

**STATE OF WASHINGTON  
DEPARTMENT OF HEALTH  
ADJUDICATIVE SERVICE UNIT**

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| In Re: Comparative Review of Certificate ) | Docket No. 04-06-C-2003CN |
| of Need Applications of Olympic )          |                           |
| Peninsula Kidney Center and DaVita, )      | AMENDED FINDINGS OF FACT, |
| dba Poulsbo Community Dialysis Center. )   | CONCLUSIONS OF LAW,       |
| )  | AND FINAL ORDER           |
| Applicant. )                               |                           |
| _____ )                                    |                           |

**APPEARANCES:**

Applicant, Olympic Peninsula Kidney Center, by  
Davis Wright Termaine, per  
Douglas C. Ross, Attorney at Law

Intervener, DaVita, Inc., by  
Law Offices of James M. Beaulaurier, per  
James M. Beaulaurier, Attorney at Law

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

**PRESIDING OFFICER:** Zimmie Caner, Health Law Judge

**RECONSIDERATION**

The Department of Health Certificate of Need Program (the Program) and DaVita filed petitions for reconsideration of the February 28, 2005 Findings of Fact, Conclusions of Law and Final Order. Pursuant to extensions granted to the briefing schedule set forth in the March 15, 2005 Order on Request for Reconsideration, the parties filed briefs on the issues raised in the petitions for reconsideration. The final brief was filed on March 20, 2005. After review of the briefs and reconsideration of the evidence, the Presiding Officer amends the Findings of Fact, Conclusions of Law and Final Order issued as follows in *italicized type*:

**INTRODUCTION**

This is an appeal of the Program comparative analysis and resulting issuance of a Certificate of Need (CON) to DaVita for a kidney dialysis treatment facility and denial of Olympic's application for a kidney dialysis treatment facility CON. Reversed.

AMENDED FINDINGS OF FACT,  
CONCLUSIONS OF LAW,  
AND FINAL ORDER

## ISSUES

Is the Program's analysis and utilization of price competition and/or patient choice reasonable and supported by the evidence in the administrative record?

Did the Program comply with the rulemaking requirements of the Washington Administrative Procedures Act when it applied a competition/patient choice factor and/or when it utilized a comprehensive review process?

## HEARING

During the hearing on October 4 and 7, 2004, Program Analyst Randy Huyck, Olympic Executive Director Jeff Lehman, Olympic Operations Administrator Robert Schwartz and DaVita Consultant Robert McGuirk testified. The deposition of Program Manager Janis Sigman was admitted in lieu of live testimony as exhibit 6. A copy of the Program's administrative record (AR pages 1 through 1083) regarding the Program's approval of the DaVita CON application, the Program's denial of the Olympic application and the Program's underlying comparative analysis was admitted as Exhibit 1. The Program's "Executive Summary of Need Evaluation of DaVita and Franciscan Health System" was admitted as Exhibit 2. A driving distance chart and maps of Kitsap County and Olympic Peninsula were admitted as Exhibits 3 through 5.

Closing arguments were presented through briefs after the hearing transcript was received by the parties. The final brief was filed on January 14, 2005.

## I. FINDINGS OF FACT

1.1 On August 1, 2003, Olympic applied to Program for a CON to establish a 12-station kidney dialysis treatment facility that would be located in Poulsbo, Washington. On August 5, 2003, DaVita applied to Program for CON to establish a 13-station kidney dialysis treatment facility within approximately three miles of Olympic's proposed Poulsbo facility. Both applications proposed to serve the same areas in North Kitsap and Jefferson counties. The closest existing facility operated by Olympic in Bremerton, is approximately 18 miles from the applicants' proposed sites in Poulsbo.

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AMENDED FINDINGS OF FACT,  
CONCLUSIONS OF LAW,  
AND FINAL ORDER

Comparative Review

1.2 Because Olympic and DaVita applied for a similar dialysis facility CON within the same week and proposed to serve the same area, the Program decided to conduct a “comparative review” of the two applications. As a result, the applications were assigned to one of the Program’s analysts who reviewed the applications together and on the same review schedule.

1.3 Prior to the commencement of the comparative review process, the Program sent DaVita and Olympic letters on August 5, 2003 stating it would conduct a comparative review of the two applications. AR at 134. Prior to the issuance of Program’s May 21, 2004 analysis and decision, Olympic did not object to the comparative review process. 10/4/04 RP at 143-4. During the review process both applicants submitted extensive information criticizing each other’s application. These documents demonstrate that they knew the Program’s review was a competitive process that might result in only one of the applicants receiving a CON. AR 1 at 187-227 and 228-317.

1.4 Randy Huyck was the Program analyst assigned to conduct the “comparative review”. During this process, Mr. Huyck and other CON analysts met on a weekly basis with their supervisor Janis Sigman to discuss the applications they were reviewing. As a result, Ms. Sigman, advised Mr. Huyck in his “comparative review” of the DaVita and Olympic applications.

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1.5 After conducting the comparative review, Mr. Huyck wrote the Program's "evaluation" report that is the basis of the denial of Olympic's application and the granting of DaVita's CON. AR at 122-336.

1.6 On May 21, 2004, after the completion of the review process, one rather than two evaluation reports were issued addressing the Program's comparative analysis of both applications. Based on this comparative review, the Program rejected Olympic's application and granted DaVita a CON for a kidney dialysis facility, as the "superior" and more "efficient" applicant under WAC 246-310-240(1). On June 18, 2004, Olympic appealed the Program's decision.

#### Determination of need

1.7 The Program's first step in this comparative review was the determination of need under WAC 246-310-280 using Northwest Renal Network (NRN) facility utilization data. AR 328. Mr. Huyck completed the needs analysis using NRN data to calculate and project the need for 12 new kidney dialysis stations for Kitsap and Jefferson counties by 2007. AR at 328 and 10/6/04 RP at 22-44. Even though the Program projected the need for 12 stations by 2007, it only granted a CON for 10 stations because the numbers and analysis provided in DaVita's application supported need or utilization projections for 10 stations. Similarly, Mr. Huyck testified that the numbers and analysis provided in Olympic's application supported need for 8 stations. 10/4/04 RP at 78-81.

1.8 Once need was determined, Mr. Huyck evaluated the "financial feasibility", "structure and process of care" and "cost containment" of each proposal pursuant to

WAC 246-310-220 through 246-310-240. Mr. Huyck initially concluded that DaVita's and Olympic's applications each complied with these criteria, but there is need for only one, not two facilities. AR at 339. As a result, Mr. Huyck turned to charity care and competition/patient choice as tie breakers to identify the "superior applicant". AR 339.

1.9 As Mr. Huyck wrote in the Program's evaluation:

Lacking a clear disqualification of either applicant on any of the other criteria, the department concludes that the need demonstrated earlier in this evaluation, coupled with the introduction of a choice of providers in this service area and the lack of provision for charity care demonstrated by Olympic leads the department to conclude that the DaVita project appears to be the best available option for the community. AR at 339.

1.10 Mr. Huyck concluded in the analysis that the "Olympic application does not meet the cost containment criteria in WAC 246-310-240." AR 337.

#### Charity care.

1.11 Prior to the October 2004 hearing, charity care was at issue. AR 330 and 339. During the hearing Mr. Huyck admitted that he erroneously concluded that Olympic did not include any provision for charity care<sup>1</sup> in its proposed budget projections (pro forma). AR 330 and 10/4/04 RP at 74-5. As a result, patient choice and price competition are the remaining factors utilized by the Program to conclude DaVita is the "superior" applicant for the Poulsbo CON.

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<sup>1</sup> In its reply brief, the Program raises charity care after presenting testimony that charity is not at issue. The Program mischaracterized Olympic's historical provision of charity care. AR 903-904. Olympic, at the time of its application, classified charity care as "deduction from revenue in annual accounting reviews included as Appendix P (AR 86) in the initial application." AR 194. Olympic requested that the accountant who audited its 2003 fiscal statements to classify charity care as a separate line item in the statement of revenue and expense. Olympic's policy is to accept all patients regardless of ability to pay for services. AR 194 Olympic has never discriminate against patients unable to pay for services. AR 194.

## Patient choice

1.12 Olympic is the only kidney dialysis provider in Kitsap County with one facility in Port Orchard and one in Bremerton. Exhibit 5. There are no dialysis facilities in Jefferson County, the county north and west of Kitsap County. Exhibit 5. Bremerton is approximately 18.6 miles south of Poulsbo. Port Orchard is further south, approximately 23.2 miles south of Poulsbo. Poulsbo is located in northern Kitsap County. Exhibit 4.

1.13 A second provider in reasonably close proximity to the existing Bremerton facility would provide a choice between two providers to the dialysis patient. But a new Poulsbo facility will be approximately a 31 minute drive to the closest existing facility in Bremerton. This facility is operated by Olympic. Therefore, granting the Poulsbo CON to DaVita rather than Olympic *may* only provide a realistic choice to a small number of patients. *It is unclear how many future patients will live or work between Bremerton and Poulsbo, but it is expected that the need in Kitsap County will increase therefore probably increasing the number of patients with a choice. AR 41, 392-3.*

1.14 What is a reasonable commute for a dialysis patient who dialyzes for approximately 4 hours, 3 times a week, 52 weeks a year? In a recent decision the Program concluded that maximum or “default” time should be reduced from 30 to 20 minutes considering that is 40 minutes round trip, three times a week. Exhibit 2.<sup>2</sup> This, of course, is all relative considering the population density and other factors. Although the Program has not consistently applied the 20 minute maximum drive time, 20

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<sup>2</sup> The Program stated in its brief that this decision was remanded to the Program for further evaluation.

minutes is a reasonable maximum commute in the case at hand considering the distance between Poulsbo and Bremerton. A 20 minute commute standard limits the area between Poulsbo and Bremerton that would encompass patients with “choice” or in other words a reasonable commute time. *Mr. Huyck stated that prior to issuing his analysis, he had not seen Exhibit 2 (a Program dialysis decision that applied a 20 minute standard rather than the 30 minute standard he applied). 10/4/04 RP at 122.*

1.15 Another factor to take in consideration is that many patients travel by public transportation therefore *often* lengthening their commute time *when* multiple stops *are necessary*. This narrows the number of patients even further. For example, only one half of Olympic’s north Kitsap County patients drive themselves to their dialysis treatments. 10/7/04 RP at 59.

1.16 A “new” provider in Poulsbo would only provide choice to those patients who either live or work in a limited area between Poulsbo and Bremerton. Patients close to or north of Poulsbo do not have a realistic choice, considering the longer round trip commuting time to Bremerton, especially those who rely on public transportation. Only five of the thirty five Olympic patients identified by Olympic who will switch dialysis care to a new Poulsbo facility from the Olympic Bremerton facility (because they live north of or closer to Poulsbo than Bremerton) are working. Of those working patients, three work north of Poulsbo and two work midway between Poulsbo and Bremerton. 10/7/04 RP at 58-9. Therefore only two of thirty five patients would have a realistic choice of providers as a result of their job location.

1.17 Population is denser between these two cities than north or west of Poulsbo, but evidence indicates that few existing patients would have a realistic “choice” due to the commute time. 10/7/04 RP at 58-59. Evidence and logic indicate that patients want shorter commutes for dialysis treatments, as several patients stated in letters. AR at 210-214.

1.18 No evidence was presented indicating patient or institutional dissatisfaction with Olympic care and services. To the contrary, the records include patient and local institution letters supporting Olympic’s application. AR at 209-214. Several patient letters discuss the high quality of care received at Olympic compared with care receive from other facilities when they travel. AR 210-214. *Medicare statistics regarding the treatment of anemia, patient survival rates and receipt of “adequate hemodialysis” indicate that DaVita and Olympic provide comparable care as the Program concluded. AR 363-371. The record did not contain statistics regarding appropriate patient referrals to renal transplant waiting lists.*<sup>3</sup>

#### Cost Containment – Price competition

1.19 The Program chose DaVita over Olympic assuming the introduction of a new provider would stimulate competition and, therefore, lower fees. The Program’s analyst Mr. Huyck admitted that DaVita’s operating revenues per treatment compared to Olympic indicate that their charges might be greater than Olympic’s charges. 10/6/04

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<sup>3</sup> *Harrison Hospital in a letter of support (AR 225) and Olympic in its brief cites a report published in the New England Journal of Medicine that concludes that non-profits provide better ESRD patient care than for-profit entities as reflected in mortality and transplant wait list referral rates. Puskal, P. Gary, MD et al “Effect of the Ownership of Dialysis Facilities on Patients and Referral for Transplantation”, New England Journal of Medicine, 199; 341: 1653-60. That general fact may be true, but each case must be evaluated by the specific facts regarding each applicant because there may be exceptions as the Medicare statistics demonstrate in this case.*

RP at 124. As Mr. Huyck calculated, the third year of operations projected net profit for DaVita is \$801,164 and \$169,820 for Olympic, projected revenue per treatment for Olympic is \$260 vs. \$374 for DaVita and projected net profit per treatment for Olympic is \$29 vs. \$101 for DaVita. AR 330-331. Mr. Huyck admits that he did not calculate/project the commercial rates, only net profit per treatment. The commercial rates will be higher than average rates because Medicare/Medicaid rates are fixed at a much lower rate and approximately 80% of the patients fall under these low fixed rates. 10/4/04 at 122-125. Olympic disclosed its current customary commercial rate of \$300, and DaVita failed to do so.<sup>4</sup> AR 244 and 10/8/04 at 24-47. As Mr. Huyck admitted, the Program should have asked the applicants to submit evidence regarding the use of price competition as a tie breaking criteria. 10/4/04 at 151. If DaVita would compete and therefore lower its rates, Mr. Huyck agreed that DaVita's revenue projections would be overstated, and it is possible that DaVita will no longer meet the financial feasibility criteria. 10/4/04 RP at 126-7.<sup>5</sup>

1.20 The Program relies on *its experience/expertise and common sense* argument to support its conclusion that patient choice will probably result in improved quality care and better price competition, therefore lower prices resulting from two

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<sup>4</sup> During the hearing, DaVita challenges Olympic's projections without providing its current customary commercial rates, erroneously claiming that it is a trade secret. 10/7/04 at 24, 40 and AR 203-205. DaVita also challenged Olympic's payer mix calculations that are supported by the record AR 907-8.

<sup>5</sup> The Program did not evaluate or address this issue in its analysis as Program did in its February 15, 2000 analysis regarding Northwest Hospital's (NW) application for a dialysis facility in Snohomish County. The Program concluded that reduced private pay rates equal to others in the area would "not render Northwest's application financially unfeasible"; that operating revenue by 2<sup>nd</sup> and 3<sup>rd</sup> year would still cover operating expenses. The Program's issuance of Northwest's CON is limited so that Northwest's private pay charges shall be no greater than the highest private pay charge in the health care service area for a period of three year post completion of the project." NW Edmonds facility 2000 Program Analysis at pages 2 and 10.

providers negotiating with HMOs/insurance companies. Ms. Sigman and Mr. Huyck admitted that they have no data, studies or other information to support this conclusion. Exhibit 6 at 17-188 and 10/4/04 RP at 109-110, 151. They did not contact any HMO or insurance company that provides dialysis coverage for patients in this service area to pursue this theory. *KPS Health Plan President submitted a letter stating that Olympic charges lower commercial fees than for-profit facilities providing similar services.*

AR 218.

1.21 No evidence was presented indicating the addition of a new provider in the Poulsbo area that *is approximately a 31 minute drive from the closest facility* would stimulate lower fees in the Poulsbo/Bremerton service area. It is unlikely that DaVita will stimulate lower Olympic commercial fees, since Olympic commercial rates and projected rates are much lower than DaVita's projected average commercial rates for the first three years of operation. AR 883-6, 902-6 and 10/4/04 RP at 123-178.

Mr. Huyck's supervisor, Ms. Sigman admits that typical market forces such as competition do not always keep a check on price of health care and did not explain when competition drives health care costs down rather than up. Exhibit 6 at 31-34. Therefore considering the proposed budgets and projected fees, DaVita's proposal may not satisfy the cost containment criteria and Olympic's proposal does.

1.22 Olympic is a non-profit and DaVita a public for-profit corporation under state and federal laws. This should not be the deciding factor. One must consider the specific facts of each case. In addition to community support reflecting good quality care AR at 209-226, Olympic has significantly lower commercial rates and projected

rates than DaVita's projected commercial rates. Evidence from DaVita's application and Olympic's analysis supports this conclusion. AR at 203-4, 293-4 and 10/7/04 RP at 178-181. The Program did not find any error in Olympic's analysis, but merely made a general conclusion regarding projected rates by other for-profit and non-profit dialysis provider applicants. AR 332. That response fails to address the specific facts in this case; *Olympic's calculations indicates DaVita commercial/private fees will be higher. DaVita did not disclose its customary commercial rates or its projected rates. The Program failed to request that information. The Program failed to adequately address facts regarding DaVita's proposed higher: costs, annual net profit, annual operating revenue per treatment and resulting higher fees. AR 330-331. Program also failed to address Olympic's statement that its charge structure is lower because all profits are "to be used to meet future facility needs, improvements in patient care and/or other additional benefits to patients."* AR 194.

### Services

1.23 *As concluded by the Program under its "structure and process (quality) of care analysis" (WAC 246-310-230), the proposed services outlined in DaVita's and Olympic's applications are similar. AR 335. DaVita proposed a 13 station facility with one training station. Olympic proposed a 12 station facility<sup>6</sup> with one isolation station for patients with communicable diseases such as Hepatitis B, HIV or open wound*

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<sup>6</sup> *In a letter dated December 10, 2003, Olympic predicts it will operate 7-stations at 80% utilization by the 3<sup>rd</sup> year of operation. Even if awarded a CON for fewer stations, Olympic intended to build out for 12-stations, but only operate the number of approved stations (to avoid the costly expense of predictable future capital expansion). AR 195. Contrary to DaVita's assertion in its brief, Olympic did not change its pro forma figures (proposed operating budget) from a 12-station facility to an 8-station facility. The Program analysis reflects this fact. AR 330-334.*

*infections. AR 202, 330-332 and 10/7/04 at 169-170. By the third year of operation, DaVita would have three registered nurses and six hemodialysis technicians on staff compared to Olympic staffing four of each. AR 332-335. As the Program concluded, the difference of one nurse to two technicians is negligible, not a large enough difference to conclude either model of care is superior. AR 334-335. The only notable difference in the applicants' proposed services is DaVita's training station vs. Olympic's isolation station. AR 202. As the Program concludes under it's WAC 246-310-210 "need" analysis, DaVita's proposed training station is not needed, but fails to address whether an isolation station is needed. AR 328. An isolation station is needed by the patients with communicable disease so they do not have to commute longer distance to another facility with an isolation station.<sup>7</sup>*

Operating expenses – financial feasibility.

1.24 *As the Program concluded, DaVita's projected operating expenses are more than Olympic's even though both facilities would provide comparable patient care and services. AR 80, 334, 500.<sup>8</sup> Olympic's projected operating expenses for year one of operation is \$1,049,443, \$1,191,528 for year two and \$1,339,794 for year three. AR at 330. DaVita's projected operating expenses for year one is \$1,585,815; \$1,761,325 for year two; and \$2,170,295 for year three. AR at 331. These figures do not accurately reflect DaVita's projected operating expenses because DaVita understated its rental expenses in its pro forma statement. 10/4/04 RP at 182-5.*

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<sup>7</sup> *As Ms. Sigman stated, a tie breaker could be a difference in proposed services. Exhibit 6 at 27.*

<sup>8</sup> *As argued by DaVita, this difference in operating costs in part may result from DaVita operating a free standing facility rather than Olympic's satellite facility.*

Therefore DaVita's operating expenses are even greater. 10/4/04 RP at 182-185, AR at 203, 500 (pro forma operating statement) and 841-2 (lease).

1.25 DaVita claimed the pro forma figures are correct because the rent figures were reduced by depreciation of tenant improvements that will be made under its lease. 10/7/04 RP at 15. Mr. Lyman, who is a certified accountant, explained that under general accounting principles it is not appropriate to combine tenant improvement depreciation with lease expenses on the rent line of the operating budget. 10/7/04 RP at 15-16. The tenant improvement depreciation should be listed separately as it relates to capital costs vs. annual operating expenses. Tenant improvements have a longer depreciation period (usable life) than one year, so rent expenses without the tenant improvement deduction more accurately reflects the annual cost of renting the facility. 10/7/04 RP at 15-16.

1.26 As a result of this accounting error, DaVita's rent expense is approximately \$36,000 more the first year of operation and \$62,000 more the second year than DaVita stated in its pro forma. 10/4/04 RP at 182-185. Therefore DaVita's projected operating expenses for year one would be approximately \$1,585,815 vs. Olympic \$1,049,443, and DaVita's year two would be approximately \$1,823,352 vs. Olympic's \$1,191,528. AR 233. This is a significant error in operating expenses, roughly one half million dollars each year. These figures raise doubt as to DaVita's financial feasibility (WAC 246-310-220) and cost containment (WAC246-310-240) indicating that DaVita is not the better applicant.

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### Estimated opening date

1.27 The Olympic Bremerton facility was operating at greater than one hundred percent capacity. AR 329.<sup>9</sup> Therefore there was an immediate need for a timely opening of a new facility in Poulsbo, as stated in the Program's analysis, and by both applicants. AR 329, 422, 435. The cost and time savings to patients and community health care facilities justify using opening time as a tie-breaking. Ms. Sigman testified that this could potentially be a tie breaking factor. Exhibit 6 at 55.

1.28 DaVita's application estimated opening in approximately fifteen months and Olympic stated it could open in approximately five months. 10/7/04 RP at 41. Even though there was a delay in the opening of one of Olympic's two existing facilities, Olympic's five month opening prediction is credible. The delay was caused by the prior tenant's (pediatric clinic) relocation difficulties. The pediatric clinic did not vacate the space as scheduled, a factor Olympic could not control or anticipate. 10/7/04 RP at 41. Olympic's proposed Poulsbo space is unoccupied; therefore prior tenant vacating the space is not at issue. Olympic has consulted with architect and contractor as to a plan and timeline. 10/7/04 RP at 41. Therefore, Olympic's estimated time to open is credible.

1.29 In a letter to the Program, the executive director of Norwood Lodge, a short-stay rehab facility listed four reasons for its support of Olympic's application. One of those reasons for support is that Olympic's facility should be completed

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<sup>9</sup> At the time the application was filed, the Olympic Bremerton facility was operating over 125%. That rate dropped as a result of Olympic's South Kitsap facility adding 5 stations to its operation on January 13, 2004. AR 326.

approximately one year earlier than DaVita, saving Norwood Lodge “many additional dollars in staff and transport time and more importantly, a tremendous inconvenience on the part of the patients.” AR at 215. Ms. Zink, the Administrator of Montclair Park and Haven Crest, a Poulsbo senior assisted living community, also wrote a letter of support because the proposed Olympic facility has an earlier planned completion time.

AR at 219.

#### Split of the stations between the two applicants

1.30 A split of the stations between the two applicants with the issuance of two CONs is not fiscally prudent. The capital cost of establishing two facilities in addition to duplicative operating/managing expenses of two facilities when one facility could serve the need would render a split financially unreasonable. AR 330-332 and 10/4/04 RP at 71-72. The main purpose of the CON is to control health care cost, and avoid unnecessary duplication.<sup>10</sup>

## **II. CONCLUSIONS OF LAW**

### Purpose of the Health Planning & Development Act

2.1 In response to the 1974 National Health Planning and Resources Development Act, the Washington legislature adopted Washington’s 1979 Health Planning & Development Act (the Act) creating the certificate of need program. Chapter 70.38 RCW and *St. Joseph Hospital & Health Care Center v. Department of Health*, 125 Wn2d 733, 753 (1995). One of the purposes of the federal and state health care

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<sup>10</sup> RCW 70.38.015(2).

planning acts was to control health care costs. *Id.* Both legislative bodies were concerned that competition in health care had:

...a tendency to drive health care cost up rather than down, and government therefore needed to restrain marketplace forces.

*St. Joseph Hospital*, at 741; see also *Wolfson, State Regulation of Health Facility Planning: The Economic Theory & Political Realities of Certificate of Need*, 4 *DePaul J. Health Care Law*, 261, 263 (2001).<sup>11</sup> The CON regulations are therefore designed in part to control rapid rising health care cost by limiting competition within the health care industry”. *Id.* Therefore, under some circumstances a second provider in a “service area”<sup>12</sup> may reduce prices providing an opportunity for competition, but not by through unnecessary duplication. The question at hand is whether the facilities are close enough to realistically create patient choice/competition, and whether DaVita’s proposal will “foster cost containment” (WAC 246-310-240) and be “financially feasible” (WAC 246-310-220) in light of Olympic’s projected lower operating expenses/fees?

2.2 The state CON requirements limit provider entry into the health care markets so the development of services and resources “should be accomplished in a planned, orderly fashion, consistent with identified priorities and without unnecessary duplication or fragmentation”. RCW 70.38.015(2).

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<sup>11</sup> This article discusses the unique dynamics that skew the classic response to supply and demand market forces because: 1. Patients (consumers) have difficulty holding providers accountable for cost comparisons due to scarcity of price information. 2. Patients usually lack expert knowledge to assess the quality and necessity of health care services, therefore relying on physician to make arrangements of health care services. 3. Health care cost are primary paid by third party payers therefore insulating patient even more from concerns of direct payment of services.

<sup>12</sup> In this case the applications and the Program’s decision state that the patient to be served will be from north Kitsap and Jefferson Counties. AR 325

2.3 This health planning process must consider the cost-effectiveness and cost-benefit analysis and provide accessible health care services “while controlling excessive increases in costs”. RCW 70.38.015(1) and (5). The Act “*encourages*” the “*involvement in health planning from both consumers and providers*”.

*RCW 70.38.015(1). Therefore consumer and provider letters submitted in the CON application review process should be considered by the Program in its analysis.*

*WAC 246-310-160 (public comment period) and WAC 246-310-010 (definition of “interested persons”).*

2.4 The Department of Health Certificate of Need Program (the Program) is responsible for managing the CON chapter under chapter 70.38 RCW.

RCW 70.38.105(1). CON shall be issued or denied in accordance with the Act and the Department rules which establish the review procedures and criteria for the CON program in chapter 246-310 WAC. RCW 70.38.115(1).

#### Certificate of Need Criteria

2.5 An applicant for a CON shall establish that it meets all applicable criteria. WAC 246-10-606. The Program then renders a decision whether to grant a CON in a written analysis that must contain sufficient information that supports its decision.

WAC 246-310-200 outlines the basic criteria that the Program must address in determining whether it should grant or deny a CON. Those criteria are “need” (WAC 246-310-210), “financial feasibility” (WAC 246-310-220), “structure and process (quality) of care” (WAC 246-310-230), and “cost containment” (WAC 246-310-240). In evaluation of these criteria, Program relied upon theories without addressing significant

questions regarding the appropriateness of their application in the case at hand, and therefore erroneously granted DaVita a CON and denied Olympic a CON.

### Burden of proof

2.6 An applicant denied a CON has the right to an adjudicative proceeding. RCW 34.05.413(2). *The purpose of the CON adjudicative process is to assure that the procedural and substantive rights of the parties are protected and that the evidence supports the Program's analysis/decision. Ear Nose Throat & Plastic Surgery Assoc., Docket No. 00-09-C-1037 Order No. 6 at 8 (April 2001). In doing so the Presiding Officer must take into consideration the experience/expertise that support Program's decision. The Program's CON written analysis on appeal must contain sufficient information to support its decision. WAC 246-310-490.*

2.7 The burden of proof in an adjudicative proceeding regarding a CON is preponderance of the evidence. WAC 246-10-606. Evidence should be the kind that "reasonably prudent persons are accustomed to rely in the conduct of their affairs." RCW 34.05.461(4). The Program's decision is not reasonable in light of substantial evidence to the contrary that Olympic is the "superior" applicant. WAC 246-310-240.

2.8 *The Administrative Procedures Act chapter 34.05 RCW sets different standards of review for intra-agency appeals vs. judicial appeals. RCW 34.05.570(3), RCW 34.05.464 and WAC 246-10-606. In an intra agency appeal, as in the case at hand, the agency head or its designee may substitute her own conclusions for those by a Program or Presiding Officer who issued an "initial" decision. Tapper v. Employment Security Dept, 122 Wn2d 397, 404 (1993) and Towle v. Wash. State Dept of Fish &*

*Wildlife, 94 WnApp 194, 206 (1999), RCW 34.05.461(1)(c); and WAC 246-10-117(2). In evaluation of the evidence, an agency may use its “agency’s experience, technical competence, and specialized knowledge.” RCW 34.05.461(5). That expertise/specialized knowledge may be used by a presiding officer issuing a final order for the agency head or by a presiding officer/program issuing an “initial” decision.*

2.9 *The APA and its rules make no reference to agency presiding officers deferring to agency program expertise. RCW 34.05.461(3).<sup>13</sup> This does not preclude the presiding officer from reasonably relying on the Program’s expert opinion as is done with expert evidence in any case, but that does not relieve the Presiding Officer from assessing the weight that should be given to that opinion as she does in other Department of Health cases where expert opinion is presented. An expert opinion is only as strong as its foundation; facts, analysis, theories, assumption relied upon and relevant expert knowledge/experience. Experts are not immune from making mistakes, as the Program did in its evaluation regarding charity care. The Program also failed to adequately address material questions related to financial feasibility and cost containment. WAC 246-310-220 and 246-310-240.*

Cost containment analysis under WAC 246-130-240

2.10 The Program initially found that both applicants qualified for the need of only one CON, therefore it had to decide which was the better applicant under

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<sup>13</sup> *This point was raised on reconsideration with misplaced reliance on cases addressing judicial deference to relevant agency expertise. St Joseph Hospital at 741, Blue Mt. Memorial Gardens v. Dept. of Licensing, 94 Wn App 38 (1999) and Brighton v. Dept of Transportation, 109 Wn App 855, 861-2 (2001). This in not a judicial appeal under Part V of the APA but an adjudicative appeal under Part IV of the APA. Chapter 34.05 RCW.*

Chapter 70.38 RCW and chapter 246-310 WAC. The Program turned to a competition/choice analysis under WAC 246-130-240(1) which concluded that “Olympic does not meet the cost containment criteria in WAC 246-310-240.” AR 337. The above findings shed great doubt on that conclusion.

2.11 The pertinent part of WAC 246-310-240 states:

A determination that a proposed project will foster cost containment shall be based on the following criteria: (1) Superior alternative, in terms of cost, efficiency, or effectiveness, are not available or practicable.

Olympic, not DaVita is the “superior” more “effective” of the two applicants for reasons outlined in the findings of fact.

2.12 *Corporate status (profit v. non profit) is not a criteria under CON laws. An anti-trust case may explain this omission. Non profit status is “no guarantee” against anti competitive behavior. US v. Mercy Health Services, 902 F Supp 968 (1995). Under the cost containment analysis of RCW 70.38.115(2)(g) and WAC 246-310-240, the specific facts regarding competition potential should be carefully evaluated when the Program distinguishes competing qualified applicants on the competition/patient choice criteria to select the “superior” applicant.*

Financial Feasibility analysis under WAC 246-310-220

*The determination of financial feasibility of a project shall be based on the following criteria. (1) The immediate and long-range capital and operating cost 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 cost and charges for health services. (3) The project can be appropriately financed. (Emphasis added.)*

WAC 246-310-220.

2.13 *The Program failed to determine what DaVita’s customary commercial fees are and/or what DaVita’s projected fees will be, and therefore could not accurately conclude whether DaVita’s project will have an “unreasonable impact on costs and charges for health services”. DaVita’s corrected projected operating expenses (with accurate annual rental expenses) are much more than Olympic’s. DaVita claims it will offer competitive fees with Olympic, but that may render its proposal financially unfeasible under WAC 246-310-220. The Program assumes that DaVita’s presence as a dialysis provider in Poulsbo will result in lower Olympic fees, but the evidence raises significant questions regarding the reliability of that conclusion, therefore raising great doubt to Program’s conclusions as to which applicant is “superior” applicant under WAC 246-310-240.*

Patient choice analysis under WAC 246-310-240

2.14 In the case at hand, the Program’s patient choice theory is too speculative. The evidence does not demonstrate that a significant number of patients would have a realistic choice because of the distance and commuting time between the facilities. In light of the evidence regarding Olympic’s projected lower fees, projected lower annual operating budget and its reputation of providing good quality care, patient choice should not be used as a criteria to determine the “superior” or more “effective” applicant that “will foster cost containment“ under WAC 246-310-240.

Rule making requirements under the Administrative Procedures Act (APA)

2.15 In some cases, patient choice may be reasonable criteria to evaluate CON application(s) under the scope of WAC 246-310-240(1) ”superior alternatives, in terms

of cost, efficiency or effectiveness, are not available or practicable.” Patient choice between facilities that are not too far apart could stimulate more effective or efficient care, because patients could choose another facility if not satisfied with provided health care. This may result in facilities increased responsiveness to patient needs, therefore providing more “effective” and/or “efficient” care.

2.16 Olympic argues that the application of patient choice and/or price competition criteria to the CON application process violates the rule making requirements under the APA. Olympic argues that these criteria are not encompassed within the existing rules and, therefore, before choice/competition criteria are applied they must first be adopted as a rule. Because the patient choice criteria falls reasonably within the scope of WAC 246-310-240(1), the application of the choice factor does not violate the rule making requirements of the APA. RCW 34.05.010. *Wash. Indep. Tel. Ass’n. v. Wash. Util. & Transp. Comm’n*, 148 Wn2d 887, 902 (2003) and *Hillis v. Dept of Ecology*, 131 Wn2d 373, 398-9 (1997). Patient Choice is not a new “qualification or requirement” related to the benefit conferred by the law since it reasonably falls under WAC 246-310-240 and the purpose of the Health Planning & Development Act to provide accessible, quality care, while controlling excessive health care costs. *Simpson Tacoma Kraft V. Dept. of Ecology*, 119 Wn.2d 640, 647-8 (1992) and RCW 70.38.015(1)(5).

2.17 The competition factor alone does not clearly fall under a reasonable interpretation of WAC 246-310-240. *However, competition may be considered under this provision when accompanied with a finding that patient choice will “foster cost*

*containment.*” The legislature adopted the CON Act to control health care costs so government could restrain/control the marketplace forces because the legislature was concerned that competition in health care has a tendency to drive costs up rather than down. *St Joseph Hospital* at 753. Therefore, competition alone is a principle of “general applicability” that alters and/or creates a new qualification for the issuance of a CON. *Failor’s Pharmacy v. Department of Social & Health Services*, 125 Wn2d 488, 493-494 (1994), *Hillis* at 398-9 and *Simpson Tacoma Craft* at 647-8. Before this criteria is applied as the sole basis (as a “tiebreaker”) of granting or denying a CON, it should go through the scrutiny of public rule making procedure under the APA. *Id.*

2.18 The Program argues that the application of the competition criteria under WAC 246-310-240 cost containment analysis is permissible citing RCW 70.38.015(4): “The development of non-regulatory approaches to health care containment should be considered, including the strengthening of price competition.” In the case at hand, the Program applied competition criteria pursuant to its regulatory interpretation of WAC 246-310-240. The Program is using a regulatory approach relying on a statute that authorizes a non regulatory approach.

2.19 Even without the application of the competition factor, Olympic is the “superior” and more “efficient” applicant under WAC 246-310-240 with a better projected budget, projected fees and a projected opening date. Because there was an immediate need for additional dialysis station and a facility in the Poulsbo area, the time factor should have been taken into consideration *with the difference in needed proposed service, and other criteria related to financial feasibility and cost containment. The cost*

*and time savings justify using opening time as a tie-breaking factor to determine which of the competing qualified applicants is the “superior alternative” in terms of “efficiency” and “effectiveness” under WAC 246-310-240.*

#### Comparative review

2.20 Mutually exclusive applications for proposed projects must be conducted concurrently when only one proposal will fulfill the identified need. *Ashbacker Radio Co. v. Federal Communications Commission*, 326 US 327 (1945). Olympic’s and DaVita’s applications are mutually exclusive. Procedures regarding concurrent review are outlined in WAC 246-310-120 and RCW 70.38.115(7). The Program chose the comparative review process that is not set forth in the WAC, rather than concurrent review that is set forth in WAC 246-310-110. Olympic argues that the application of comparative review process violates the rule making requirements of the APA since this procedure is not contained in the CON rules.

2.21 WAC 246-310-110(1) limits the categories of review of “any” CON application. Comparative review is not listed in WAC 246-310-110(1). The word “shall” clearly states that choice of review procedures are limited to one of those procedures listed in WAC 246-310-110(1): “regular review, concurrent review, emergency review or expedited review”. *When words are clear and unambiguous and not amendable to more than one reasonable interpretation, the words will be given their plain meaning. State v. Roggenkamp, 153 Wn. 2d 614 (2005).* It is clear that one of the review categories of WAC 246-310-110(1) should have been used in the case at hand, but the Program failed to do so. The comparative review process Program did use to review

