



Memorandum

To: Bart Eggen, Executive Director, Community Health Systems, Department of Health
Bart.Eggen@doh.wa.gov and fslcon@doh.wa.gov
Janis Sigman, Manager, Certificate of Need, Department of Health
Janis.Sigman@doh.wa.gov

From: Stan Bower, Director of Operations


Date: January 15, 2014

Subject: Comments in preparation for January 22nd meeting

In preparation for the upcoming Certificate of Need work session on January 22nd, the following comments are submitted on behalf of Fresenius Medical Care (Fresenius) in response to the below noted proposals summarized by the Department of Health (Department) in a document dated January 3rd.

A caveat. These issues are complex. While we've done our best to provide you with thoughtful comments, our opinions may change as we continue to weigh any new information provided, pros and cons, etc. So, please consider these comments in that context. Thank you.

Department proposal #1: 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).

To recap, this +2 proposal was intended to provide relief to individual facilities experiencing a high patient census, without regard to whether there was a need for more stations in a given planning area. At the December meeting, there was extensive discussion among the participants concerning this issue. Our recollection is that the number 6, representing 100% utilization, was seen as too high a threshold. The problem was that at this number, facilities are experiencing substantial scheduling difficulties. There was also feedback from the group that providers were rarely at 6 for two or more consecutive quarters. Further, it's important to build in some grace by setting a number below 6 because it does take time to add stations, even if no major construction is involved. For that reason we think the trigger number should be 5.4, which is 90%.

We know the group talked about allowing a +2 every 12 months. We don't recall a decision about a limit on the number of times a facility could add +2. Some thinking was that expansion via the +2 route would naturally come to an end due to the physical limitations of the facility. But, if this new provision goes into place, facilities could build larger buildings in anticipation. In order to create a level playing field we think the +2 option should be limited to two times for a total of 4 stations.

In thinking further about this issue, we believe that in order to assure consumer access this exception needs some additional flexibility. We recommend that dialysis facilities should be allowed to add a +2 every six months (if the 5.4 trigger continues to be met). While we believe this set of circumstances would occur infrequently, this option would give a facility experiencing a very high rate of growth additional flexibility to meet patient demand in a shortened period of time. Again, a limit would remain on the total number of stations (4) that would be added under this +2 scenario.

In summary, we have the following recommendations.

1. A trigger of 5.4% or 90% facility utilization for +2.
2. The +2 option is only available to add a maximum of 4 stations.
3. Dialysis facilities would be allowed to add +2 every six months if the 5.4 trigger continues to be met, for a maximum of 4 additional stations.

Department proposal #2. 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 are not certain if this example assumes that there is need...or no need...in the planning area. If there is need in the planning area we would oppose this approach because it would block the filing of a CN for a new facility.

If there is no need in the planning area, we are uncertain as to our position at this time. We know that the largest facility in Washington is 38 stations and the next largest are 27 and 28. Given the small number of larger providers, we're uncertain whether this option is necessary.

Department proposal #3. Please submit comments regarding the criteria of "No Construction" for facilities that qualify for an automatic capacity expansion. Are there any circumstances where minimal construction to accommodate these additional stations should be allowed?

The short answer is "yes." As commonly understood, the word "construction" could be interpreted to include virtually anything from changes in plumbing to electrical to putting up or taking down a wall, etc. We think that adopting a criteria of "no construction" essentially negates DOH proposal #1.

We would suggest a set monetary amount per station be established as a limit, with the following caveats. The amount would not include the costs of equipment. And any construction would need to take place without an expansion of square footage of the facility.

Department proposal #4. 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?

First, a comment. We believe the statement concerning the +2 above is not accurate. Our recollection is that the +2 is facility specific, regardless of whether there is any need in the planning area. Do others remember that differently?

Second, in response to the specific question, we believe the number should remain at 5.4 or 90%. If we are to assure that patients continue to have adequate access to dialysis services, we think 5.4 makes sense. As previously stated, there were numerous comments from providers that operating above 90% creates significant challenges for scheduling.

Department proposal #5. Please re-read WAC 246-310-240, and understand what the current rules say. Please submit comments on suggested revisions to the superiority analysis.

While we understand the importance of the question, at the present time we do not have any suggestions for revisions. The bottom line, from our perspective, is how the Department determines the "winner" between competing applications. Currently, the Department uses the tiebreaker system to choose among competing applications when all other requirements have been met. We believe the Department must first determine superiority based on criteria which we will hopefully develop, before using tiebreakers. We don't agree with the use of tiebreakers to determine superiority. And we are uncertain about the concept of tiebreakers in general, given the unintended consequences that have resulted from their use. We welcome the opportunity to participate in a discussion on the broader issue of how the Department determines the "winner."