

**West Virginia Health Care Authority**  
**Renal Dialysis CON Standards Meeting**  
**09/25/2008 – 1:00 pm EST**  
**Conference ID # 137202**

**Ms. Sonia Chambers:** Well actually it looks like we've got everybody, a lot of the folks that at least RSVP'd they were going to be here, either here or on the phone, so why don't we go ahead and get started and whoever else is going to come in can join us when they get here or click in on the phone. I'm chair of the West Virginia Health Care Authority and with me today is Marilyn White, who is a board member of the Health Care Authority. Sam Kapourales unfortunately could not be here. The purpose of today's meeting, I guess there's a larger purpose. The legislature has been looking at the whole issue of Certificate of Need in West Virginia and examining, I guess looking at whether the state should have Certificate of Need or not and if so, for what service, and they have asked the Health Care Authority for some recommendations. We have also been providing them with a lot of information about what services are regulated, how they're regulated, and what we had determined to do was before you would make any recommendations to them at all about Certificate of Need, we thought it would be reasonable for us to have meetings around each of the services we regulate to get input from everybody as to whether they should be regulated, how they should be regulated, just give everybody a chance to say the piece, I guess, or at least have a dialog about that. And so this is our second meeting and we have reached out to everybody we could think of to come and provide us with some input. You're also welcome to provide us with written comments if you would like after this or anybody who was not able to be here today who might want to provide written comments, we'd be happy to entertain those. So what I'd like to do is probably start with those who are on the phone and if you could identify yourselves and then we will go around the room here at the Health Care Authority so everybody knows who's participating today, so whoever would like to start on the phone.

**Dr. Rick Latos:** This is Dr. Rick Latos, a nephrologist in Wheeling.

**Dr. Rebecca Schmidt:** This is Dr. Rebecca Schmidt, a nephrologist at West Virginia University.

**Dr. Julian Espiritu:** This is Dr. Espiritu from Charleston, West Virginia.

**Mr. Bill Highland:** This is Bill Highland from DaVita.

**Ms. Jessica Stewart:** Jessica Stewart from Fresenius.

**Ms. Nora McQuain:** Nora McQuain, Bureau for Medical Services.

**Ms. Tina Boyd:** Tina Boyd for Dr. Gordino, Mountain Ridge Dialysis, Summersville.

**Mr. Clark Morgan:** Clark Morgan from Greenbrier Dialysis.

**Ms. Sonia Chambers:** I'm sorry Mark, tell me your last name?

**Mr. Clark Morgan:** It's Clark C. Morgan.

**Ms. Sonia Chambers:** From Greenbrier...

**Mr. Clark Morgan:** Dialysis, it's DaVita.

**Ms. Sonia Chambers:** Okay. Anybody else? Okay, then why don't we go around the room here? We can start on the far side of the room and you may have to speak up so they can hear you.

**Ms. Martha Morris:** Martha Morris, I'm with the Consumer Advocate's office in the Office of the Insurance Commissioner.

**Mr. Ed Hamilton:** My name's Ed Hamilton. I'm with Mountain State Blue Cross Blue Shield.

**Ms. Raymona Kinneberg:** Raymona Kinneberg with Bill Crouch Associates.

**Mr. Scott Wagstaff:** Scott Wagstaff, DaVita Dialysis.

**Mr. Dayle Stepp:** Dayle Stepp, CON Director.

**Ms. Barbara Goode:** Barbara Goode, State Medical Association.

**Ms. Debbie Frazier:** Debbie Frazier, Fresenius Medical Care.

**Mr. Jim Swan:** Jim Swan, Fresenius Medical Care.

**Mr. Bob Coffield:** Bob Coffield, Flaherty, Sensabaugh & Bonasso

**Mr. Tim Adkins:** Tim Adkins, West Virginia Health Care Authority, Certificate of Need Department.

**Ms. Kay Myers:** Kay Myers, West Virginia Health Care Authority, Certificate of Need

**Ms. Jill McDaniel:** Jill McDaniel, Hospital Association.

**Mr. Mike Spiker:** Mike Spiker, Goodwin & Goodwin, Attorneys at Law.

**Ms. Marianne Kapinos:** Marianne Kapinos, Health Care Authority.

**Ms. Sonia Chambers:** All right. I think what I'd like to do is have Dayle briefly go over the current standard and then we'll just throw it open for discussion. Dayle, I guess, do you have, one of the other things is I think you also did an inventory, didn't you, of the dialysis providers in West Virginia, is that attached?

**Mr. Dayle Stepp:** Yeah, you've got a map and...

**Ms. Sonia Chambers:** All right and I believe for folks on the phone, this was emailed to you.

**Dr. Rick Latos:** Correct. I have a question, but I'll hold it until after he discusses it with regards to the map and the data in it.

**Ms. Sonia Chambers:** Okay. All right Dayle, go ahead.

**Mr. Dayle Stepp:** Okay. Starting, it says that these standards apply to provision of dialysis treatment for patients with chronic end stage renal disease. They do not apply to in-patient dialysis treatment for acute renal failure or to in-patient dialysis for other conditions. The standards also do not apply to the treatments that are in dialysis such as transplants. And then we talk about in-center to home center and we say a facility presently offering in-center based renal dialysis, but wanting to offer home based renal dialysis need only meet the following criteria and you must show that the provision of home based dialysis is medically preferable for a significant group of patients or is preferred by a significant group of patients. As far as offering new services, we do not have a population-based need methodology as we do in most of our other standards. Really, the only requirement here, because of the extensive Federal regulation of the reimbursement and pervasive Federal presence in the provision of renal dialysis services, an applicant shall be deemed to establish need if they demonstrate that the services will meet the certification requirements under the existing rules and regulations of the Federal Medicare program. Then we just have the quality standards, you have to be in compliance with all Medicare standards and that the services meet the existing guidelines by the pertinent medical specialty. You have to have written practices and procedures for the patients. You have to demonstrate that it's financially feasible and show how you'll provide transportation in the area for those who would like adequate transportation. So that's basically the standards that we currently have.

**Ms. Sonia Chambers:** So they're a bit different than our...

**Mr. Dayle Stepp:** Yeah in that they're not population-based. We don't have a required use rate for the...

**Ms. Sonia Chambers:** And so as long as one meets the Medicare certification requirements then...

**Mr. Dayle Stepp:** Then they have demonstrated need consistent with the state health plan.

**Ms. Sonia Chambers:** All right. Why don't you go into the map?

**Mr. Dayle Stepp:** The map is basically just showing locations of each map by counties, of counties, and then the last sheet is just names and cities and counties, and it's sorted by county.

**Ms. Sonia Chambers:** In alphabetical order, okay.

**Mr. Dayle Stepp:** Right, by county, right.

**Ms. Sonia Chambers:** All right, and the last page are decisions.

**Mr. Dayle Stepp:** Right, someone had asked if we had denied any and what we approved in the last 10 years, so I didn't find any that we had denied and those are what we've approved within the last 10 years.

**Ms. Sonia Chambers:** Okay. We are actually recording this meeting and we'll have a transcript of such, so before you speak you have to identify yourself and that's going to be hard sometimes when there's back and forth, but I'll remind you if you forget. Did we have somebody just join the call?

**Dr. Rick Latos:** I hit the wrong button and I...

**Ms. Sonia Chambers:** You know, it's comforting to know that I'm not the only person that does that so...

**Dr. Rick Latos:** I've been doing it for 30 years, Sonia, so I haven't gotten any better. I'll wait. It sounds like somebody was in the middle of a discussion. I do have a question about that graph data. I'll wait until you finish this one, thank you.

**Ms. Sonia Chambers:** Yeah, Ed Hamilton from Blue Cross Blue Shield had a question.

**Mr. Ed Hamilton:** Patient prevalence counts. Is that number of patients required during a period of time and based upon what data?

**Mr. Dayle Stepp:** It's the data from the Mid-Atlantic Renal Coalition is what we use and that covers the Mid-Atlantic states.

**Ms. Raymona Kinneberg:** Dr. Espiritu, who is probably more familiar with this decision than I am, there actually was a denial of a proposal that he made prior to, I don't know when that was. Dr. Espiritu, can you...

**Dr. Julian Espiritu:** I'm here.

**Ms. Raymona Kinneberg:** Yes, there was a denial years ago. When was that?

**Dr. Julian Espiritu:** I think that was in Kanawha City, Dr. Amman was trying to, I don't know how long ago, maybe seven years ago...

**Ms. Raymona Kinneberg:** Yeah, it was a different direction. The authorities had taken a different on that decision, that decision was a denial based on the status quo being a superior alternative and I do have a copy of that decision back in my office. I didn't bring it with me.

**Mr. Dayle Stepp:** Yeah. If you check that, I think it was more than 10 years.

**Ms. Raymona Kinneberg:** Yeah, it was awhile ago. I don't remember when it was and the more recent decisions have been based on the need as opposed to superior alternatives.

**Dr. Rick Latos:** I have a question with the data. If this information is obtained from the ESRD network that governs West Virginia, the data is at least one year old and probably longer. I don't know the report from which this was obtained. This, I guess, is county of residence by patient. It doesn't accurately reflect what is going on within the facilities that are designated by the triangles on the graph. What you probably need to have access to, and this is easily available, is to have the facility population, as well, especially those of us who deal with border counties, we have substantial numbers of patients who dialyze in a West Virginia-based facility who actually don't live in West Virginia and this is especially important in rural areas of which most of West Virginia is, but anybody on the border counties knows exactly what I'm talking about. As an example, in Ohio County the facility in Wheeling, listed at 27 Ohio County residents, the census presently is somewhere north of 90.

**Dr. Rebecca Schmidt:** I can just speak to that, as well. I can see that some of these numbers are not correct.

**Dr. Rick Latos:** They're based on a time frame, Becky, that's very old and it doesn't really tell you what you need. This is just prevalence of patients by the counties in which they live and that really helps if you're worrying about servicing your county patient, but few of us do just that.

**Ms. Sonia Chambers:** Do you understand that, Dayle?

**Mr. Dayle Stepp:** Right, yeah, and maybe we need to do some kind of annual survey of ESRD facilities to get the proper utilization.

**Dr. Rick Latos:** And that's available through mark and I think it's updated on December 31 every year. Things do change within a year, but the facility census reports are also in there and you probably have access to that. It's available on the web. If not, I can get it to you if you don't have it. You need to have the accurate information, is all I'm saying, before any final decisions are made.

**Mr. Dayle Stepp:** Okay.

**Mr. Jim Swan:** I think Dayle did a great job getting the information together. There is a time lag to the extent that the mark data is 12/31/07 for the individual facilities census. The more current zip code census is August of this year, so maybe there's a disconnect in the numbers. I think Dayle's done a good job in getting that together.

**Ms. Sonia Chambers:** Have we had some folks join us on the phone? I hear lots of clicking in and out. All right, so any other questions about the standards or the data?

**Ms. Rebecca Schmidt:** I think that Dr. Latos is pointing out there are ways to get this information and I agree with the guy who was complementing the work of Dayle. It is difficult to put together sometimes, because you have to get that information from different sources. We can just tell because I'm sitting in Randolph County right now. I know how many patients are which from which county. That's why we are able to tell you in real time because we're sitting there.

**Ms. Sonia Chambers:** Let me ask you this: for other services we do, do surveys or require those facilities to get information to us on an annual basis. We do it for nursing homes and home health and hospice. Is there such a survey that exists for dialysis facilities that you submit to other entities on a yearly, monthly, quarterly basis? Rick, are you there?

**Dr. Rick Latos:** I'm here. Somebody is on a funny connection because we're getting a lot of bleed in, but that information is available....

**Ms. Sonia Chambers:** Are you there? Oh, he hit the wrong button again, I guess. Hello? Rick?

**Dr. Rebecca Schmidt:** I'm getting that same static, but I'm still here and I think what he was going to say is that the networks have a lot of this information, they should have all of the information...hello?

**Ms. Sonia Chambers:** Yeah, we can hear you. Actually, could everybody who is not speaking put their phone on mute, please? That will often happen. If somebody is in the car on a cell phone, that will create that background noise.

**Dr. Rebecca Schmidt:** How do we do that? I did not get that in a directive?

**Ms. Sonia Chambers:** Um, how do we do it on the conference call?

**Dr. Rebecca Schmidt:** Yes.

**Ms. Sonia Chambers:** Do you have a mute button on your phone?

**Dr. Rebecca Schmidt:** Well I don't, but usually these calls you can do \*6, but I was afraid to do that for fear of losing you.

**Ms. Sonia Chambers:** Kay, can you go ask Linda what we need to do to do that? Okay, I'm sorry. Dr. Schmidt you were saying...

**Dr. Rebecca Schmidt:** I was just saying I think what Rick was going to say is yes, this information could be retrieved and it's easy for us to say where it's not correct because we're sitting here, but it can be retrieved and suffice it to say that probably all these numbers are lower on the paper than they are in reality.

**Dr. Rick Latos:** I guess if you have specific data requests, all you have to do is submit that to the network and they'll get it for you. It depends on what information you actually want. In the very near future, every bit of that data is going to be handled directly from each facility straight to CMS, so there will be almost instantaneous real time data availability. The folks from the chain dialysis units can attest to how complicated that's going to be, but at least the current information flow that goes to the network office is generally deemed to be very accurate. I do have one last question and then I'll stop talking here. The way I understand the description of the current policy and regulation is that if there is a location in which a new facility is intended to be placed, it could be five feet away from a nearby facility or it could be in a very remote geographically underserved area and there would be no reason to deny the applicant, who is submitting that application, for any reason. I can't imagine how a facility would not be approved by Medicare because there are no requirements for Medicare. As long as you pass the state health department survey and if the person or entity that's going to submit the application has already done the financial feasibility, what difference does it make to the HCA whether an independent entity is going to go broke or not go broke, because the patients are going to be covered if there's a nearby facility from an access standpoint. Maybe I'm missing something here. Then if I understand the regulation the way you've described it and the way I read it, I can't think of a reason why anyone should be denied the ability to establish a new outpatient dialysis facility.

**Ms. Raymona Kinne berg:** This is the reason I brought up the denial. Under these standards, there has been one denial. It may have been more than 10 years ago, it wouldn't have been more than 12, and in that instance they determined that it was a duplication of services and the status quo was the superior alternative. That's the only denial that I'm aware of because recent approvals have not taken that position.

**Ms. Sonia Chambers:** Well, but I think if the board has considered these, we have certainly looked at the, and I think in some of the hearings and all the things, we've had a lot of discussion about the capacity of existing facilities, about how many shifts those existing facilities are running, what the access for patients is, what they're drive and commute times would be, whether they're having to come in on third shifts or any of those different kinds of things and we've certainly had a lot of discussion in all of our hearings about that and I think the board has been very interested in that before we have looked at approving an additional facility. I mean I can think of a couple of instances right off the top of my head where we've had a lot of discussion about that. If a facility was running pretty much, was full, running third shift patients, whether it was a fairly far drive for a lot of those patients, then we've certainly taken those things, those are the kinds of things that we have traditionally looked at.

**Ms. Raymona Kinne berg:** I think going along with that, you'd asked is there a way, would anything be denied under these standards and I think based on what Sonia said it could be, but they're looking at it from capacity and statuses and [inaudible], but it would not be based on need if you can show that you meet the Medicare requirements. It would be based on the [noise inaudible].

**Ms. Sonia Chambers:** I think we've traditionally, I think that's [noise inaudible].

**Mr. Bob Coffield:** The only other thing I would add is although need is presumed, you still need to calculate the number of potential you're going to serve, because that plays into your revenue as to whether or not you can prove financial feasibility, so I just want everyone to understand that the assumption that there is no need methodology is I think, you meet the regulation, that's correct, but you still need to develop and project numbers of patients for purposes of financial feasibility.

**Ms. Raymona Kinneberg:** Right, and you need to project those patients...

**Mr. Bob Coffield:** Under some need methodology.

**Ms. Raymona Kinneberg:** Yeah, without cannibalizing somebody else's patients.

**Ms. Sonia Chambers:** So let me throw out the question, I guess. Should this service be subject to Certificate of Need review or not?

**Mr. Roger Bowles:** This is Roger Bowles. I'm with DaVita. I'd like to weigh in. Just to give you an idea, we were told our competitor was putting a clinic in Green Briar, where we have a facility, which is nowhere near capacity, and I dare to say that they run models just like we do and based on the performance that we have there, we were told it would be basically granted, that like you said, in the last 10 years nothing had been denied, so it's going to be tough for both of us to survive there and so I see the process as just an exercise in futility.

**Dr. Rick Latos:** What exercise are you referring to that would be in futility?

**Mr. Roger Bowles:** The Certificate of Need. It is a duplicate of services in Greenbriar where we are. There's only 35, 36 patients, so we've got a center that has a capacity of, I don't know, 80 patients, so why go through the process?

**Ms. Raymona Kinneberg:** I think what you're saying is, if everything's going to be approved, why have Certificate of Need.

**Mr. Roger Bowles:** Correct.

**Ms. Raymona Kinneberg:** Without looking at existing capacity.

**Mr. Roger Bowles:** Correct.

**Dr. Julian Espiritu:** It sounds like it's just an extra expenditure. We have a situation when the big chains open a unit, they go uncontested and independent unit, they want the review of some sort, so I think it's just a delay, just costly and why can't we learn from the other surrounding states, all 40-some states that don't have a CON, so we don't have to speculate?

**Ms. Sonia Chambers:** Am I hearing you correctly Dr. Espiritu? You think it should not be a regulated service?

**Dr. Julian Espiritu:** I think so. I don't think it should be regulated.

**Mr. Scott Wagstaff:** I guess my concern is I'm relatively new to the CON process and everything in the state of West Virginia. Is some clarification about, and some hard guidelines, about need? In reading this, capacity is not into it and I understand the financial feasibility of patient...I mean you have to have

patients to survive economically, but to some extent that probably falls on the provider to do that, to make that determination that they will [noise inaudible] be able to keep the doors open to the unit. My [noise inaudible] frustration is there's not any hard numbers or guidelines. It seems to be subjective and [noise inaudible]. Completely, this is new to me and of course, being new to the process [noise inaudible] component to it and it doesn't appear like there is or there is at times and there isn't at other times.

**Ms. Sonia Chambers:** Dr. Latos, what do you think?

**Dr. Rick Latos:** Well, I've been in West Virginia practicing nephrology since 1977 [noise inaudible] fairly logarithmic growth of dialysis facilities throughout the state presumably meeting very important needs and I don't know that there's too much over utilization. In fact, we probably need more capacity than less at the present time, but that doesn't mean that every community is underserved. In the Pittsburgh area, which is just one hour from Wheeling, Pennsylvania, I recall, has not had CON for ESRD services for a long time, there was period of a couple of years ago when dialysis units just blew up on every street corner practically and facilities that had long experiences covering patients lost large numbers of patients to competitive chains in those cases for whatever reason, some of which the doctors had switched allegiances and they moved from one chain to another and they took their patients and it is my understanding that there are several facilities in the Pittsburgh area that have either closed or are in the process of being closed because they could not keep their patient volume up. Now, I'm not in a position to say that one of those facilities is better than the other, the quality is better, less expensive, whatever, I don't know anything about that, but I'm just stating the reality and since we are not part of a large dialysis organization in our facilities, I don't have the same sense of growing concern, although as an independent dialysis provider, I do have concerns about opening up the flood gates to anyone who wishes to set one up. Unless you have a nephrologist that's willing to support a given dialysis unit, nobody is going to set up another dialysis unit next door. [noise inaudible] problem in West Virginia, we have a very, relatively low number of nephrologists and they are saturated, not saturated, but located in, four in Wheeling and five or six in Morgantown and half a dozen in Charleston, but very few out in other communities and it makes it difficult, so I have mixed feelings about it. I'm going to give this some more thought and I will submit my concerns. I don't have, unfortunately, a strong recommendation pro or con. I have feelings on both sides of that equation and so I apologize for being sort of middle of the road on that, but I'm going to have to get more thought to what I would ultimately recommend. [noise inaudible] I'd be interested in hearing more from some of the large dialysis folks who potentially would be a stronger competitive force for somebody like myself than another independent, but I'm just curious. Competition's good, except when it's against me.

**Ms. Sonia Chambers:** [Laughter] Very honestly said.

**Dr. Rick Latos:** It's just the way it is. If we're not able to provide the capacity, then there needs to be somebody to take care of that business and I heard somebody from Green Briar say that they have a facility that can handle 80 patients. What would be the value of the community of having one more facility that's going to split the difference and have 17 patients each? One has blue carpeting and another has red carpeting and one has X machines and one has Y machines and I guess patients are going to go to which facility is closest [noise inaudible] where they're doctor happens to be, I guess.

**Ms. Marilyn White:** Dr. Latos I've got a question for you. I want to make sure that I understood. I think you said that if a, let's say a freestanding dialysis center would come into any town, did I understand you right that they also have got to guarantee or have a nephrologist...

**Dr. Rick Latos:** They have to have a nephrologist covering. One of the medical requirements is that you have a medical director or a suitably trained internist who has credentials to be able to practice

nephrology. The new conditions of coverage are a little bit soft on that, but not really. They're requiring a nephrologist. That doesn't mean that the individual has to be in that community.

**Ms. Marilyn White:** Ah, that was my question. It does not mean that, okay.

**Dr. Rick Latos:** No, it doesn't mean that, but again in rural West Virginia, we work in New Martinsville, but we don't live there. I'm down there twice a week minimum taking care of the patients, but what I'm saying is that the community or the facility needs to have a nephrologist who's able to provide the care for the patients in that facility and then there are no regulations that say how many times a hour you have to visit those patients. If you want to get paid you have to visit them at least once a month, but if you don't visit, you don't get paid.

**Ms. Marilyn White:** And that would be a Medicare requirement then? They would be the ones to insure that there's a nephrologist there at least once a month?

**Dr. Rick Latos:** I didn't say that. The conditions of coverage are not prescriptive in terms of the number of visits or the number of encounters between the nephrologist. In fact, you probably ought to have access to the new conditions of coverage and I'll send you that document so you'll have it. The interpretative guidelines are in draft form right now and that's where the rubber meets the road and those are not yet in final form. They're due out any day now, but I'll be happy to send you a draft of what I have.

**Ms. Marilyn White:** Okay, thank you. That would be great.

**Ms. Sonia Chambers:** But just to follow that line of questioning though, however, I would presume, though, in order for a facility to be participating with Medicare, you do have to have a suitably trained medical director, correct?

**Dr. Rick Latos:** Absolutely.

**Ms. Sonia Chambers:** But what you're telling me is there aren't really clear, detailed guidelines on how much time that medical director has to spend with each patient.

**Dr. Rick Latos:** The medical directors do not necessarily have to provide patient care services. The attending nephrologist does that. The medical director role, under the conditions of coverage, is an administrative role, but it requires that the medical director assures that patient care is provided however. An example would be if a nephrologist doesn't see a patient but every two months, the medical director for that facility should be very concerned about that and should have some procedure in place to deal with that, because most people would agree that that's inadequate, but that's as far as it goes. The Medicare requirements under CON do not address the responsibilities of attending nephrologists or individual patient nephrologists who provide the care. It's simply the medical director responsibilities and the language is pretty extensive on that, of what that individual would be required to do, but the medical director could live someplace else and wouldn't necessarily have to be on site. Most medical directors do have on site responsibilities that range anywhere from once a day to once a month probably or I don't know what the pattern is across this state. There's a difference between the medical director responsibilities and the nephrologists who provide the care.

**Ms. [??] [??]:** Dr. Latos, in terms of the attending physician, do they actually have to go to the facility or can they see the patient in their office?

**Dr. Rick Latos:** That is correct. The patients can be seen in an office. It does not have to be in the dialysis unit.

**Ms. [??] [??]:** Right, so theoretically it's possible for a physician never to be in a dialysis office.

**Dr. Rick Latos:** That's correct, although one of the recommendations is that the patients should be seen, while undergoing dialysis, at least once a month, but that's a should and geographic issues have to play there.

**Ms. [??] [??]:** Is that a requirement for the facility or for the attending physician?

**Dr. Rick Latos:** It's not even a requirement. It's one of the recommendations under the nephrologist's payment schedule.

**Ms. [??] [??]:** Okay, so that would be a recommendation for the physician who is just part of the certification for the renal dialysis facility.

**Dr. Rick Latos:** Right. I don't think there's any requirement that mandates that patients be examined by a physician while they're actually on the machine. We think that's a good idea, but I can fully understand circumstances where that's not feasible. The nephrologist or the physician might not be able to be at that facility during the hours that the patient is dialyzing and so you miss them. That doesn't mean that good care isn't being rendered, but I think the recommendation is one that the patient should be seen, if possible, during dialysis by a physician or his or her designate, which could be a nurse practitioner or physician's assistant.

**Ms. [??] [??]:** So the certification requirements that are in the CON standard have nothing to do with the physician care for the patient.

**Dr. Rick Latos:** That's correct. When you say nothing to do, that's not exactly right, but there's almost no language that talks about the attending nephrologist's responsibility.

**Ms. [??] [??]:** Okay. I just want to clarify one other thing in terms of your dilemma about where you fall on should there be CON or should there not be CON and I drew this conclusion from your comments and I could be wrong, and that is if you decide that there should be CON, do you believe that it should include something that relates to preventing duplication of services, creating over capacity [noise inaudible] so we don't have a repeat of what happened in Pittsburgh?

**Dr. Rick Latos:** Yeah, if you take the pure approach, let the market decide, but I'm not that pure on that. For example, you have language in there that talks about home dialysis, having to show such and such. To my view, any facility [noise inaudible] even for a single patient who wants it.

**Ms. Sonia Chambers:** Wait, I'm sorry Dr. Latos. Somebody made some noise and it completely stepped on what you said.

**Dr. Rick Latos:** I was just referring to my views on home dialysis. I feel that any dialysis facility should be able to provide home dialysis supervision and support without a CON. That's a no brainer from my view. If you have a facility, you ought to be able to do home dialysis support, either peritoneal or hemo. There are other areas that govern the suitability of the state licensure department and survey and certification to cover that. That should not be a requirement or reviewed by HCA in my view. [noise inaudible] home dialysis of any type, but it's a little different when you get to the picture of if I have a facility here, for example in Wheeling, and we are 70% occupied and my patients are happy and another independent nephrologist wants to set up, or a chain, wants to set up a dialysis unit in the same community, well what realistically should preclude that from happening? If we have an open dialysis

policy where other nephrologists can practice within the facility, we're not preventing nephrologists from carrying out their work. **[noise inaudible]** one of those situations that it's a real double-edged sword. ON the one hand you wouldn't want to have five dialysis units in a community the size of New Martinsville, for example, and why would somebody want to do that? Well, I can see where someone might want to do it. If they think they can make a buck here, there, or wherever and provide good care, somebody, somewhere is going to set up a facility. That happens in other parts of the country. Is that good care? I don't think any data says otherwise. What happens if another facility shuts down? Well, under the free market system that happens as long as the care is being provided in another location in the same community. I think you need to talk to individuals who work in states where there has been no CON and see what the issues are. I can't talk about those. That's why I'm deferring to the people who work in the chain facilities, because they have access to that kind of information in other states.

**Ms. Sonia Chambers:** All right. Those of you from chains, I think he just asked for you to say something.

**Mr. Bob Coffield:** Just piggybacking on what Dr. Latos was saying, what is the role of the Health Care Authority? Is it to lead providers or is it simply to review and approve CON applications? I hear quite a bit of dialog about Dr. Latos thinking some parts of CON are good as long as it's not competing at his back door. I can understand that, but there are lots of communities in West Virginia, lots of patients that are not served, so how can the Health Care Authority work with providers, how can providers work with the Health Care Authority to focus the energy in that direction and attend to the needs of those that need treatment?

**Dr. Rick Latos:** That's a great point.

**Ms. Sonia Chambers:** That has been one of our challenges. I think sort of in a perfect world we could say to providers, all right, you want the lucrative Kanawha market where there's going to be a large concentration of people, then you also have to take Braxton County...

**Mr. Bob Coffield:** Oh you don't go there. This is take one, take all.

**Ms. Sonia Chambers:** Clay County or wherever else...

**Ms. Bob Coffield:** The economics are very, very different there. I don't think that's an appropriate trade off.

**Dr. Julian Espiritu:** I think rather than digress from the main issue, I think the main issue is who are we protecting here? Are we protecting the business or are we protecting the patients? There's so many restrictions. Believe me, I've learned the hard way about all these aspects of dialysis and I think I've done pretty well and basically, there's so many restrictions. It's hard to get staff, the profitability is getting smaller and smaller. I think it would be foolish for a facility to put up a dialysis unit and it is their doing or undoing if they don't do well. This competition is so...I think it's just the American way and there's nothing wrong as long as the patients are served.

**Mr. Roger Bowles:** This is Roger Bowles again with one of the chains that we've been talking about, with DaVita, and we go through a process of creating what we call a model to make sure that we're economically viable to be able to take care of the patients. I'm sure that everybody else in the community is going to say that they want to provide great care. Well we have that interest and we state it pretty loudly, but we also want to make sure that we're going to be there, so we're going to do the financial digging, if you will, to make sure that we're viable before we spend 1 to 1.3 million dollars to put up a facility and then invite the community with kidney failure to come on in, so another point is to the

physician that was talking about the Pittsburgh experience, I was in Pittsburgh when the CON process was dropped in Pennsylvania and there was a big influx of new clinics that came on board, but again, that cannot happen without a nephrologist, so unless there are additional nephrologists in town or nephrologists who are not tied up in a contract with a provider, then you're not going to see, all of a sudden like mushrooms, clinics popping up all over West Virginia, because again, you can have all the brick and mortar you want, but because of conditions of coverage, without a medical director you're not going to do anything.

**Ms. Sonia Chambers:** So I guess to play a little bit of the devil's advocate, I think one of the original, I think there are a lot of motivations for CON and a lot of reasons to do it. One is to not have over capacity in the system and therefore increase cost and my understanding of dialysis is that certainly the bulk of it is paid by Medicare and there are very set fee schedules for Medicare. My understanding is that for, is for the sixty days, no, for six months that a patient starts on dialysis...

**Group of people:** 90 days.

**Ms. Sonia Chambers:** 90, I knew it was some period of time, 90 days, then whatever their original carrier is pays for that, whether it be Blue Cross or...

**Mr. Scott Wagstaff:** That's a Medicare patient for the first 90 days. We won't [noise inaudible] first for their care. There is coordination of methods for private insurance. Commercial insurance would be primary for that patient for 30 months, I believe.

**Ms. Sonia Chambers:** For 30 months?

**Mr. Scott Wagstaff:** I think it's 30 months.

**Dr. Rick Latos:** Yes, it's 30 months.

**Ms. Sonia Chambers:** Well okay, so before I go down that other road, let's just stop here and we can clarify this for us. What is your payer mix, Medicare, Medicaid, and other?

**Mr. Roger Bowles:** It varies from center to center. It's not a hard and fast number.

**Ms. Sonia Chambers:** Okay, just roughly? Is it...

**Mr. Jim Swan:** In the Fresenius applications or BMA applications, I think we say historically it's about 85% Medicare [noise inaudible] from the beginning, so we're looking at something less than 15% that's commercial. That will be facility-specific based on our models. We do the same thing as DaVita does as far as modeling, but on a historical basis we're about 85% Medicare and then maybe another 4 or 5% Medicaid on top of that in some places.

**Ms. Sonia Chambers:** 4 or 5%?

**Ms. Jim Swan:** On top of that.

**Ms. Sonia Chambers:** Okay, so it's roughly that or similar...

**Mr. Scott Wagstaff:** That's probably a good number if you look at it globally.

**Ms. Sonia Chambers:** Okay, what about you Dr. Latos and Dr. Espiritu? Is that fairly close to your experience, as well?

**Dr. Rick Latos:** We have one facility, we have 94% Medicare/Medicaid. In another facility it's about, we have probably less than 10 to 15% commercial pay.

**Dr. Julian Espiritu:** Yes, about 10% commercial pays, about average.

**Dr. Rebecca Schmidt:** Ours is about that or less, too.

**Ms. Sonia Chambers:** Okay so it is really predominately Medicare with some amount of other, be it whatever, and one of the rationales for Certificate of Need is that if you have over capacity in the system then you end up, a lot of that can either end up driving up the price, as everybody tries to compete for the same patients, or it will drive up the volume. With Medicare and a set fee schedule there's a little less room, you don't get to negotiate so much with Medicare, do you?

**Dr. Rick Latos:** There is zero negotiating room and it is nearly impossible to drive up the volume if patients don't have advanced kidney failure and that's where we are under capacity. Dr. Schmidt will tell you, West Virginia has an epidemic, that's growing every year, of people who have advancing kidney failure.

**Ms. Sonia Chambers:** Dr. Latos, I think that is one of the reasons that a number of people have said do we really need to have Certificate of Need for dialysis? If it is indeed predominately reimbursed by Medicare, with whom you don't get to negotiate for price and there's not much room to optimize your volume, then does it really follow the traditional reasons for why you might want to have Certificate of Need, but I guess one of the other things that Certificate of Need is sometimes designed to do is to not necessarily allow...I'm trying to figure out how to say this as **[inaudible]** correctly as possible, how to not allow the big guys to come in and gobble up the little guys by low balling because they have large reserves to be able to come in and low ball things, take the market away from people who have been in the business for awhile.

**Mr. Roger Bowles:** I doubt that you're going to see that happening. The patient are tied to their physicians, to their nephrologists, so DaVita or Fresenius can't just come in, set up a clinic, and then all of a sudden start providing dialysis for 50 bucks a treatment and drive the guy out of town. You're not going to see that. I would also state that it would be highly unlikely that the market will not allow the over capacity that you were talking about. Again, talking with what we've been talking about before, free markets, the market will provide for adequate dialysis and adequate chairs to be able to treat patients, so I don't think we're going to see a problem with that.

**Ms. Sonia Chambers:** Dr. Espiritu, I believe you were arguing just that very thing to us not too long ago.

**Dr. Julian Espiritu:** That's correct. I think we should do away with the Certificate of Need because I think common sense will prevail.

**Ms. Debbie Frazier:** How can we prevent the dilution of the market in these areas that are densely populated with the ESRD patients and continue to provide care to **[inaudible]** patient and give them accessibility to facilities that they're not having to drive huge distances?

**Mr. Roger Bowles:** I would think DaVita's answer to that would be that Medicare is already pushing us to provide home dialysis more than we are currently doing it in the market and we certainly are pushing on our end to provide additional modalities to have patients be able to treat themselves at home.

**Ms. Debbie Frazier:** And we are doing that, as well, but not every patient is a candidate for home care.

**Mr. Roger Bowles:** Right, I understand that, but we have seen a tremendous interest in what we're doing in terms of home. When I started over 20 years ago, home dialysis was much bigger a piece of the pie, if you will, than it is now and we're currently trying to push to get to 15 or 20% penetration of home patients.

**Ms. Sonia Chambers:** Before we go to that, I asked Dr. Espiritu my question. All right, Dr. Schmidt and Dr. Latos, I'm going to ask you guys that. All right, Dr. Latos I believe you said competition is great as long as it's not in my backyard...

**Dr. Rick Latos:** Please, that was a cynical comment and I'm enough of a realist to know that that can never be.

**Ms. Sonia Chambers:** Well no, I understand that, but again, we've had a number of these applications in front of us, at least since I've been here, and sometimes it has been the physicians who have had the independent facilities saying I need to protect my investment and my patients and they big guys are coming in here. They have deep pockets and all the money and they're just going to destroy the business I've built.

**Dr. Rick Latos:** I'm not sure what the exact question is. I mean, that's a true statement.

**Ms. Sonia Chambers:** Well I guess the question is, is there any role for Certificate of Need in that respect? Now I understand we could have some discussions about how the standards are currently written and whether they do indeed protect that or not, but I'm just kind of curious as to your comments about that, because I have heard that from physicians. These chains have deep pockets and all kinds of money and I cannot fairly compete with them.

**Dr. Rebecca Schmidt:** May I make a comment, unless you wanted to answer that, Rick?

**Dr. Rick Latos:** No, go ahead Becky.

**Dr. Rebecca Schmidt:** I'm not sure what the question was. I'm a physician at the University and I guess my concern and my take on this is we need to bring it back to the patients. I think someone said the before. I don't think any of us are really here...I think Rick's comment was very meant in jest and my concern with this current guideline is I'm not sure...it seems somewhat nebulous to me and maybe I'm missing something, but it seems to equate to financial wherewithal which presumes a population in need, and as everyone has said and I think we're all agreeing, perhaps the CON, if we are going to continue having a CON, needs to take into account not only patient need, but the resources that are available to that patient. It does no one any good to have a dialysis unit in Braxton County if there's no doctor, no nephrologist. We also may not need another dialysis unit in a highly populated area with several dialysis units, so I guess for me, the way this is written, I'm not sure it fits the situation that we have in West Virginia and particularly given the fact that short of just giving bad chronic kidney disease care prior to ESRD, we don't want to drive up these volumes because it's a bad thing for patients. I'm just wondering if we're going to have a CON, should it be rewritten to set what our situation is here. Such that you have to have a nephrologist, you have to have the patient need. It doesn't matter how much money one has and there also perhaps needs to be some distance between the units. I'm not sure what the right answer is, but

I'm not sure this guideline really fits, the way it's written, really fits our situation and is helpful to anybody.

**Ms. Sonia Chambers:** Just for those of you who are not long-time students of the Certificate of Need process, there are some around the room who are more than others, I guess there are two different issues, larger issues on the table. One is should Certificate of Need apply to dialysis in West Virginia and that is a matter of statute and it just says if a covered service and that's the sum total of what it says. The way Certificate of Need in West Virginia works is that there are services that are listed to be covered and then the agency is charged with developing how those services are regulated and how they are covered and what different things go into showing that there is a need and unmet need, so I think one question is should dialysis be covered by Certificate of Need and that is really kind of the question that is immediately before us with this upcoming legislative session and if the answer to that is no, then the rest of it doesn't matter. If the answer to that is yes, and it continues to be covered, then I think it is reasonable for us to go back and look at the standards and how it is regulated, because I'm hearing a lot today that makes sense to me. This isn't one of those that we have reviewed recently and haven't updated. We've done that with lots of other standards, particularly cardiac ones. We've very busy with those, but I certainly think if this is a service that's going to continue to be regulated, then we need to go back and pull together a group like this to address the standards. But I guess what I've heard from Dr. Espiritu is it should not be regulated and I don't know that I've heard from anybody else a definitive opinion.

**Dr. Julian Espiritu:** Let me just say something. In my area, and I'm new to this obviously, but I feel since there was competition here in Charleston, I think the standard of care has improved and I could enumerate the little things, but those little things mean a lot to the patient and that's why I'm so for this, for healthy competition, and in fairness to the big chains, when Derrick was saying he's going to put you out of business, the big chains are very intelligent people. They will negotiate with you. If you can't make and compete with them, they'll offer to buy you out. There's nothing wrong with that and I think it's a very healthy competition and the patient should benefit in the long run.

**Ms. Sonia Chambers:** Ed Hamilton, do you have any particular comments about...

**Mr. Ed Hamilton:** Unofficially.

**Ms. Sonia Chambers:** Oh, I don't think you could ever comment unofficially in a setting like this, Ed.

**Mr. Ed Hamilton:** Well, then I better hold it until later and submit it in writing.

**Ms. Sonia Chambers:** Okay.

**Mr. Scott Wagstaff:** I do work in an area in Ohio, as part of a little bit of Ohio and a little bit of Kentucky [noise inaudible] has a CON and was in Ohio when the CON was... at first it was [noise inaudible] and there were a lot of units that popped up in a short period of time. I think the benefit of that is accessibility for the patients. It's incredibly costly for patients to get the treatment. Some patients will never get a treatment because they can't get there and then the other benefit that, I completely agree with Dr. Espiritu, is the competition side of it among clinics has made the outcome of patients better. I think that has definitely had a big influence on the patients' outcomes. And then lastly, it just sort of crossed my mind that if you look at the dialysis units that actually surround West Virginia and on the border of West Virginia, what is West Virginia losing economically because of that?

**Dr. Rebecca Schmidt:** Maybe I'm just too new to this process, but I'm not sure what would change if we didn't have a CON. Can anybody answer that for me? Why is that going to be better for patients?

**Dr. Julian Espiritu:** For people who are trying to build up more units and based on my personal experience and my patients, there's a least a \$40,000 to \$100,000 price tag to get a CON because the chains are going to fight you every which way you turn and that's not only a delay, it's an unnecessary expense and I know it's intended to make you think twice at least and that's totally unnecessary.

**Dr. Rebecca Schmidt:** Okay. I guess from my point of view, I have mixed feelings on this, obviously and I'm sure you can tell, but I guess I'm just not sure what...in a lot of the areas in West Virginia where we don't have good services or there are no dialysis units, in two of my dialysis units people drive an hour or two hours to get to dialysis, is the lack of a CON going to change that? Is someone going to come down and put a unit in those areas anyway? I guess what I'm hearing is...I'm just not sure why this is going to change anything, not having it.

**Dr. Rick Latos:** Well Becky, I think in those areas where...For example, when we made the decision to establish a facility in the New Martinsville area, there was no one within an hour and a half drive in any direction practically and so that was a no brainer and yet to go through the process of the CON was costly and very timely and so on that kind of an example, and there are lots of those that you're talking about out in the hinterlands of West Virginia, that should be not even an issue. I think you get into the dilemma when you facilities that are sort of close, like within a half an hour's drive of one another, and for a patient who has to drive 45 minutes as opposed to 30 minutes, that's a big deal. On the one hand it's a big deal, especially with gas prices being what they are.

**Ms. Rebecca Schmidt:** This is not a one size fits all answer.

**Dr. Rick Latos:** Yeah, really it isn't and so this is what creates some of the angst that some of us have. I think if somebody wants to set up a dialysis unit in Sistersville or wherever and if they can get the patients to get there, that's terrific. Even though that may be 30 minutes away from a facility that I coordinate, I don't have a problem with that really. At the end of the day, that's how I would come down for it.

**Mr. Roger Bowles:** I would agree with that. There have been multiple times where our physicians have worked or see patients in competitor's clinics and if they're five minutes from that clinic and they're 30 minutes from ours, they should go to the competitor. If I were a patient, that's what I would want to happen.

**Dr. Julian Espiritu:** I think the Health Care Authority already set up a precedent on this situation. There's a Fresenius unit that's going to be one and a half miles away from my unit, so I think that tells you something. This is no longer an issue, we should get rid of the CON.

**Mr. Jim Swan:** I've written five CON applications for Fresenius and presented to the Health Care Authority. First, I don't think it's an overly burdensome process. That's my specialty. I'm not a physician, I'm not a clinic manager, and I'm not with the Health Care Authority. I write CON applications. Bill Highland from DaVita is on this phone call. He does the same thing. I'm not sure that he's written any up here, but I know Mr. Highland from professional work. Writing the application allows the proponent to present to the Health Care Authority their plan for taking care of the folks that live within the state. I mean that's what we're doing. We're taking care of the citizens of West Virginia and we take it seriously. I think that even given the current standards, which are not need-based...I mean if a facility can demonstrate conformity with or the ability to become [noise inaudible] and comply with 405 2100, you've got to have a physician, you've got have the staff, and you've got to have the water and all the other elements that go along with that that are addressed in 405 2100, there's still not been a long line at your front door with CON applications to develop facilities in the rural and remote areas of West Virginia.

**Ms. Sonia Chambers:** That's exactly what I was trying...yeah.

**Mr. Jim Swan:** In some ways, I would suggest that the Health Care Authority can lead providers through a need methodology to these areas. There are patients, by my count looking at the mark data recently, more than 20% of the population, dialysis population that's reported by mark, is traveling out of county for their own treatment. There are some counties that could support a facility. You've got to have a nephrologist. I mean that's key. I think Dr. Espiritu, Dr. Latos, and Dr. Schmidt would all agree you've got to have the doc. Without the doc you can't have a facility, so as Fresenius has done in the recent years, once we have a doc on line and we're rated to move forward, we're giving you an application and each of our applications, I think Mr. Stepp would agree, provide a need methodology. We show you the number of patients we're going to treat, we support the financial projects on the facility or the application through those need projections, but the Health Care Authority can lead providers by targeting areas that need services and I suggest that again, what I said a few moments ago, the Health Care Authority and the providers working hand in hand and I realize that may an ideal world, but we're in it, so let's do it.

**Dr. Julian Espiritu:** Again, for the record, I'd like to disagree if you're suggesting that we should keep the CON as it is. I've attended at least two CON applications and this is a template thing and I can tell you we make our own CON. I hate to play this down, but this is an exercise in futility and it may deter, since Dr. Schmidt is concerned about those far flung areas, it might deter somebody like me, for example, I'm planning to put one there, but it's a marginal viability when you factor in another hassle on top of that. It just becomes a big disincentive and that's what I think the CON process for dialysis units is, a disincentive, and if you want to open the flood gates to those rural areas, go for it.

**Dr. Jim Swan:** I want to say for the record that chains, whether it's Fresenius or DaVita, the two predominate chains, are not the only folks that request public hearings.

**Ms. Sonia Chambers:** All right, other comments?

**Dr. Rick Latos:** I guess just to submit written things to you just goes directly to you at the office, is that correct?

**Ms. Sonia Chambers:** Yes please.

**Dr. Rick Latos:** Do you have a time frame on that?

**Ms. Sonia Chambers:** I certainly think 30 days.

**Dr. Rick Latos:** Okay, that's fine.

**Ms. Sonia Chambers:** I think, how about for this one by the end of October?

**Dr. Rick Latos:** That's terrific and I'm going to have to leave. I've got to make rounds on my dialysis patients, but I want to thank you and the rest of the people for this helpful opportunity to discuss this. This is not a simple issue and we're here to help and you all are here to help and this is a good start.

**Ms. Sonia Chambers:** Well, we really appreciate you taking your time to participate. I always appreciate your and everyone else's input. Dayle has a question. Is it directed at Dr. Latos before he runs away?

**Mr. Dayle Stepp:** Well yeah, the physicians. Is there an appropriate travel time or an inappropriate travel time for dialysis patients?

**Dr. Rick Latos:** Well, anything over an hour, you'd like to have it less than that and the shorter the better, but in West Virginia, two miles might be 30 minutes. I think the standards, for Medicare, at least, not standards, but the rule of thumb that Medicare uses is an hour. Becky, is that not correct?

**Dr. Rebecca Schmidt:** I think.

**Dr. Rick Latos:** I may be wrong on that, but no one would quibble about that. The social workers that work in the facilities and the patients would say, well if I can have something in 45 minutes, that's better than an hour and they're right, because when you think about it that's three 4 hour dialysis sessions a week plus 45 minutes two times, that's a long day three days a week and it's just really a problem, so the shorter the better, but you just cannot...I wish it were such that you could have dialysis...the only way you could do that is to have home dialysis encouraged and supported in whatever way you can accomplish that, whether it's peritoneal or some of the newer hemodialysis techniques, and I just want to again emphasize that I think no matter what you do, you should make a provision of any modality of home dialysis absolutely non-reviewable. It ought to be reportable, but non-reviewable.

**Mr. Dayle Stepp:** Okay and I had a couple more and this is probably for DaVita or Fresenius. When you look at your models is there a minimum size facility, as far as number of stations looked at and a minimum number of patients that makes a facility feasible?

**Mr. Scott Wagstaff:** The short answer is no, there's not a minimum size. I guess that there probably is, but they vary quite a bit. [noise inaudible] do have an affect as far as the number of patients and what you feel like the need is of those patients in that area to make in economically feasible. That's considered into that.

**Ms. [??] [??] [noise inaudible]**

**Ms. Sonia Chambers:** That there is not?

**Ms. [??] [??]:** There really isn't. We don't have [noise inaudible] we don't do less than 10 stations at a facility or anything like that. There's not really a standard, but it's basically when we look at an area where we're going to move to, we try to consider the population and the growth in that population of ESRD patients and consider how many stations we could reasonably take care of that market with.

**Mr. Jim Swan:** I've done more than 100 CON applications in the last couple of years. We don't have a minimum size, but one thing we do want to make sure is that [noise inaudible] is financially feasible. There's no point in developing a facility, getting the patients there, and having to shut the doors because you're going broke. The smallest I've seen successful, in my experience, was an 8-station model, but that's not to say that there is a...there's not a Fresenius rule for that that I'm aware of and I don't [noise inaudible] accurate rule for size either.

**Ms. Sonia Chambers:** All right. Any other questions, comments?

**Mr. Bob Coffield:** The only other question for you guys is to whether or not there's any data or information that you would like specifically provided? One of the things we've looked a little bit about is how many states have CON right now for end stage renal dialysis. There are 14 of those. I think there are 36 total that have CON's. Would you like some summary of what those other states are doing? Is that valuable for this group to have and I didn't know whether you already had that data or not?

**Ms. Sonia Chambers:** Well we have some of it. Well, I would say we have the number of other states that do review, but any information you might have on how those other states, how that compares to how we review, that might be helpful.

**Mr. Bob Coffield:** And just anything else. If I can't get DaVita's the same way, operating in a number of states, they probably have a little more resource to know what those standards are and if there are any questions, throw those out to us after this meeting.

**Mr. Dayle Stepp:** At what point do you consider your unit to be at capacity? Is it 70% or you know, you have a total capacity, but then you have an effective capacity. Is it 85% of your total time you consider that to be full capacity?

**Mr. Jim Swan:** Well Dayle this is Jim again and I do a lot of work in North Carolina and 80% is our target there. Four patients per station is 100% capacity unless you're going to go to a third shift. Most patients don't like a third shift. I think that the terrain, the winter weather conditions in West Virginia, would seemingly say let's not do a third shift unless it's in a more urban area where the patients are requesting it because of employment or patient lifestyle choices, but if we can keep a facility at 80% **[noise inaudible]** grow it again, I think that's a good target for us.

**Mr. Scott Wagstaff:** Just a question. Has there been any contact with states that have eliminated the CON within the last 10 years in Ohio and Pennsylvania as to what happened when they did and what it looks like now? I mean there may have been a rash of units that were built, but what does it look like now? Is it positive or negative?

**Mr. Dayle Stepp:** I don't think so and one of the problems is that nobody tracks that, pre-CON and post-CON. It just seems to be one of the things that's lost. Once CON goes away, a lot of the data goes away.

**Mr. Jim Swan:** I think another hard part of that is because of the growing patient population, it would be hard to measure the number of **[noise inaudible]** good thing when you lost CON. I mean, you could do some statistical number crunching on it, but certainly the landscape should have changed because there's obviously more dialysis patients today than there was 10 years ago.

**Mr. Scott Wagstaff:** **[noise inaudible]** and centers administratively for the state and I understand the centers have grown, the number of available chairs has grown, the population has grown during that period of time, but has there been any negative impact that is recognizable with the elimination of it?

**Ms. Sonia Chambers:** I think it's difficult to gauge that because as Dayle said, there's nobody continuing to watch it and there's nobody reporting on it. I mean, there's nobody whose job it is to do that and it isn't something that has been specifically studied in **[noise inaudible]** in terms of specifically what happens with dialysis when CON goes away and because it is largely a service that's paid by Medicare, I guess except if Medicare's watching it, there really isn't anybody else whose job it is to collect that data and report on it other than if we happen to ask, like you who has been there when it has **[noise inaudible]** and that's kind of been our difficulty. We've gone out there and looked a lot in the literature to see if there are case studies and those kinds of things and there aren't. Anything else? Anybody on the phone.

**Dr. Rick Latos:** No, thanks.

END OF AUDIO