a competitive application process.

***The group discussed a “two-pronged” approach. The first “prong” was immediate relief for facilities above an agreed threshold #, despite other providers being below this # AND the planning area was not showing any need - the plus two concept. The second “prong” dealt with the scenario of facilities above an agreed threshold #, despite other providers being below this # AND the planning area was also demonstrating need for new stations. This second “prong” approach would allow the successful facilities in the planning area, along with any new providers, to submit a CN application. Some members of the group proposed that the threshold # for the second-prong approach should be higher than the first-prong. Please submit comments on what the threshold # should be in order for an existing provider to be able to submit a new CN application? Some suggested numbers like 5.6? 5.7?***

For the 2<sup>nd</sup> prong, we would propose the following. Any provider can apply for new stations in a concurrent review cycle if:

- a) There is demonstrated need; and
- b) Any 2 of the following are true
  - a. One facility in the planning is operating  $\geq 5.0$  pps;
  - b. All facilities are operating  $\geq 4.8$  pps;
  - c. The entire planning area (not individual facilities) is operating  $\geq 4.0$  pps;  
or
  - d. It has been 4 years since the last new facility was awarded.

DaVita does not think it is appropriate to limit this approach only to existing providers in a planning area. We believe any provider should be allowed to apply.

***Please re-read WAC 246-310-240, and understand what the current rules say. Please submit comments on suggested revisions to the superiority analysis.***

One part of the Cost Containment rule requires the Department to determine the superior alternative in terms of cost, efficiency or effectiveness. Another rule (WAC 246-310-200(2)(a)) requires the Department to make the superior-alternative determination by considering the consistency of the proposed project with service or facility standards contained in the Department rules. We believe it already is clear the Department is required to apply the dialysis tiebreakers as dialysis service and facility standards to determine the superior alternative. The Program has consistently done so in recent years.

Some unsuccessful applicants have advocated in adjudicative proceedings for an open-ended examination of all possible cost, efficiency and effectiveness criteria. This

approach has led to needless appeals, prolonged delays in meeting dialysis need, increased CN-related costs, and increased complexity and unpredictability in the process. We believe there are ways to clarify further the required use of tiebreakers in the superiority analysis and we also have some suggestions for improving the tiebreaker approach.

### **Use of Tiebreakers as Mandatory Standards for the Superior Alternatives Comparison**

This legal issue currently is subject to judicial review in Thurston County Superior Court and we prefer to hold further comments until the matter is resolved on review.

### **Proposed Revisions to Tiebreakers**

We believe the tiebreakers properly focus on cost, efficiency and effectiveness and suggest revisions we believe will maintain and improve that focus. We suggest reducing the number of competitive factors, some of which have had unintended and unwanted effects. We would eliminate Economies of Scale, move Patient Geographical Access into the noncompetitive category using only a minimum distance requirement, and unlink Provider Choice from Patient Geographical Access. We would clarify that the Permanent Bed Station requires a minimum amount of floor area for access and allows use of a full recliner.

We would organize the tiebreakers as follows:

#### **NONCOMPETITIVE**

- (a) ***Training services***
- (b) ***Private room(s) for isolating patients needing dialysis***
- (c) ***Permanent bed stations at the facility***  
Add a minimum floor area requirement and allow full recliners
- (d) ***Evening shift***
- (e) ***Meeting the projected need***
- (a) ***Patient geographical access***  
Based on a minimum distance (3 miles?) from existing facilities

#### **COMPETITIVE**

- (a) ***Historical provider (1 point)***
- (b) ***Provider choice (1 point)***  
Not linked to Patient Geographical Access