HAWAI`I STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ADMINISTRATIVE APPLICATION - CERTIFICATE OF NEED PROGRAM

Application Number: #23-10A Date of Receipt:
To be assigned by Agency

APPLICANT PROFILE

Project Title: Acquisition of PET-CT Services from Kaiser Foundation Hospitals

Project Address: 2828 Pa'a Street, Honolulu, HI 96819

Applicant Facility/Organization: Kaiser Foundation Health Plan, Inc.

Name of CEO or equivalent: Greg Christian

Title: President, Kaiser Foundation Health Plan and Hospitals – Hawaii Market

Address: 711 Kapiolani Street, Honolulu, HI 96817

Phone Number: (808) 286-9410 Fax Number: (808) 432-5391

Contact Person for this Application: Chris Lutz

Title: Outside Medical Services Director

Address: 3288 Moanalua Road, Honolulu HI, 96819

Phone Number: (808) 342-3060 Fax Number: (808) 432-7736

CERTIFICATION BY APPLICANT

I hereby attest that I reviewed the application and have knowledge of the content and the information contained herein. I declare that the project described and each statement amount and supporting documentation included is true and correct to the best of my knowledge and belief.

Signature

11/01/2023
Date

Greg Christian
Name (please type or print)

President, Kaiser Foundation Health Plan and Hospitals - Hawaii Market
Title (please type or print)

1. **TYPE OF ORGANIZATION**: (Please check all applicable)

Public	____
Private	X
Non-profit	X
For-profit	____
Individual	____
Corporation	X
Partnership	____
Limited Liability Corporation (LLC)	____
Limited Liability Partnership (LLP)	____
Other: _____	____

2. **PROJECT LOCATION INFORMATION**

A. Primary Service Area(s) of Project: (please check all applicable)

Statewide:	____
O`ahu-wide:	X
Honolulu:	____
Windward O`ahu:	____
West O`ahu:	____
Maui County:	____
Kaua`i County:	____
Hawai`i County:	____

3. **DOCUMENTATION** (Please attach the following to your application form):

A. Site Control documentation (e.g., lease/purchase agreement, DROA agreement, letter of intent)

Not Applicable

B. A listing of all other permits or approvals from other government bodies (federal, state, county) that will be required before this proposal can be implemented (such as building permit, land use permit, etc.)

Not Applicable.

C. Your governing body: list by names, titles, and address/phone numbers
See **Attachment A**.

D. If you have filed a Certificate of Need Application this current calendar year, you may skip the four items listed below. All others, please provide the following:

- ☐ Articles of Incorporation – See Attachment B.
- ☐ By-Laws – See Attachment C.
- ☐ Partnership Agreements – Not Applicable.
- ☐ Tax Key Number (project's location) – 1-1-007-039-0000.

4. **TYPE OF PROJECT.** This section helps our reviewers understand what type of project you are proposing. Please place an "x" in the appropriate box.

	Used Medical Equipment (Over $400,000)	New/Upgraded Medical Equip. (Over $1 million)	Other Capital Project (Over $4 million)	Change in Service	Change in Beds
Inpatient Facility					
Outpatient Facility				X Change in Ownership	
Private Practice					

5. **BED CHANGES.** Please complete this chart only if your project deals with a change in your bed count and/or licensed types. Again, this chart is intended to help our reviewers understand at a glance what your project would like to accomplish. Under the heading "Type of Bed," please use only the categories listed in the certificate of need rules. **Not Applicable - No Changes to Beds.**

Type of Bed	Current Bed Total	Proposed Beds for your Project	Total Combined Beds if your Project is Approved
TOTAL			

6. PROJECT COSTS AND SOURCES OF FUNDS

A. List All Project Costs:

		AMOUNT:
1.	Land Acquisition	_____
2.	Construction Contract	_____
3.	Fixed Equipment	_____
4.	Movable Equipment	_____
5.	Financing Costs	_____
6.	Fair Market Value of assets acquired by lease, rent, donation, etc.	_____
7.	Other: _____	_____
	TOTAL PROJECT COST:	**$0.00**

B. Source of Funds

1.	Cash	_____
2.	State Appropriations	_____
3.	Other Grants	_____
4.	Fund Drive	_____
5.	Debt	_____
6.	Other: _____	_____
	TOTAL SOURCE OF FUNDS:	**$0.00**

With respect to KP, this is a non-cash, non-value change in ownership – internal-related entities reorganization. The "Total Project Cost" is the current value of the assigned project, and the "Total Source of Funds" is the current value of the interests transferred by reason of the reorganization.

7. **CHANGE OF SERVICE:** If you are proposing a change in service, then please briefly list what services will be added/modified. Be sure to include the establishment of a new service or the addition of a new location of an existing service. Please reference the Certificate of Need Rules Section 11-186-5 for the categories of services. If you are unable to determine which category best describes your project, please consult with agency staff.

This application is for a change in ownership-applicant from Kaiser Foundation Hospitals to Kaiser Foundation Health Plan. The board of directors of both organizations are the same. In this application, no expansion of services are proposed; the proposed services described in the approved Certificate of Need application #23-02A remain the same.

8. **IMPLEMENTATION SCHEDULE:** Please present a projected time schedule for the completion of this project from start to finish. Include all of the following items that are applicable to your project:

a) Date of site control for the proposed project – Not Applicable. The entire project will be completed within the existing KP Mapunapuna Medical Office Building, a satellite-substantially related property of KP's Moanalua Medical Center.
b) Dates by which other government approvals/permits will be applied for and received – Not Applicable.
c) Dates by which financing is assured for the project – Not Applicable.
d) Date construction will commence – Not Applicable.
e) Length of construction period – Not Applicable.
f) Date of completion of the project – Concurrent with CON approval.
g) Date of commencement of operation – Concurrent with CON approval.

Please remember that the Agency does monitor the implementation of Certificates approved. Non-implementation of a project as described in your application may result in a fine and/or withdrawal of the certificate of need.

9. **EXECUTIVE SUMMARY:** Please present a brief summary of your project. In addition, provide a description of how your project meets each of the certificate of need criteria listed below. If a new location is proposed, please attach an easy-to-read map that shows your project site.

a) Relationship to the State of Hawai'i Health Services and Facilities Plan.
b) Need and Accessibility
c) Quality of Service/Care

d) Cost and Finances (include revenue/cost projections for the first and third year of operation)
e) Relationship to the existing health care system
f) Availability of Resources.

Executive Summary

Kaiser Foundation Hospitals and Kaiser Foundation Health Plan, Inc. (herein collectively referred to as "Kaiser Permanente" or "KP") request approval from the State Health Planning and Development Agency for a change in ownership-applicant from Kaiser Foundation Hospitals to Kaiser Foundation Health Plan, Inc. for approved Certificate of Need application #23-02A Establishment of Positron Emission Tomography/Computed Tomography (PET-CT) services.

This change in ownership-applicant is due to the change in location for the PET-CT services from the Kaiser Permanente Moanalua Medical Center at 3288 Moanalua Road, Honolulu, Hawaii 96819 (the "PET/CT Facility") to the Kaiser Permanente Mapunapuna Medical Office Building ("MOB") medical complex at 2828 Paa Street, Honolulu, Hawaii 96819.

Existing services at the KP MOB include specialty services (including gastroenterology, pediatric specialties, neurology, and physiatry), primary care, ambulatory surgery, physical therapy, diagnostic imaging (including general rad, ultrasound, and CT), laboratory, and pharmacy. KP refers to and treats the Mapunapuna MOB as an extension / satellite of KP's Moanalua Medical Center, which is 2.4 miles away. Over the past 10 years, numerous specialty and diagnostic services have been shifted from the Moanalua Medical Center to the Mapunapuna MOB. The Mapunapuna MOB is also at least as accessible as the Moanalua Medical Center for patients, and there is a KP shuttle that transports patients back and forth between the Moanalua Medical Center and the Mapunapuna MOB. The shuttle runs continuously through the day. The Mapunapuna MOB is 2.4 miles from the Moanalua Medical Center site and has ample parking, including conveniently located handicap-accessible stalls. The drive-time between the two sites is about seven minutes, and each location has comparable access to public transportation. The proposed relocation would not significantly affect the delivery of PET/CT services to the target group.

Kaiser Permanente is an integrated managed care consortium that provides care in Hawaii. It is made up of three interdependent groups of entities: the Kaiser Foundation Health Plan, Inc. and its regional operating subsidiaries; Kaiser Foundation Hospitals; and regional Permanente Medical Groups. Although each entity of Kaiser Permanente formally has its own management structure, the structures are interdependent and cooperative.

The technical change in ownership-applicant within KP is not intended to change the scope of services to be provided as approved in Certificate of Need application #23-02A, nor is it anticipated to change any staffing. The internal-related entities reorganization and change of project site are intended to improve KP's internal operations and facilitate patient services.

Certificate of Need Criteria:

a. Relationship to the State of Hawai'i Health Services and Facilities Plan

The Certificate of Need application #23-02A proposed services' relationship to the State of Hawai'i Health Services and Facilities Plan was established by its approval. No changes will result from KP's internal reorganization and change of project site.

b. Need for and Accessibility of the proposal

The need for and accessibility of Certificate of Need application #23-02A proposed services were established by its approval. No changes will result from KP's internal reorganization and change of project site.

c. Quality of Service/Care

The quality of service/care to be provided under the Certificate of Need application #23-02A proposed services was established by its approval. No changes will result from KP's internal reorganization and change of project site.

d. Cost and Finances

KP does not anticipate that the proposed change in ownership - internal reorganization and change of project site will have any negative impact on the overall costs of health care services to the community. The financial feasibility of Certificate of Need application #23-02A will be unchanged, both immediately and in the longer term. The change in ownership - internal reorganization will be a non-cash, non-value change with respect to KP.

e. Relationship to the Existing Health Care System

KP's change in ownership - internal reorganization and change of project site are not expected to have any impact on the existing health care system because it will not result in any change in KP's proposed operations or scope of services. The staffing is projected to remain the same. Accordingly, KP's patients and other health care providers will be unaffected by the proposed change.

f. Availability of Resources

No new resources are required for the reorganization. The staffing for the proposed services will remain the same.

Eligibility to file for Administrative Review. This project is eligible to file for administrative review because: (Check all applicable)

_____ It involves bed changes, which will have a capital expense of $1,000,000 or less, and which will have an increased annual operating expense of less than $500,000.

_____ It involves service changes which will have a capital expense of $1,000,000 or less, and which will have an increased annual operating expense of less than $500,000.

_____ It is an acquisition of a health care facility or service, which will result in lower annual operating expenses for that facility, or service.

__X__ It is a change of ownership, where the change is from one entity to another substantially related entity.

_____ It is an additional location of an existing service or facility.

__X__ The applicant believes it will not have a significant impact on the health care system.