92746-4

No. 73630-2-I

COURT OF APPEALS, DIVISION I
OF THE STATE OF WASHINGTON

DAVITA HEALTHCARE PARTNERS INC.,

Petitioner,

v.

WASHINGTON STATE DEPARTMENT OF HEALTH
and NORTHWEST KIDNEY CENTERS,

Respondents.

PETITION FOR REVIEW

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A. Identity of Petitioner.

Petitioner, DaVita HealthCare Partners Inc. ("DaVita"), petitions for the relief set forth below.

B. Court of Appeals Decision.

DaVita petitions for review of the published decision terminating review, filed on December 28, 2015, by Division I of the Court of Appeals. A copy of the decision is attached to this Petition.

C. Statement of Issues Presented for Review.

The Court of Appeals' decision raises the following issues warranting Supreme Court review:

1. Was it error for the Court of Appeals to interpret WAC 246-310-288 ("Section 288"), the "Kidney disease treatment centers—Tie-breakers" adopted by the Washington State Department of Health (the "Department") to create a consistent, objective, and balanced standard for choosing between competing Certificate of Need ("CON") applications to establish or expand kidney dialysis facilities, to mean that *the stated factors* to decide between competing applications *are not used* if there are *other factors* on which one application can be said to be superior to the other, contrary to the language and structure of Section 288 and the Department's intent in adopting the regulation?

DaVita submits that this was error, and that by failing to correctly interpret Section 288 pursuant to the principles of regulatory interpretation, the Court of Appeals' decision has distorted the approval process for kidney dialysis facilities in Washington and nullified the Department's intent in adopting Section 288.

2. Was it error for the Court of Appeals to interpret Section 288 to mean that competing kidney dialysis facility CON applications may be compared solely on cost, without regard to the other factors identified in Section 288, which will preserve dialysis-provider monopolies, because they can be expanded at lower cost than new facilities can be built, and deprive dialysis patients of a choice of providers and new locations at which they may obtain care?

DaVita submits that this was error, and that the Court of Appeals' misinterpretation of Section 288 will limit the options available to dialysis patients by preserving provider monopolies and preventing new facilities from being approved.

* * *

These issues warrant review under RAP 13.4(b)(4), because they involve matters of "substantial public interest that should be determined by the Supreme Court."

D. Statement of the Case.

1. Kidney dialysis saves lives.

The loss of kidney function is normally irreversible. End-Stage Renal Disease ("ESRD") is a condition of advanced kidney impairment. There are approximately 382,000 ESRD patients in the United States. For these individuals, there are only two methods of sustaining life: kidney transplantation or dialysis. Administrative Record ("AR") 2098.

Dialysis refers to the removal of toxins, fluids, and salt from the blood of ESRD patients by artificial means. ESRD patients generally require dialysis at least three times a week for the rest of their lives. AR 2098. Each treatment takes about four hours. AR 1630.

2. CON approval is required to establish or expand kidney dialysis facilities.

In Washington, healthcare providers must obtain CON approval from the Department before establishing or expanding certain types of healthcare facilities. *See* RCW 70.38.105(4); WAC 246-310-020(1). The Department will issue a CON only if it determines that the proposed facility is needed by the population to be served and satisfies certain other criteria. *See* RCW 70.38.115(2); WAC 246-310-200. Kidney dialysis facilities are among the types of healthcare facilities requiring CON approval. *See* RCW 70.38.105(4)(a); RCW 70.38.025(6); *see also* WAC 246-310-020(1)(a); WAC 246-310-010(26).

3. The Department has adopted a consistent, objective, balanced standard to decide between competing kidney dialysis facility applications.

The Department is required to evaluate CON applications based on the standards set forth in its regulations. *See* WAC 246-310-200(2)(a)(i). All CON applications are reviewed under several general criteria. *See* WAC 246-310-200 (bases for findings); WAC 246-310-210 (need); WAC 246-310-220 (financial feasibility); WAC 246-310-230 (structure and process of care); WAC 246-310-240 (cost containment). The Department also has adopted specific criteria to review certain types of facilities, including kidney dialysis facilities. *See* WAC 246-310-280 *et seq.*

Historically, the regulations governing dialysis applications did not identify specific standards for comparative evaluation of two or more competing applications, i.e., the criteria on which the Department should choose between two or more qualifying projects, when there is not sufficient need to warrant approval of both. Therefore, the Department relied upon a general CON criterion that "[s]uperior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable" to determine which project should be approved. WAC 246-310-240(1). As might be expected, evaluating competing applications under a general "superiority" standard resulted, in practice, in the use of ad hoc criteria.

The opinion of the Court of Appeals, Division II, in *DaVita, Inc. v. Department of Health*, 137 Wn. App. 174 (2007), arose out of just such a situation. The Department approved DaVita's application over the competing application of Olympic Peninsula Kidney Center ("OPKC"), because DaVita would add a new choice of provider in the planning area; the presiding officer in the adjudicative proceeding commenced by OPKC reversed and approved OPKC's application over DaVita's application, because OPKC's project was lower cost and could be completed more quickly. *See DaVita*, 137 Wn. App. at 178-80.

This historical approach—in which comparative review of competing dialysis applications was conducted using ad hoc standards; applicants could not know on what basis competing applications would be evaluated; and the criteria varied from application to application and from decision-maker to decision-maker—persisted for years. It finally was eliminated, or should have been, when the Department adopted Section 288.

Section 288 creates a standard for the Department to follow in deciding between competing dialysis applications. It does so by identifying nine objective criteria, each of which is worth one point. *See* WAC 246-310-288. They are (1) provision of training services; (2) provision of a private room for patients requiring isolation; (3) provision

of a permanent bed station; (4) provision of an evening shift; (5) provision of the number of stations projected to be needed; (6) role as a historical provider; (7) lowest capital expenditure; (8) geographic diversity; and (9) provider choice. *See id.* Whichever applicant receives more points is awarded the CON. If the applicants receive the same number of points, both are approved, with the needed stations split between them. *See id.*

The Department's rulemaking history underscores that Section 288 was adopted to "provide clarity and consistency for applicants because they will know how stations will be awarded in the event of a tied decision." *See* Significant Analysis, Rules Concerning Kidney Dialysis Treatment Centers, Revision of WAC 246-310-010 and 280 (July 2006). The adoption of Section 288 accomplished this. As the Department explained in its evaluation in this matter, "[t]he tie-breaker criteria are objective measures used to compare competing projects and make the determination between two or more approvable projects which is the best alternative." AR 2448. The Department accordingly uses these criteria as the exclusive basis to compare competing applications. AR 2449-50.

4. DaVita and NKC apply to meet the need for additional dialysis stations in King County Planning Area #4.

King County Planning Area #4 is a geographic area south of Seattle containing Burien, Des Moines, Normandy Park, SeaTac, and

Tukwila. *See* WAC 246-310-280(9)(a) (defining planning area). More than 100,000 people live in the planning area. AR 1791. It currently is served by a single kidney disease treatment center, NKC's 25-station facility in SeaTac. AR 2430. Based on the Department's projections, five additional dialysis stations are needed in the planning area. AR 2429-30.

DaVita and NKC each submitted CON applications to meet this need. AR 2426. DaVita applied to build a new, 5-station facility in Des Moines. AR 1773-2293. NKC applied to add five stations to its existing facility in SeaTac. AR 2477-2616.

DaVita and NKC both are highly-regarded, high-quality providers of kidney dialysis services, with extensive experience applying for CONs to establish or expand dialysis facilities in Washington. At the time of the applications at issue, DaVita operated twenty-five dialysis facilities statewide. AR 2422. NKC operated fifteen, all but one in King County. AR 2422.

5. The Department grants DaVita's application and denies NKC's application based on Section 288.

In its evaluation, the Department determined that both applications would satisfy all applicable review criteria as stand-alone applications. Therefore, the Department applied the Section 288 standard to decide between the applications. AR 2449-53. DaVita and NKC each qualified

for five of the points: training services, private room, permanent bed station, evening shift, and meeting the need. AR 2452. NKC also qualified for the economies of scale point, and therefore received a total of six points. AR 2452. DaVita also qualified for the patient geographical access and provider choice points, and therefore received a total of seven points. AR 2452. Because DaVita prevailed under the Section 288 standard, seven points to six points, the Department approved DaVita's application and denied NKC's application. AR 2427.

6. In the adjudicative proceeding commenced by NKC, the Department defends its reliance upon the Section 288 criteria.

NKC commenced an adjudicative proceeding to challenge the Department's decision. AR 1-48. A Health Law Judge (the "HLJ") conducted the requested hearing. AR 1191.

The CON Program Analyst who wrote the Department's evaluation explained the rulemaking process that resulted in Section 288, in which "all of the dialysis providers in the community" met with Department staff "and determined what they believed would be tiebreaker points, what are important for comparing applications to each other to determine which is the better application." AR 1414. She also testified that, from the Department's perspective, Section 288 was intended to supersede the general superiority standard as the basis on which

competing dialysis facility applications must be compared. AR 1452-53. Finally, she explained how the points were awarded in this case, resulting in the Department's approval of DaVita's application. AR 1414-19.

7. The HLJ reverses the Department's decision, grants NKC's application, and denies DaVita's application, based on criteria other than the Section 288 standard.

The HLJ identified two differences between the projects which he considered to be of particular significance. First, the HLJ found that it would cost DaVita more to build its proposed new facility than it would cost NKC to add five stations to its existing facility. AR 1203. Second, the HLJ found that DaVita would receive higher reimbursement from commercial insurers for dialysis services provided at its proposed facility than NKC receives from commercial insurers for dialysis services provided at its existing facility, although he did not make any findings quantifying these rates or the difference between them. AR 1203.

Because NKC's project was "lower cost" than DaVita's project, the HLJ approved NKC's project and denied DaVita's project. AR 1203-05 (denying DaVita application under financial feasibility and cost containment criteria); *see also* AR 1200-01, 1203-04 (confirming that denial was based solely on a comparison with NKC's application, not on criteria as applied to DaVita's application standing alone).

8. The Department and DaVita request reconsideration, which the HLJ denies.

The Department and DaVita sought reconsideration of the HLJ's decision. AR 1232-63, 1214-30. The Department emphasized that the HLJ's order "would effectively invalidate the Dialysis Tiebreaker rule by replacing the objective, and required, tiebreakers with a standardless and open-ended comparison of selected elements from the applications." AR 1215. The Department explained that the HLJ's "new facility standard," to use projected revenues as the basis to decide between competing dialysis facility applications "directly violates WAC 246-310-200(2)(a), which requires the Presiding Officer to use facility standards contained in chapter WAC 246-310"; "violates WAC 246-310-200(2)(b) because it was not obtained from an authorized source"; and that "[t]he ex post facto adoption of a new standard defeats the public comment opportunity during the application process" and "deprives applicants of the due process and fundamental fairness requirements of advance disclosure of applicable standards." AR 1220.

The Department also warned that the HLJ had come up with "a significant new policy for the Department" that "attacks the wisdom of WAC 246-310-288 – adopted in consultation with kidney dialysis providers, including NKC" and "steer[s] the Department into uncharted

territory," a "bold new direction that should be undertaken only through rule-making with public input[.]" AR 1242.

Finally, in an extraordinary step, the Department publicly expressed its concern with having to defend in the courts the HLJ's "casting aside the Department's objective tiebreaker rule, in favor of his own subjective superiority analysis." AR 1350. The Department identified the challenge of defending on appeal a decision in which "the HLJ has offered only the thinnest rationale for disregarding and not giving effect to the Department's own tiebreaker rule[.]" AR 1350. The HLJ denied the reconsideration motions. AR 1375-80.

9. Internal Department review of HLJ decisions was not available at the time of the HLJ's order in this matter.

The CON procedures have been amended to allow for administrative review of HLJ decisions. A healthcare provider whose application has been denied by an HLJ may now seek review of the HLJ decision by a final decision-maker appointed by the Secretary of Health. *See* RCW 18.130.050(10); WAC 246-10-701. The Department advocated for this new procedure precisely so that the Department could ensure consistency in its decision-making. *See* S. 63-1381, Laws of 2013, ch. 109, at 3 (Mar. 28, 2013) ("Having the internal review with the Secretary will help ensure the policy approach is consistent across the agency and

across the different administrative law judges. . . . DOH supports providing an opportunity for the Secretary to complete a final review of administrative proceedings.").

Unfortunately, this new procedure did not become available until a few weeks after the HLJ's reconsideration order was issued, so DaVita and the Department were not able to avail themselves of this procedure and seek review of the HLJ's action by a final Department decision-maker appointed by the Secretary of Health. Therefore, the HLJ's decision that nullified the Department's intent in adopting Section 288 paradoxically became the Department's own "final" decision.

10. DaVita seeks judicial review of the HLJ's decision.

DaVita sought judicial review of the HLJ's decision in Thurston County Superior Court. The Superior Court affirmed the HLJ's decision. Clerk's Papers ("CP") 185-86. DaVita then sought judicial review of the HLJ's decision in the Washington Court of Appeals, Division II. The case was transferred to Division I. The Court of Appeals affirmed the HLJ's decision in a published opinion. *See DaVita HealthCare Partners, Inc. v. Wash. State Dep't of Health*, No. 73630-2-I (Wash. Ct. App. Dec. 28, 2015).

E. Argument Why Review Should Be Accepted.

1. The CON laws serve an important role in the Washington healthcare system, and it is essential that they be correctly interpreted and applied statewide.

The Supreme Court has recognized the importance of the CON laws to the healthcare system in Washington, and accordingly has granted review in several recent CON cases.

In *Washington State Hospital Association v. Washington State Department of Health*, 183 Wn.2d 590 (2015), the Supreme Court granted direct review from a superior court decision in a case involving the scope of hospital transactions governed by the CON laws. The Department had been inconsistent on this issue, historically not requiring CON review for a change of control of a hospital but more recently requiring such review. The Supreme Court's final resolution of this issue, determining that CON review is required only for the purchase, sale, or lease of a hospital, not other changes of control, ensured that healthcare providers statewide are treated consistently by the Department.

In *King County Public Hospital District No. 2 v. Washington State Department of Health*, 178 Wn.2d 363 (2013), the Court granted review in a case involving the Department's ability to settle a dispute with a CON applicant notwithstanding the objections of affected persons. The Supreme Court's determination that the Department had the authority to issue the

CON to the applicant pursuant to a settlement allowed a new hospice provider to open a facility in King County, and gave patients a new choice of provider of these services.

In *Overlake Hospital Association v. Department of Health of the State of Washington*, 170 Wn.2d 43 (2010), the Court granted review in a case involving the Department's need-forecasting methodology relating to proposed ambulatory surgical facilities. Existing providers of outpatient surgery argued for a restrictive interpretation of the regulatory methodology that would prevent the CON applicant from opening a new facility. The Supreme Court's rejection of this interpretation authorized the applicant to open a competing facility and accordingly gave patients a greater choice between providers and improved access to such services.

In *University of Washington Medical Center v. Washington State Department of Health*, 164 Wn.2d 95 (2008), the Court granted direct review from a superior court decision in a case involving the evidentiary standards applied in CON adjudicative hearings. The superior court's decision preventing the CON applicant from providing liver transplants protected the existing provider's status as the monopoly provider of this service in Washington. The Supreme Court's reversal ended this monopoly by allowing the applicant to also provide this service.

* * *

Like all four of these cases in which the Supreme Court granted review, the present case involves an interpretation of the CON laws that affects providers and patients statewide. However, unlike hospice facilities and ambulatory surgical facilities, which may be applied for a few times per year, or a change of control of a hospital or a new organ-transplant program, which may be proposed every few years, numerous dialysis facilities are built every year. Therefore, the Court of Appeals' decision in this case affects far more proposed facilities than did the lower courts' decisions in the other cases. Additionally, the Supreme Court's decisions in the *King County Public Hospital District No. 2*, *Overlake Hospital Association*, and *University of Washington Medical Center* cases resulted in increased provider choice and access to services; a ruling in favor of DaVita in the present case would have the same effect, consistent with what the Supreme Court has determined to be the overriding purpose of the CON laws. *See* discussion *infra* § E.3.

2. The Court of Appeals did not apply the principles of regulatory interpretation to the Department's regulation.

This is a regulatory-interpretation case. But the Court of Appeals did not apply the principles of regulatory interpretation to Section 288. Had it done so, it would have concluded that the Department's original interpretation (and DaVita's) was correct, and that Section 288 must be

used as the standard to compare competing dialysis applications. These principles include (1) interpreting a regulation in a manner that is consistent with the underlying policy of the enabling statute; (2) construing a regulation to give effect to the agency's intent in adopting it; (3) recognizing that a specific regulation will supersede a general one when both apply; (4) giving effect to a more recently enacted regulation over an older regulation if an apparent conflict exists between them; (5) construing a regulation such that all language is given effect, with no portion rendered meaningless or superfluous; (6) avoiding an interpretation that leads to an absurd result; and (7) seeking to harmonize regulations whenever possible. *See Overlake Hosp. Ass'n*, 170 Wn.2d at 52 (legislative intent); *Dep't of Licensing v. Cannon*, 147 Wn.2d 41, 57 (2002) (agency intent); *Kustura v. Dep't of Labor and Indus.*, 169 Wn.2d 81, 88 (2010) (specific supersedes); *Am. Legion Post #149 v. Dep't of Health*, 164 Wn.2d 570, 585-86 (2008) (more recent preferred); *State v. Hirschfelder*, 170 Wn.2d 536, 543 (2010) (not rendering language superfluous); *N. Cent. Wash. Respiratory Care Servs., Inc. v. Dep't of Revenue*, 165 Wn. App. 616, 624 (2011) (avoiding absurd results); *In Re Combs*, 176 Wn. App. 112, 117 (2013) (harmonizing provisions).

The Court of Appeals did not consider these principles. Instead, it determined that Section 288 is "plain on its face" that it is only applied if

neither application is "superior" to the other. *See DaVita*, No. 73630-2-I, slip op. at 12 n.6 ("Because we conclude that the language of WAC 246-310-288 is plain on its face and unambiguous, we do not reach DaVita's arguments that the legislative and agency intent favor its interpretation. Nor do we reach any of DaVita's arguments based on other canons of construction.").

The Court of Appeals' interpretation cannot be reconciled with the language of Section 288 or the structure of the CON laws as a whole. Moreover, a court should "avoid a literal reading of a provision if it would result in unlikely, absurd, or strained consequences." *Cannon*, 147 Wn.2d at 57 (2002). The Court of Appeals' interpretation results in the unlikely, absurd, and strained consequence that *the factors* the Department identified, by rule, *that will be used* to decide between competing dialysis projects *need not be used* if there are *other factors* on which one application can be said to be superior to the other. Thus, the Court of Appeals not only failed to apply the principles of regulatory interpretation, it also misapplied the "plain language" approach it sought to follow. *Cf. Olympic Healthcare Servs. II LLC v. Dep't of Soc. & Health Servs.*, 175 Wn. App. 174, 187-88 (2013) (rejecting interpretation that "would clearly undermine the purpose" of regulations at issue).

3. The Court of Appeals' decision nullifies the Department's determination, through rulemaking, that competing dialysis projects must be compared based on an objective, consistent, and balanced set of criteria.

The Legislature's "overriding purpose" in enacting the CON laws was to "promote, maintain, and assure the health of all citizens in the state, provide accessible health services, health manpower, health facilities"; "controlling costs" was "of *secondary* significance[.]" *Overlake Hosp. Ass'n*, 170 Wn.2d at 55 (emphasis added). The Department's intent in adopting Section 288 was to create an objective, consistent, and balanced approach to deciding between competing applications. The rule expressly takes into account "access" to facilities through the "patient geographical access" point, and implicitly does so through the training services, bed station, isolation room, evening shift, and provider choice points.

The Court of Appeals' decision is inconsistent with the legislative intent in enacting the enabling statute, because the decision allowed cost control to become paramount, *and* the Department's intent in adopting Section 288, because the decision allowed dialysis applications to be compared based on cost alone, without regard to other factors such as provider choice and geographic access.

4. The Court of Appeals' decision will harm Washington's healthcare system and dialysis patients statewide.

NKC is the monopoly provider of dialysis services in the King 4 planning area. It operates 25 dialysis stations at the only dialysis center in the planning area; no other dialysis provider is authorized to operate a single station.

The Department's regulatory standard balances several factors. The "economies of scale" point favors *existing* facilities, whereas the "patient geographical access" point favors *new* facilities. The "historical provider" point rewards an *established* provider, while the "provider choice" point rewards *new* providers. Several points, including for an isolation room and an evening shift, are easier for large facilities to satisfy, but also can be obtained by smaller facilities. But the key point is that *all* of these factors were included in Section 288 because the Department determined them to be important, and *all* of these factors, by rule, must be considered in comparing dialysis projects.

The HLJ's approach, determined to be correct by the Court of Appeals, allows monopoly providers, such as NKC, to prevent any new facilities from being approved in their area, so long as they are willing to continue expanding their own facilities. The incumbent like NKC will always be able to expand for less money than a new provider will have to

spend to build a new facility. Because this approach considers only cost, the result for these applications, as well as future applications, is to preclude choice and limit geographic access to dialysis services.

F. Conclusion.

The Supreme Court should grant review to determine the correct interpretation of Section 288; give effect to the Department's intent in adopting the regulation; ensure that dialysis facilities are approved pursuant to the consistent, objective, and balanced standard developed by the Department; and prevent the harm to Washington's healthcare system, ESRD patients, and dialysis providers that results from the use of ad hoc standards, such as the HLJ's "cost only" approach in the present case.

Respectfully submitted this 25th day of January 2015.

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CERTIFICATE OF SERVICE

I certify that today I caused to be served the foregoing document on the following persons by the method so indicated:

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I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Signed this 25th day of January, 2015, at Seattle, Washington.

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Appendix 1

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DAVITA HEALTHCARE PARTNERS, INC.,	)	No. 73630-2-I
Appellant,	)	DIVISION ONE
v.	)	PUBLISHED OPINION
WASHINGTON STATE DEPARTMENT OF HEALTH and NORTHWEST KIDNEY CENTERS,	)	
Respondents.	)	FILED: December 28, 2015

APPELWICK, J. — Both DaVita and Northwest Kidney Centers (NKC) submitted certificate of need applications for five kidney dialysis stations in south King County. DaVita sought to build a new facility to accommodate the stations whereas NKC sought to expand an existing facility. The Department of Health's Certificate of Need Program concluded that DaVita's application satisfied more of WAC 246-310-288's criteria than NKC's application. It awarded DaVita the certificate of need. The health law judge reversed and granted NKC's certificate of need application. He reasoned that the program erred in utilizing the tie breaker criteria in WAC 246-310-288, because NKC's application met all of the review standards under WAC 246-310-210, -220, -230, and -240 and DaVita's did not. We affirm.

BACKGROUND

In 1979, the Washington legislature enacted the State Health Planning and Resources Development Act (Act), chapter 70.38 RCW. Univ. of Wash. Med. Ctr. v. Dep't of Health, 164 Wn.2d 95, 99, 187 P.3d 243 (2008). The Act allows

Washington to control the number of healthcare providers entering the market by requiring the facility or program to obtain a certificate of need (CN). King County Public Hosp. Dist. No. 2. v. Dep't of Health, 178 Wn.2d 363, 366, 309 P.3d 416 (2013). The legislature intended the CN requirement to provide accessible health services and assure the health of all citizens in the state while controlling costs. Id.; RCW 70.38.015(1), .015(2).

CN applications for new health care facilities, new services, and expansion of existing health care facilities are subject to concurrent review. RCW 70.38.115(7). Concurrent review is "for the purpose of comparative analysis and evaluation of competing or similar projects in order to determine which of the projects may best meet identified needs." Id. During the review process, the Department of Health (Department) is required to evaluate CN applications based on criteria set forth in its regulations. WAC 246-310-200(2). All CN applications are reviewed by the Department on the basis of need, financial feasibility, structure and process of care, and cost containment. WAC 246-310-210 (need); WAC 246-310-220 (financial feasibility); WAC 246-310-230 (structure and process of care); WAC 246-310-240 (cost containment).

Kidney dialysis facilities are among those facilities required to obtain CN approval. RCW 70.38.105(4)(a), (4)(h); RCW 70.38.025(6); WAC 246-310-020(1)(a), (1)(e); WAC 246-310-010(26). The Department has also adopted additional CN criteria that apply to only kidney disease treatment centers. See WAC 246-310-280 through -289. WAC 246-310-282 states that kidney dialysis facilities are, like other CN applications, to be reviewed concurrently. RCW

70.38.115(7). The facilities competing to provide services in the same planning area are reviewed simultaneously by the Department. WAC 246-310-280(3). Applications to establish kidney disease treatment centers are reviewed on one of four quarterly review cycles, which allows the Department to compare the competing applications for specific planning areas. WAC 246-310-282; WAC 246-310-280(9).

Like other CN applications, a kidney dialysis facility must meet the applicable review criteria in WAC 246-310-210, -220, -230, and -240. WAC 246-310-284. If two or more applications "meet all applicable review criteria and there is not enough station need projected for all applications to be approved, the department will use tie-breakers to determine which application or applications will be approved." WAC 246-310-288.

The tie breaker system awards points for various criteria. See WAC 246-310-288. The first five criteria (training services, private rooms for isolating patients, permanent bed stations, evening shift, and meeting the projected need) allow multiple applicants to receive points. WAC 246-310-288(1)(a), (b), (c), (d), (e). The remaining four tie breaker points (economies of scale, historical provider, patient geographical access, and provider choice) may be awarded to only one applicant. WAC 246-310-288(2)(a), (b), (c), (d).

FACTS

NKC is a Washington not for profit 501(c)(3) corporation that owns and operates 14 dialysis facilities in Washington. Thirteen of NKC's Washington dialysis facilities are in King County including one facility in SeaTac. DaVita is a

publicly held, for-profit corporation that provides dialysis services in multiple states including Washington. DaVita owns or operates 24 kidney dialysis centers in Washington and four are in King County.

In May 2011, NKC applied for a CN to add five dialysis stations to its SeaTac facility. The application proposed to increase the existing SeaTac facility's capacity from 25 dialysis stations to 30 stations. NKC's initial estimated capital expenditure for the project was $100,969. That same month, DaVita applied for a CN to build a new, five station dialysis facility in Des Moines. DaVita's initial capital expenditure was estimated at $1,824,465. DaVita amended its application in June 2011 and revised the capital expenditure estimate to $1,992,705.

Both NKC's and DaVita's CN applications sought to add dialysis stations located in King County Planning Area No. 4. King County Planning Area No. 4 is a geographic area south of Seattle that includes SeaTac, Burien, Normandy Park, Tukwila, and Des Moines. WAC 246-310-280(9)(a). The planning area is currently served by one kidney disease treatment center—NKC's 25 station facility in SeaTac.

Because both applicants proposed to serve residents in the same planning area within King County, the Program reviewed the applications concurrently.[1] The Program considered whether both applicants satisfied the WAC 246-310-210, -220, -230, and -240 requirements. The Program concluded that both NKC and DaVita satisfied the need, financial feasibility, and structure and process of care

[1] Because the health law judge's decision is ultimately the Department's final decision, we refer to the Program's initial decision as the Program's decision. See DaVita, Inc. v. Dep't of Health, 137 Wn. App. 174, 181, 151 P.3d 1095 (2007).

requirements. But, it concluded that only DaVita's project met the cost containment criteria in WAC 246-310-240(1) and (2).[2]

As to the cost containment criteria, the Program noted that it performs its analysis by taking a multi-step approach. It stated that step one is determining whether the application has met the criteria of WAC 246-310-210, -220, and -230. Because it found both NKC and DaVita met the applicable review criteria, the Program proceeded to step two.

In step two, the Program stated that it assesses the other options the applicant or applicants considered prior to submitting their applications. The Program explained that if it determines that the proposed project is better or equal to other options the applicant considered before submitting its application, it proceeds to step three. Here, the Program found that there were no superior alternatives that either NKC or DaVita considered or should have considered.

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[2] WAC 246-310-240(1) through -240(2) states:

> A determination that a proposed project will foster cost containment shall be based on the following criteria:
>
> (1) Superior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable.
>
> (2) In the case of a project involving construction:
>
> (a) The costs, scope, and methods of construction and energy conservation are reasonable; and
>
> (b) The project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.

Consequently, the Program continued to its third step—applying the tie breaker criteria under WAC 246-310-288. The Program awarded both NKC and DaVita five tie breaker points for those points that may be allotted to multiple applicants: training services, private rooms for isolating patients, permanent bed stations at the facility, evening shift, and meeting the projected need. But, for those points that only one applicant may receive, the Program awarded DaVita two points (patient geographical access and provider choice) and NKC only one (economies of scale). Because DaVita received more tie breaker points than NKC, on March 5, 2012, the Program awarded DaVita the CN for its proposed five station facility. It denied NKC's application.

On March 8, 2012, NKC requested an adjudicative proceeding. Among other things, NKC argued that instead of evaluating which of the applications under review represented the superior alternative in terms of cost, efficiency, and effectiveness as required by WAC 246-310-240, the Program improperly jumped directly to a tie breaker analysis under WAC 246-310-288. Citing to the plain language of WAC 246-310-288, NKC claimed that a tie breaker analysis is relevant only after a determination is made that the competing applications satisfied all criteria—including the criteria listed under WAC 246-310-240. NKC argued that only its application satisfied all criteria—DaVita's application failed the financial feasibility criteria in WAC 246-310-220(2) and NKC's application was the superior application under WAC 246-310-240.

At an administrative hearing before a health law judge (HLJ), the parties presented evidence and argument. The HLJ issued an order on March 22, 2013

effectively reversing the Program's decision and awarding the CN to NKC. The HLJ found that the Program properly determined that both NKC and DaVita met the WAC 246-310-210 determination of need requirement and the WAC 246-310-230 structure and process of care requirement. But, the HLJ found that financial feasibility under WAC 246-310-220 was where the differences between the two applications became the most distinct.[3]

The HLJ found that both applicants could finance their projects. He next turned to whether operating costs could be met. NKC projected that its net profit for the five dialysis stations after three years[4] would be $76,465. DaVita initially reported that in its third year it would have a net loss of $22,717. But, DaVita revised its pro forma to show a net gain of $21,841 in its third year. It did so by removing landlord operating expenses (landlord taxes, common area maintenance charges, and insurance charges).

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[3] WAC 246-310-220 provides:

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

[4] The HLJ recognized that the Program has developed a practice of considering the income and expenses for the third year of operations as an indicator of financial feasibility.

Applying either DaVita's initial third year projection or the revised third year projection, the HLJ commented that he was struck by the difference in net revenues. He noted that both applications involved the same number of dialysis stations and both have a high percentage of Medicare/Medicaid patients who would provide the same fixed reimbursement for dialysis service to both facilities.[5] The HLJ assumed that because the geographical area covered by the five additional dialysis stations would be the same, the projected need for the dialysis is the same, the ratio of Medicare/Medicaid to commercial payor reimbursement patients would be the same, and thus the income should be the same for both facilities.

But, he noted that DaVita's income was projected to be much higher and found that DaVita would only achieve this higher income by charging commercial insurance carriers more. The HLJ thus found this would have an impact on the cost of health services, because insurance companies would adjust their premiums to cover the increased cost of dialysis at DaVita's facility. But, he reasoned that whether this would have an "unreasonable impact" on the costs of health services under WAC 246-310-220 depended upon the available alternatives.

Thus, the HLJ stated that whether the applicants met the criteria of WAC 246-310-220 was dependent upon WAC 246-310-240's superior alternative analysis. In other words, the HLJ reasoned that WAC 246-310-220(2)'s financial

[5] In terms of revenue, the majority of patients who seek dialysis treatment pay through Medicare/Medicaid. The rest either have other insurance (commercial payors) or private funding. Medicare/Medicaid reimbursement rates for health services are fixed by the federal government, but commercial rates are negotiated by each facility.

feasibility criteria—whether the costs of the project will result in an unreasonable impact on the costs and charges for health services—could not be considered in isolation of WAC 246-310-240(1)'s criteria that the Department must consider superior alternatives in terms of cost, efficiency, and effectiveness. The HLJ reasoned that the "superior alternative" prong of the cost containment analysis was not only a comparison of each individual applicant's proposal to its own alternatives, but also a comparison of the applicants' proposals to each other.

After considering the first "superior alternative" prong of WAC 246-310-240's cost containment analysis, the HLJ found that given the alternative, NKC's project, DaVita's project had an unreasonable impact on health care costs and thus did not meet the criteria in WAC 246-310-220. He reasoned that because DaVita was reporting higher revenues, either patients would be paying more or insurance companies would be paying more and passing those costs onto their insureds. The HLJ then considered the other two prongs of WAC 246-310-240's cost containment criteria.

The HLJ ultimately found that NKC's application met all four required criteria whereas DaVita's met only the need and structure and process of care criteria (WAC 246-310-220 and -230). Consequently, the HLJ awarded NKC the CN. DaVita and the Program moved for reconsideration. In its motion for reconsideration DaVita argued that the HLJ improperly elevated the importance of cost over access to health care. And, it claimed that the HLJ's order erroneously rejected the Program's three step approach for comparing applications under WAC 246-310-240. DaVita asserted that the order effectively invalidates the tie breaker

rule by replacing the objective tie breakers with a standardless and open-ended comparison. The HLJ denied the motions for reconsideration.

On July 31, 2013, DaVita petitioned for review to the superior court. The superior court affirmed the HLJ's decision. It concluded that the HLJ correctly interpreted and applied the CN statutes and regulations and that substantial evidence supports the HLJ's findings. It reasoned that the language in WAC 246-310-288 is clear that the tie breakers are to be reached only in the event that the two applicants first satisfy all of the applicable review criteria in WAC 246-310-210, -220, -230, and -240. DaVita appeals.

DISCUSSION

In reviewing administrative action, this court sits in the same position as the superior court, applying the Washington Administrative Procedure Act (WAPA), chapter 34.05 RCW, to the record before the agency. DaVita, Inc. v. Dep't of Health, 137 Wn. App. 174, 180, 151 P.3d 1095 (2007). The agency decision is presumed correct and the party challenging the validity of the agency's action bears the burden of showing the action was invalid. RCW 34.05.570(1)(a); Providence Hosp. of Everett v. Dep't of Social & Health Servs., 112 Wn.2d 353, 355, 770 P.2d 1040 (1989). All the parties agree that the HLJ's written order is the final decision of the agency that is the subject of this court's review—not the Program's written evaluation.

Under WAPA, this court grants relief in only limited circumstances. DaVita, 137 Wn. App. at 181. This court may grant relief where the agency engaged in unlawful procedure, RCW 34.05.570(3)(c); the agency has erroneously interpreted

or applied the law, RCW 34.05.570(3)(d); or substantial evidence does not support the agency's order. RCW 34.05.570(3)(e). Id. This court reviews the interpretation of agency rules de novo using the same principles it applies to interpreting statutes. Grays Harbor Energy, LLC v. Grays Harbor County, 175 Wn. App. 578, 583-84, 307 P.3d 754 (2013).

I. When to Apply WAC 246-310-288

DaVita argues the HLJ failed to apply the standards set forth in the Department's CN regulations, because he did not use the tie breaker criteria set forth in WAC 246-310-288 to decide between competing kidney dialysis facility applications. It first argues that under the plain language of the regulations, the regulatory tie breakers are the only permissible basis to compare competing kidney dialysis facility applications. And, it argues that the Department is required to use these tie breakers when choosing between competing applications.

If the meaning of a rule is plain and unambiguous on its face, the court should give effect to that plain meaning. Overlake Hosp. Ass'n v. Dep't of Health, 170 Wn.2d 43, 52, 239 P.3d 1095 (2010). If there is more than one reasonable interpretation of a regulation, an ambiguity exists. Id. If a regulation is deemed ambiguous, this court may resort to statutory construction, legislative history, and relevant case law in order to resolve the ambiguity. Id.

Therefore, we first look to the plain language of WAC 246-310-288. WAC 246-310-288 states in part:

> If two or more applications meet all applicable review criteria and there is not enough station need projected for all applications to be approved, the department will use tie-breakers to determine

> which application or applications will be approved. The department will approve the application accumulating the largest number of points.

DaVita relies on the language that the "department will use tiebreakers" and that the "department will approve the application accumulating the largest number of points" to argue that the plain language of the regulation is clear and the tie breakers must always be applied. Id. (emphasis added). But, in so arguing, DaVita ignores the opening clause of the regulation: "If two or more applications meet all applicable review criteria." Id. (emphasis added). WAC 246-310-200 provides the applicable review criteria for the Department to follow when reviewing certificate of need applications. And, WAC 246-310-284 provides the applicable review criteria and standards for review of kidney treatment facility CN applications specifically. They both mandate consideration of the criteria in WAC 246-310-210, -220, -230, and -240. WAC 246-310-200(2); WAC 246-310-284. We conclude that the plain language is clear that the tie breakers are applied only if both applications first satisfy all other review criteria in WAC 246-310-210, -220, -230, and -240. Thus, the HLJ did not err simply because he never reached the tie breakers.[6]

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[6] Because we conclude that the language of WAC 246-310-288 is plain on its face and unambiguous, we do not reach DaVita's arguments that the legislative and agency intent favor its interpretation. Nor do we reach any of DaVita's arguments based on other canons of construction. But, we note that since WAC 246-310-288 became effective on January 1, 2007, two other HLJs have similarly interpreted WAC 246-310-288. Ruling Granting in Part Motion for Summary Judgment & Den. Cross-Motion for Summary Judgment, In re Certificate of Need on the Applications of Puget sound Kidney Centers and DaVita, Inc., No. M2008-118573 (Dep't of Health Feb. 27, 2009); Ruling on Motion for Summary Judgment & Order on Motion for Partial Summary Judgment, In re Evaluation of Two Certificate of Need Applications Submitted by Cent. Wash. Health Servs. & DaVita, Inc., M2008-118469 (Dep't of Health April, 15, 2009). And, WAC 246-310-288 remains unchanged.

II. Comparative Review

Next, DaVita argues that the HLJ erred as a matter of law by directly comparing NKC's and DaVita's applications when determining whether DaVita's project would have an unreasonable impact on health care costs. The HLJ concluded as compared to NKC's project, DaVita's project has an unreasonable impact on health care costs, because it does not meet the criteria in WAC 246-310-220. He therefore found that NKC was the superior alternative under WAC 246-310-240.

WAC 246-310-220 is the "financial feasibility" criteria. One criterion under -220 is that the costs of the project will probably not result in an unreasonable impact on the costs and charges for health services. WAC 246-310-220(2). Here, the HLJ found that NKC's expenses are reasonable. By contrast he found that because DaVita's expenses were 19 times that of NKC's, it would have to increase its billing to non-Medicare patients who have insurance or other funding in order to account for its higher expenses and in order to reach its projected revenues. He found that this would have an impact on the costs of health services. But, he stated that the remaining question of whether DaVita's impact on the costs of health services were unreasonable depended upon the costs of health services attributable to the alternative applications—here, NKC.

WAC 246-310-240 is the "cost containment" criteria. WAC 246-310-240(1) states that superior alternatives in terms of cost, efficiency, or effectiveness are not available or practicable. The HLJ concluded that NKC was the superior

alternative under WAC 246-310-240, because DaVita's project had an unreasonable impact on health care costs.

DaVita argues that the HLJ erred as a matter of law when he improperly converted a reasonableness standard into a binary comparison between the applications. In other words, DaVita argues that each application should have been evaluated based on whether they would individually have an objectively unreasonable impact on health care costs. But, both the general CN application process and the specific kidney treatment center CN application process are, by law, concurrent review processes. RCW 70.38.115(7); WAC 246-310-282; WAC 246-310-280(3). The processes are considered to be and designed to be competitive review processes. RCW 70.38.115(7). Thus, we conclude that the HLJ did not err to the extent he directly compared the two applications under the relevant review criteria and determined reasonability comparatively.

III. Type of Evidence Considered During Comparative Review

Next, DaVita argues that the HLJ erred when he considered commercial reimbursement rates[7] when comparing the two applications. DaVita also argues that the HLJ erred when he considered capital costs, because capital costs are only appropriately considered as a tie breaker criterion.

The HLJ considered both the estimated capital costs and commercial reimbursement rates when analyzing and comparing the two applications under

[7] Commercial reimbursement rates represent the amount of money the facility receives from insurance companies for various health services and procedures. There is a difference between the gross charge to an insurance company for a health service and what each facility actually collects from the insurance company.

WAC 246-310-220 and WAC 246-310-240. He reasoned that the only way DaVita would be able to generate enough income to meet operational expenses by its third year—because of its higher capital costs—would be to receive higher reimbursements from non-Medicare patients who have insurance or other funding. He stated this was so, because the dollar amount of Medicare reimbursements for dialysis are fixed by federal law so that the only area where profit can be increased is by increasing billing to those non-Medicare patients who have insurance or other private funding. He concluded this, by definition, has an impact on the costs of health services.

DaVita contends that the commercial reimbursement rate is not a proper basis for comparison, because the Department chose not to include it as one of the tie breaker criteria. But, as stated by the HLJ, the commercial payor reimbursement rates have the capability of directly impacting the cost of health services and the cost of the project to the public—criteria directly enumerated in WAC 246-310-220 and -240.

DaVita also contends that its higher commercial reimbursement rate is an improper consideration, because it is an inaccurate measurement of actual cost of health services. DaVita asserts that commercial insurers pay it more not because they need to do so to make up for a higher actual cost of health services, but because of the strong quality of dialysis care DaVita provides. DaVita cites to its vice president's testimony that most of the health care costs for a patient needing dialysis is not for dialysis, but for hospitalizations and more expensive care. DaVita relies on that testimony and asserts that a higher commercial reimbursement rate

may reflect the fact that an insurer is willing to pay more for dialysis services, because it will reduce a patient's total health care costs. But, the HLJ specifically found that basic dialysis procedures are standardized and similar and that there would be no reason why commercial payors would expect DaVita's dialysis care to result in fewer health care costs later on. DaVita does not challenge this specific finding nor does it submit controverting evidence. Therefore, we conclude that DaVita did not satisfy its burden of showing that the HLJ's consideration of commercial reimbursement rates was invalid.

DaVita also argues that consideration of capital costs is only an appropriate basis for comparison as one of the tie breakers. DaVita provides no additional argument or authority to support this assertion. While there is an "economies of scale" tie breaker in WAC 246-310-288, both WAC 246-310-220 and -240 specifically direct that the costs of the project be taken into consideration. And, WAC 246-310-240(1) specifically directs the superior alternative be determined by considering cost, efficiency, or effectiveness. Capital costs are relevant to this analysis. Therefore, we conclude that DaVita did not satisfy its burden of showing that the HLJ's consideration of capital costs during its comparison of the applications was invalid.

IV. Substantial Evidence

Finally, DaVita argues that the HLJ's finding that its project would have an unreasonable impact on health care costs was not supported by substantial

evidence.[8] DaVita argues that there was no evidence in the record of the actual impact of the costs to build DaVita's facility or the impact of the differential between the commercial reimbursement rates received by DaVita and NKC on health care costs. DaVita contends that the HLJ's finding was based on mere speculation that does not constitute substantial evidence.

This court reviews an agency's factual findings to determine whether they are supported by substantial evidence sufficient to persuade a fair minded person of the declared premise. DaVita, 137 Wn. App. at 181. We overturn an agency's factual findings only if they are clearly erroneous. Id. As the party challenging the HLJ's findings, DaVita must establish that the findings are erroneous. Univ. of Wash. Med. Ctr., 164 Wn.2d at 104. The court will review the evidence in the light most favorable to the party who prevailed in the highest forum that exercised fact finding authority—here, NKC. Id.

Evidence in the record indicates that DaVita's capital costs were 19 times that of NKC's ($1,992,705 as compared to $100,969). NKC's revenue would exceed its expenses in every year of operation while DaVita's revenue would not if DaVita included all necessary operating expenses in its profit and loss statement. There was evidence that NKC's expenses per treatment would thus be significantly lower than DaVita's. And, there was evidence of the differential between NKC's

[8] DaVita also argues the HLJ's WAC 246-310-240(2)(b) analysis was legally flawed. And, it argues that the HLJ's finding that DaVita's application failed WAC 246-310-240(2)(b) is not supported by substantial evidence. But, DaVita raises these arguments for the first time in its reply brief. This court does not consider arguments raised for the first time in a reply brief. Nakatani v. State, 109 Wn. App. 622, 625 n.1, 36 P.3d 1116 (2001).

and DaVita's commercial reimbursement rates in the record. DaVita stipulated to the fact that it negotiates and receives higher commercial reimbursement rates than NKC. And, there was evidence in the record—in the form of estimated calculations—that DaVita received $1,187.60 per treatment from commercial payors whereas NKC received only $1,048.82 from commercial payors.[9]

Substantial evidence in the record shows that DaVita's more expensive proposal will result in significantly greater costs to provide the dialysis services than NKC. The inference that those costs will be passed to private pay patients and/or their insurers is not unreasonable.

DaVita argues that notwithstanding the evidence that DaVita's commercial reimbursement rates are higher than NKC's, that the HLJ's determination still requires additional evidence: (1) that reimbursement rates for one service (kidney dialysis) would have a material effect on the overall cost of health insurance and (2) that opening one five station facility in Des Moines would cause an increase in the premiums charged by health insurers. But, this misstates the standard. Instead, the Department should find that the costs of the project will probably not result in an unreasonable impact on the costs and charges for health services. WAC 246-310-220(2). DaVita provides no authority that the unreasonable impact contemplated in this regulation applies to anything more than the services to be offered pursuant to the CN process. Substantial evidence demonstrates that

[9] The CN application process is based on the submission of pro formas based largely on estimates. Much of the documentation of costs to be incurred and charges to be made contained in materials submitted to the Department are merely estimates. This fact does not render the calculations made from those numbers speculative.

significantly higher rates for dialysis services will be charged to private pay patients and/or their insurers under DaVita's proposal. This evidence strongly undercuts a required finding that the costs of the project will probably not result in an unreasonable impact on the costs and charges for health services. Viewing the evidence in the light most favorable to NKC, the HLJ's finding of a probable unreasonable impact on costs or charges was not clearly erroneous.

We affirm.

WE CONCUR:

Appendix 2

WAC 246-310-288

Kidney disease treatment centers—Tie-breakers.

If two or more applications meet all applicable review criteria and there is not enough station need projected for all applications to be approved, the department will use tie-breakers to determine which application or applications will be approved. The department will approve the application accumulating the largest number of points. If sufficient additional stations remain after approval of the first application, the department will approve the application accumulating the next largest number of points, not to exceed the total number of stations projected for a planning area. If the applications remain tied after applying all the tie-breakers, the department will award stations as equally as possible among those applications, without exceeding the total number of stations projected for a planning area.

(1) The department will award one point per tie-breaker to any applicant that meets a tie-breaker criteria in this subsection.

(a) ***Training services (1 point)*:**

(i) The applicant is an existing provider in the planning area and either offers training services at the facility proposed to be expanded or offers training services in any of its existing facilities within a thirty-five mile radius of the existing facility; or

(ii) The applicant is an existing provider in the planning area that offers training services in any of its existing facilities within thirty-five miles of the proposed new facility and either intends to offer training services at the new facility or through those existing facilities; or

(iii) The applicant, not currently located in the planning area, proposes to establish a new facility with training services and demonstrates a historical and current provision of training services at its other facilities; and

(iv) Northwest Renal Network's most recent year-end facility survey must document the provision of these training services by the applicant.

(b) ***Private room(s) for isolating patients needing dialysis (1 point).***

(c) ***Permanent bed stations at the facility (1 point).***

(d) ***Evening shift (1 point)*:** The applicant currently offers, or as part of its application proposes to offer at the facility a dialysis shift that begins after 5:00 p.m.

(e) ***Meeting the projected need (1 point)*:** Each application that proposes the number of stations that most closely approximates the projected need.

(2) Only one applicant may be awarded a point for each of the following four tie-breaker criteria:

(a) ***Economies of scale (1 point)*:** Compared to the other applications, an applicant demonstrates its proposal has the lowest capital expenditure per new station.

(b) ***Historical provider (1 point)*:**

(i) The applicant was the first to establish a facility within a planning area; and

(ii) The application to expand the existing facility is being submitted within five years of the opening of its facility; or

(iii) The application is to build an additional new facility within five years of the opening of its first facility.

(c) ***Patient geographical access (1 point)*:** The application proposing to establish a new facility within a planning area that will result in services being offered closer to people in need of them. The department will award the point for the facility located farthest away from existing facilities within the planning area provided:

(i) The facility is at least three miles away from the next closest existing facility in planning areas that qualify for 4.8 patients per station; or

(ii) The facility is at least eight miles from the next closest existing facility in planning areas that qualify for 3.2 patients per station.

(d) ***Provider choice (1 point)*:**

(i) The applicant does not currently have a facility located within the planning area;

(ii) The department will consider a planning area as having one provider when a single provider has multiple facilities in the same planning area;

(iii) If there are already two unrelated providers located in the same planning area, no point will be awarded.

[Statutory Authority: RCW **70.38.135**. WSR 06-24-050, § 246-310-288, filed 12/1/06, effective 1/1/07.]