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October 19, 2022

Washington State Department of Health
P.O. Box 47890
Olympia, WA 98504-7890
Submitted via email to: CNrulemaking@doh.wa.gov

Re: Comments on Certificate of Need Regulations for Kidney Dialysis Facilities

Dear Secretary Shah and Department of Health team,

Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Health Plan of Washington, and Kaiser Foundation Health Plan of Washington Options, Inc. in concert with our Permanente Medical Groups (collectively "Kaiser Permanente"), appreciate the opportunity to provide feedback to the Washington State Department of Health (DOH) on the certificate of need (CON) process for kidney dialysis facilities. Kaiser Permanente is an integrated health care system that covers and cares for more than 760,000 members in Washington State. We are committed to delivering affordable, coordinated, and high-quality care and coverage that supports not only our members but also the communities we serve.

We understand the DOH is considering opening WAC 246-310-800, 246-310-803, 246-310-806, 246-310-809, 246-310-812, 246-310-815, 246-310-818, 246-310-821, 246-310-824, 246-310-827, 246-310-830, and 246-310-833 to review standards and need forecasting methodology for kidney dialysis facilities. We applaud the DOH for tackling an area of regulation that has been a pain point in Washington for years as the growth of the Washington state dialysis population has been outpacing the CON capacities set by these regulations.

As we will outline in this letter, we urge the DOH to remove the CON process for kidney dialysis facilities, allowing more private companies to build facilities to address the unmet need of Washingtonians to receive timely services from kidney dialysis facilities within the state of Washington.

Lack of timely access to outpatient dialysis chairs adversely impacts dialysis patients
Outpatient hemodialysis is necessary to keep patients with end stage renal disease (ESRD) alive. It is generally performed three times a week for approximately four hours a session. Our nephrologists find they must place patients on waitlists at kidney dialysis facilities closest to their home early in their pre-ESRD process before patients need dialysis (especially in rural communities) because wait list times and numbers are long (multiple months, and often 15-17 patients deep for small facilities in rural communities). Dialysis chairs are usually vacated only if there is a death or a transplant within that facility.

A lack of dialysis chairs in Washington communities directly impacts patient care for both dialysis patients and non-dialysis patients

1. We prefer that our patients initiate their dialysis at an outpatient kidney dialysis facility vs. a setting with a higher level of clinical care such as a hospital. With the current system which limits outpatient dialysis chairs in Washington, it is difficult to find an open chair for urgent start

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dialysis patients. As a result, patients are sent to the hospital to initiate dialysis. The patient care experience suffers because of inadequate access to dialysis chairs.

2. Due to unprecedented ER/hospital census, especially in the last 2.5 years, patients admitted to the hospital have not been able to be dialyzed in a timely manner due to shortages of acute dialysis staff/hospital beds and become at risk for a sentinel event (respiratory failure, cardiac arrest). New patients must be able to initiate dialysis care safely.
3. The lack of dialysis chairs causes extended hospital stays for new dialysis patients who are otherwise stable to be discharged, but they cannot be discharged due to a lack of a place to send them to for chronic dialysis. This has a direct impact on increased spending for hospitalization when the patient could clinically be treated in an outpatient setting if chairs were available. On average, patients will spend weeks and sometimes months in the hospital because they can't get an outpatient chair assigned.
    a. Our inability to discharge patients to outpatient treatment creates a ripple effect that impacts hospitals' ability to admit patients who are sick with illnesses that *do* require hospitalization. Our hospital is often on diversion for patients from rural/outlying areas—both for dialysis and non-dialysis patients—which in turn affects morbidity and mortality for our communities.
    b. Unnecessarily lengthy stays at a hospital increases risks for nosocomial infections. Some of our patients have gotten COVID, pneumonia, or C. Difficile from the hospital while waiting for a dialysis chair to open in the community.
4. If existing patients at an outpatient dialysis facility have fluid overload or hyperkalemia, the dialysis units are already operating at full capacity and cannot accommodate additional treatments for these patients. This can lead to hospitalization (best-case scenario) or possibly the patient's death.
5. Patients must dialyze at an outpatient kidney dialysis facility that has an open chair, which may not be the facility nearest to their home. This can make a dialysis treatment day a long ordeal for patients. In the past five to six years some of our patients have had to drive 40+ miles for the nearest open dialysis chair. If you add the four-hour dialysis treatment time to the travel time (which is sometimes impacted by I-5 traffic), this can result in an exhausting and long seven- to eight- hour day.
    a. For new dialysis patients, they are often served during the third dialysis shift of the day, which means their treatment ends at 10-11 p.m.
    b. These patients are often placed under the care of a different nephrologist who doesn't know them, but has privileges at the local kidney dialysis facility, which is not ideal for continuity of care.

Oregon doesn't have a CON process and has better access to kidney dialysis than Washington
Beyond the statewide issues mentioned above, we also want to note the differences in care for our Southwest Washington members. We provide care for dialysis patients in both Oregon and Southwest Washington, where different regulatory structures are in place for outpatient kidney dialysis facilities. As nephrologists, we have for many years noted a stark and disturbing disparity between dialysis availability in the two states. Oregon doesn't have a CON process for the placement of dialysis units, while Washington has a CON process that intentionally limits the availability of dialysis chairs. As a result, there are markedly fewer dialysis chairs per capita in Washington.

In Oregon, we can find chairs for dialysis patients near their homes and during hours they can easily attend. In Washington, we have patients dialyzing at all hours of the day, often far from their homes. Imagine a dialysis patient in their 80s who must dialyze at midnight due to an inability to find a chair.

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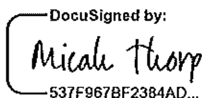
Right now, we have Washington patients dialyzing in Oregon because of the lack of availability. The pandemic has only made the problem worse. Staffing at units is in decline everywhere, and units are closing shifts as a result. The fact that Washington has a limited number of chairs to start with has only made the problem worse. To add some perspective, since the beginning of the year we have only been able to place two patients in outpatient dialysis chairs in Washington, while we have placed dozens in Oregon. Many of those currently dialyzing in our Oregon units are from Washington.

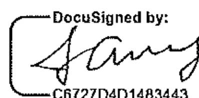
Patient need for kidney dialysis outweighs the original intent for a CON process
The CON process for kidney dialysis facilities was originally created to address the risk of monopolies in the state for kidney dialysis services. Kidney dialysis facilities are owned and operated by private for-profit companies. Most patients receiving kidney dialysis are Medicare patients. Claims are paid primarily by Medicare plans with set rates that won't increase based on supply or demand. If private companies overbuild and provide too many dialysis chairs, this does not alter the cost of dialysis and only adds to the availability of dialysis for patients. Medicare oversees quality and is quite rigorous, regardless of the number of dialysis units or chairs in a facility. There is absolutely no reason for a CON process to exist from a cost or quality standpoint.

Removing the CON for kidney dialysis will increase patient access to care
In conclusion, there is no benefit for the State of Washington to have a CON process for building new dialysis units or adding to existing ones, and we urge the removal of this process. Doing so will benefit Washingtonians and increase their access to life-saving care.

We thank you for the opportunity to provide comments on the topic of kidney dialysis facility CON. As DOH continues to pursue this topic, please add us as stakeholders when materials are distributed. Please do not hesitate to contact us with questions.

Sincerely,





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