STATE OF WASHINGTON
THURSTON COUNTY SUPERIOR COURT

THE STATE OF WASHINGTON, PLAINTIFF, v. DAVITA INC.; TOTAL RENAL CARE, INC.; FRESENIUS MEDICAL CARE HOLDINGS, INC., D/B/A FRESENIUS MEDICAL CARE NORTH AMERICA LLC; RENAL CARE GROUP NORTHWEST, INC. DEFENDANTS.	NO. COMPLAINT FOR DECLARATORY RELIEF, INJUNCTIVE RELIEF, AND CIVIL PENALTIES UNDER THE WASHINGTON NONCOMPETE ACT AND THE CONSUMER PROTECTION ACT

I. NATURE OF THE CASE

1. Plaintiff, State of Washington, by and through its Attorney General Nicholas W. Brown, brings this action under the Washington Consumer Protection Act ("CPA"), RCW 19.86.080, and the Washington Noncompetition Covenants Act ("NCA"), RCW 49.62.080, for declaratory relief, injunctive relief, and civil penalties against Defendants Davita Inc. and Total Renal Care Inc. (collectively referred to as "DaVita"), and Fresenius Medical Care Holdings, Inc., d/b/a Fresenius Medical Care North America and Renal Care Group Northwest, Inc. (collectively referred to as "Fresenius").

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2. Defendants are for-profit corporations that collectively control the majority of dialysis centers in Washington and the United States. The business of dialysis is lucrative for Defendants, and they dwarf their competitors by both their size and their geographic reach.

3. This action challenges Defendants' longstanding practice of requiring nephrologists that serve as medical directors to agree to noncompete covenants. Medicare regulations require each center to have a medical director. Defendants' medical directors are part-time independent contractors that are tasked with the managerial and administrative job of overseeing dialysis centers and ensuring that they meet safety and quality standards. Nevertheless, Defendants have asked medical directors to agree to noncompete covenants that restrict entire nephrology groups and stifle competition.

4. Indeed, Defendants' agreements with their medical directors frequently contain noncompete covenants that bind entire nephrology practice groups to provisions prohibiting nephrologists from serving as medical directors for other dialysis providers in their geographic area. Often, these noncompete covenants extend these restrictions for all practice group members for a period of time even after the contract ends.

5. These covenants were inconsistent with Washington's common law governing noncompete provisions and are void and unenforceable under the NCA, which took effect on January 1, 2020.

6. Defendants' use of noncompete covenants hinders competitors' ability to open competing dialysis centers by making it harder to secure a medical director as required by Medicare regulations.

7. Defendants' use of noncompete covenants creates artificial barriers to competition and constitutes an unfair method of competition under the CPA. Defendants' use of noncompete covenants is deceptive and violates public policy as established by both the common law and the NCA, making these contractual terms unfair or deceptive in violation of the CPA.

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8. After investigating this matter, the State brings this case to enforce the law and protect the citizens of Washington by promoting open competition in the dialysis market.

II. PARTIES

9. Plaintiff is the State of Washington, through its Attorney General. Washington has a sovereign interest in the enforcement of the CPA and NCA and has authority to bring this action under RCW 19.86.080 and RCW 49.62.080.

10. Defendant DaVita Inc. is a Delaware for-profit corporation with its principal place of business in Denver, Colorado.

11. Defendant Total Renal Care, Inc., is a California for-profit corporation with its principal place of business in Denver, Colorado. Total Renal Care, Inc. is a wholly owned subsidiary of DaVita Inc.

12. DaVita currently operates 51 dialysis centers in Washington.

13. DaVita Inc. and Total Renal Care have participated and engaged in the conduct alleged in the Complaint, including by directing employees to negotiate contracts with nephrology practices that contain noncompete covenants and ultimately entering into such agreements that purport to bind not just the medical director but entire nephrology practices.

14. Defendant Fresenius Medical Care Holdings, Inc., d/b/a Fresenius Medical Care North America is a New York for-profit corporation with its principal place of business in Waltham, Massachusetts. Fresenius's parent corporation is Fresenius Medical Care AG, a German corporation based in Bad Homburg vor der Höhe, Germany.

15. Defendant Renal Care Group Northwest, Inc. is a Delaware for-profit corporation with its principal place of business in Waltham, Massachusetts. Defendant Renal Care Group Northwest, Inc. is a wholly owned subsidiary of Fresenius.

16. Fresenius currently operates 29 dialysis centers in Washington.

17. Fresenius and Renal Care Group Northwest, Inc. have engaged in the conduct alleged in the Complaint, including by directing employees to negotiate contracts with

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nephrology practices that contain noncompete covenants and ultimately entering into such agreements that purport to bind not just the medical director but entire nephrology practices.

III. JURISDICTION AND VENUE

18. The State files this complaint under the Consumer Protection Act, RCW 19.86.020, RCW 19.86.080, and the Noncompetition Covenants Act, RCW 49.62.030, RCW 49.62.080.

19. The Court has jurisdiction over this matter pursuant to RCW 19.86.080 and RCW 49.62.080.

20. Defendants both operate and do business in Washington. Their activities were intended to, and did have, a substantial and foreseeable effect on Washington trade and commerce, including in Thurston County.

21. Thurston County Superior Court is the proper venue because Defendants operate in Thurston County.

IV. FACTUAL BACKGROUND

A. Patients with Kidney Failure Require Dialysis Treatment, Which is Largely Provided Within Dialysis Centers.

22. Kidney failure, or end-stage renal disease ("ESRD"), occurs when a patient's kidneys no longer function well enough to keep a patient alive. Patients with ESRD need to receive dialysis to filter waste and fluid from their blood. Patients with ESRD remain on dialysis unless they receive a kidney transplant.

23. There are two main types of dialysis treatment: hemodialysis and peritoneal dialysis.

24. The process of hemodialysis involves filtering a patient's blood through a dialysis machine. The machine pumps the patient's blood through a specialized filter called a dialyzer to filter the blood, remove excess waste, and balance electrolytes in the patient's body. This treatment occurs approximately three times a week and each treatment takes several hours.

Hemodialysis is the dominant form of dialysis provided to patients in the United States, and most receive treatment at dialysis centers. The Center for Medicare and Medicaid Studies ("CMS") indicated that approximately 84 percent of dialysis patients received in-center hemodialysis in 2025.

25. Alternatively, dialysis patients can receive peritoneal dialysis, which utilizes the lining of the abdomen as a natural filter to remove waste from the patient's blood. This treatment requires a catheter to be placed in the abdomen. A cleansing fluid flows through the catheter into and out of the abdomen to filter the waste. Although far less common than hemodialysis, the use of peritoneal dialysis has grown in the United States in recent years.

26. Dialysis can be performed in a patient's home, but home treatment is not common in the United States. The National Kidney Foundation estimates that only 14 percent of U.S. dialysis patients receive either form of dialysis in a home setting.

27. More than 14,000 Washingtonians live with ESRD and approximately 9,000 receive dialysis treatment.

28. Nephrology is the medical specialty focused on the study, diagnosis, and treatment of the kidneys. Nephrologists are often organized into their own physician-owned practices or affiliated with a larger health system. Nephrologists' day-to-day work may involve a variety of different interactions with patients, including treating patients in their clinical practice as well as in a hospital setting. Nephrologists make rounds at dialysis centers to see their patients in their role as a dialysis patient's physician. A nephrologist can also serve as the medical director of a dialysis center, which is responsible for overseeing health and safety standards at a clinic, as discussed *infra*, Section IV, C.

B. Washington is the Birthplace of Modern Dialysis Treatment Which Made ESRD a Treatable Disease.

29. Before the 1960s, dialysis was only used to temporarily stabilize a patient. Glass shunts (now obsolete) were used in dialysis treatment and caused damage to a patient's veins

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and arteries – making recurring dialysis impossible. Therefore, patients with ESRD did not survive.

30. In 1960, a team from the University of Washington Division of Nephrology developed a shunt that did not damage a patient's veins and arteries. This allowed for ongoing dialysis treatment for the first time. The first outpatient dialysis center, the Seattle Artificial Kidney Center – later renamed Northwest Kidney Centers – was opened in Seattle in 1962.

31. The work of the University of Washington Division of Nephrology also allowed peritoneal dialysis to be offered for the first time in 1970.

C. Medicare is the Primary Payer for Dialysis and Each Dialysis Center Must Have a Medical Director Physician Under CMS Regulations.

32. In 1972, the United States Congress passed legislation that authorized the End Stage Renal Disease Program to extend Medicare Coverage to patients with ESRD, regardless of their age. As a result, today most dialysis patients are covered by Medicare, though some patients are covered by Medicaid or a commercial healthcare plan.

33. For patients that begin dialysis while on a commercial healthcare plan, their commercial insurance will typically cover the primary cost of dialysis payments for up to 30 months of the patient's treatment before Medicare becomes the primary payer.

34. For those patients already on Medicare, the program pays for most of the cost of dialysis directly, and patients can purchase supplemental coverage to help cover additional costs.

35. Because Medicare is the primary payer for dialysis services, CMS stringently regulates dialysis. CMS certifies dialysis centers and contracts with the Washington Department of Health ("DOH") to evaluate compliance with Medicare conditions for coverage for ESRD facilities through surveys of dialysis centers.

36. CMS regulations require each certified dialysis center to have a medical director. To be eligible to serve a medical director, a physician must have: (1) at least a year of experience

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providing care to patients receiving dialysis; and (2) completed certain training in nephrology. 42 C.F.R. §494.140(a)(1).

37. While DaVita or Fresenius may contract with a nephrology practice for medical director services, each of those contracts sets forth a specific physician to serve as the medical director. Other physicians in the medical director's physician group may serve as a preapproved backup physician when the medical director is unavailable.

38. The medical director position is a part-time role. CMS guidance to dialysis centers states that the financial report that "each facility must file annually with CMS considers the medical director position to reflect a 0.25 FTE."

39. It is possible for a nephrologist to serve as the medical director of more than one center, depending on the physician's other work responsibilities.

40. CMS regulations set forth the responsibilities of the medical director. These responsibilities are focused on ensuring the quality of medical care provided to patients at the dialysis center. 42 C.F.R. §494.150.

41. The medical director's responsibilities include quality assessment and performance improvement; staff education and training; and involvement in the development and maintenance of policies and procedures at the clinic and ensuring that those providing treatment at a dialysis center adhere to all policies and procedures of the center relative to admissions, patient care, infection control, and safety. *Id*.

42. The medical director thus serves an administrative and management function at the dialysis clinic.

43. The medical director is generally not responsible for directly dialyzing patients as that role is performed by nurses and dialysis technicians.

D. DOH Regulates Dialysis Centers Through its Certificate of Need Program.

44. In Washington, dialysis centers are subject to Washington's Certificate of Need ("CN") program. The CN program requires dialysis providers to obtain state approval before

building new dialysis facilities or expanding services at an existing dialysis center. WAC 246-310-020. Centers are approved for a specific number of dialysis stations. A dialysis station is an area equipped to provide dialysis services for one patient at a time.

45. In order to submit a CN application to open a new dialysis center, a provider must provide the required materials to DOH. A CN applicant must include a proposed agreement with the medical director ("Medical Director Agreement" or "MDA") in the application materials to establish the applicant will be able to meet CMS regulations to operate a center. *See* WAC 246-310-230.

46. Approval of a CN application is, in part, based on need – a published numeric methodology based on population and utilization to project how many stations will be needed in a five-year period. *See* WAC 246-310-800; WAC 246-310-812.When there are competing applicants, a contract will go to the applicant who will provide all needed stations.

47. The CN applications are public in Washington and available on the DOH's website, which means that dialysis competitors (or potential competitors) can view copies of the MDAs that are submitted during the CN process.

E. Defendants are For-Profit Dialysis Providers with Dominant Market Positions in Various Regions of Washington.

48. Defendants are large, publicly traded corporations that operate as for-profit dialysis providers. They operate over 70 percent of dialysis centers in the United States, making them the two largest operators of dialysis centers in the country and in Washington.

49. The operation of dialysis centers has been a profitable business for these entities.

50. DaVita reported dialysis revenue of $11.79 billion in the United States in 2025. DaVita's reported net income in 2025 was $1.1 billion. As of the end of 2025, DaVita operated 2,657 dialysis centers in the United States – approximately 35 percent of the dialysis centers in the country. DaVita reported that for the fiscal year ending December 31, 2025, approximately

68 percent of its dialysis patient services revenue was generated from government-based programs covering approximately 89 percent of its total patients.

51. Fresenius AG, the parent company of Fresenius Medical Care North America, is based in Germany and reported a net income of €1,995 million in 2025 – approximately $1.3 billion. Fresenius reported dialysis revenue of $13.28 billion in the United States. At the end of 2025, Fresenius owned or operated 2,622 dialysis clinics in the United States – approximately 35 percent of the dialysis centers in the country. Fresenius is also the dominant firm in the manufacturing and sale of dialysis machines for hemodialysis treatment. Fresenius supplies approximately 90 percent of the machines used for hemodialysis in the United States. DaVita utilizes Fresenius equipment in its dialysis centers.

52. Defendants operate the majority of the dialysis centers in Washington. In many Washington counties, including Benton, Clark, Grant, Lewis, Mason, Spokane, Stevens, and Thurston, DaVita or Fresenius are the only two options for in-center dialysis treatment.

53. DaVita operates all the dialysis stations in several Washington counties, including Chelan, Douglas, Franklin, Kittitas, Yakima, and Whatcom.

54. Fresenius operates all the dialysis stations in several other counties, including Adams, Cowlitz, Grays Harbor, Okanogan, and Walla Walla.

55. Fresenius and DeVita both operate dialysis centers in several other counties including Clark, King, Pierce, and Skagit.

56. Defendants are markedly larger than other dialysis providers in Washington, including nonprofit providers Northwest Kidney Centers and Puget Sound Kidney Centers. Northwest Kidney Centers is based in Seattle and operates 20 dialysis centers in Western Washington. Puget Sound Kidney Centers is based in Everett and operates 11 dialysis centers in Western Washington.

F. Washington Law has Long Limited the Enforceability of Noncompete Covenants.

57. Washington law has long reflected a commitment to open competition. Indeed, when Washington became a State in 1889, it codified a prohibition on monopolies and trusts in its Constitution. *See* Article XII, § 22, Wash. Con. ("Monopolies and trusts shall never be allowed in this state[.]").

58. In 1961, Washington enacted the Consumer Protection Act, which prohibits certain conduct to "protect the public and foster fair and honest competition." RCW 19.86.920.

59. Washington's preference for fair and open competition is also reflected in how Washington courts examined noncompete covenants at common law. It has long been the case that overbroad noncompete covenants were unenforceable at common law.

60. Washington courts examined noncompete covenants under the reasonability test, which analyzed "(1) whether [the] restraint is necessary for the protection of the business or goodwill of the employer, (2) whether it imposes upon the employee any greater restraint than is reasonably necessary to secure the employer's business or goodwill, and (3) whether the degree of injury to the public is such loss of the service and skill of the employee as to warrant nonenforcement of the covenant." *Perry v. Moran*, 109 Wn.2d 691, 698, 748 P.2d 224 (1987) (citation omitted).

61. Washington courts have struck down or reformed noncompete covenants that were unreasonable under this test.

G. Washington Enacts the NCA to Further Restrict Noncompete Covenants.

62. In 2019, the Washington legislature passed the Noncompetition Covenants Act, Engrossed Substitute House Bill 1450, to further restrict noncompete covenants. The legislation went into effect on January 1, 2020.

63. The law sets forth several protections for employees and independent contractors. RCW 49.62.030(1) states "[a] noncompetition covenant is void and unenforceable against an independent contractor unless the independent contractor's earnings from the party

seeking enforcement exceed two hundred fifty thousand dollars per year. This dollar amount must be adjusted annually in accordance with RCW 49.62.040."

64. The earnings threshold for independent contractor noncompete covenants was $250,000 in 2020 and has been adjusted upward on an annual basis.

65. In 2026, the independent contractor threshold is $317,147.09. WSR 25-20-099.

66. If an independent contractor noncompete does not meet this threshold, the noncompete is void and unenforceable, and no further inquiry into whether the noncompete is reasonable is required under the NCA.

67. The NCA sets forth a specific definition of a noncompete covenant. The definition is broad, and "includes every written or oral covenant, agreement, or contract by which an employee or independent contractor is prohibited or restrained from engaging in a lawful profession, trade, or business of any kind." RCW 49.62.010(4).

68. Thus, for these noncompete covenants against independent contractor physicians to have any possibility of enforcement in Washington, the party retaining the independent contractor must meet the compensation threshold set forth in RCW 49.62.030.[1]

H. Defendants' Medical Director Agreements Frequently Contain Noncompete Covenants.

69. Defendants' agreements with their medical directors ("Medical Director Agreement" or "MDA") frequently contain noncompete covenants.[2]

70. There is some variability in the noncompete covenants in these MDAs. However, they often include at least one (and sometimes all three) of the noncompete covenants described below:

[1] In 2026, Washington enacted additional restrictions on noncompete covenants in Engrossed House Substitute Bill 1155. However, as that legislation does not go into effect until June 30, 2027, the State brings suit under the current version of the NCA.

[2] The State is not asserting claims related to any MDAs that: 1) do not contain noncompetition covenants; or 2) contain noncompetition agreements that are carved out of the NCA because they were entered into by a "person purchasing or selling the goodwill of a business or otherwise acquiring or disposing of an ownership interest, but only if the person signing the covenant purchases, sells, acquires, or disposes of an interest representing one percent or more of the business." RCW 49.62.010(4)(d).

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a) An **exclusivity provision** that prevents a nephrologist from serving as a medical director for another dialysis center within a certain geographic area from the center the nephrologist is serving.

b) A **tail provision** that extends the noncompete for a certain period after the termination of the agreement. These tail provisions generally range from 12 to 24 months.

c) A **joinder provision** that purports to bind all the nephrologists in a contracted medical director's practice group to the terms of the noncompete covenants. The effect of these provisions is to purport to bind physicians to the noncompete covenant even though they are not actually serving as a medical director under that agreement.

71. Each of these three provisions constitutes a separate noncompetition covenant.

72. The length of the MDAs varies by agreement, but the contracts often range from three to ten years.

73. Separate and apart from the noncompete covenants described above, DaVita and Fresenius both include specific non-solicitation provisions and covenants that are intended to protect the dissemination of confidential information or trade secrets. These contractual terms are not considered noncompetition covenants under the NCA.

74. For instance, one DaVita MDA with Memorial Nephrology Associates for medical director services at Olympia Dialysis Center, effective on December 30, 2022,[3] contains a joinder provision, a 12-month tail after termination of the MDA, and a 15-mile geographic radius in which the medical director (and four joinder physicians) were restricted from competing for the length of the MDA and the tail period.

[3] As detailed in Section IV, G, *supra*, Washington's noncompete legislation went into effect on January 1, 2020, which rendered noncompete covenants with independent contractors earning below $250,000 (adjusted annually) void and unenforceable.

75. In another example, a DaVita MDA with Pacific Nephrology Associates for services at Lacey Dialysis, effective June 2, 2021, contains a joinder provision binding three joinder physicians and the medical director, a two-year tail provision, and a 30-mile geographic radius in which the bound physicians cannot provide hemodialysis services at a dialysis center and a 40-mile geographic radius in which bound physicians cannot provide peritoneal or home hemodialysis.

76. Fresenius also frequently employs noncompete covenants. A Fresenius MDA with a Washington medical practice for medical director services at its Gig Harbor location, effective October 27, 2022, has a nine-year term. The compensation paid to the medical practice was well below the independent contractor threshold under the NCA, but the MDA purports to bind four physicians (the medical director and three joinder physicians) to the covenant not to compete. The exclusivity provision runs during the term of the agreement and covers a geographic area within a five-mile radius. While the MDA does not contain a noncompete tail provision, if one of the four physicians becomes a "former member physician" by leaving the practice, the noncompete covenant applies until the earlier of the end of the nine-year agreement or two years from the date that the nephrologist becomes a former member physician. Thus, for a physician leaving the group, the noncompete covenant would apply for two years following the physician's departure.

77. If a possible competitor wants to open a competing dialysis center, these noncompete covenants are a barrier to the group hiring the restricted physician to serve as the medical director of a new center. And the joinder provision prevents an even larger group of nephrologists from serving as a medical director for a competitor in a large geographic area, making it even more difficult for other dialysis centers to hire medical directors. In this way, the noncompete covenants foreclose competitors from hiring certain nephrologists within a geographic market.

78. The injury to the public is significant. Dialysis patients are a medically vulnerable population that require dialysis treatment to prevent kidney failure and death. The lack of competition in this space reduces the incentive for improved quality, innovation, and access to care. The lack of competition causes concrete harm to the patient population.

I. DaVita and Fresenius Oppose a Competitor's Certificate of Need Application and the Competitor Notes that Noncompete Covenants will Soon be Prohibited by the NCA.

79. DaVita and Fresenius have both raised noncompete covenants as a basis to deny a competitor's CN application. Defendants have argued that certain physicians were bound by noncompete covenants and thus could not serve as a valid medical director for the applicant. In one CN application process related to a potential center in Arlington in 2018 and 2019, the repeated focus on noncompete covenants led one competitor, Puget Sound Kidney Centers, to note that "[g]iven the rapidly growing dialysis population in the State, and the documented shortage of nephrologists, DaVita's expansive and restrictive noncompete requirements are burdensome on the entire delivery system[.]"

80. In another instance, DaVita and Fresenius both opposed Puget Sound Kidney Center's CN application to build a Vancouver dialysis center. DaVita raised the issue of a purported noncompete agreement involving a physician's existing medical director role with DaVita. Puget Sound Kidney Centers responded that "[a]dditionally, and as importantly, effective January 1, 2020, non-compete clauses in medical director contracts will no longer be lawful in Washington State except in extremely limited circumstances that do not apply here . . . Following the effective date of that law, the decision of whether to provide services to multiple dialysis providers will for most purposes be left to the professional judgment of the licensed medical professional himself."

81. This disputed CN application highlights how the NCA was already being discussed by dialysis providers in 2019, as a major dialysis competitor noted that noncompete covenants would no longer be permissible in MDAs. DaVita and Fresenius were thus confronted

by the NCA and its application to medical director noncompete covenants before the statute even took effect.

J. DaVita recognizes that the NCA is a "Huge Deal" for its Medical Director Noncompete Covenants but Decides to Keep Using Them.

82. Internal communications also show that DaVita was aware of the NCA and its application to its MDA noncompete covenants as the legislation was moving through the Washington legislature. The DaVita Group Vice President for DaVita's North Star Division (the DaVita region that includes Washington) acknowledged in a March 15, 2019, email to colleagues that "[t]here is a Bill in WA State to restrict noncompetes for individuals and contractors. ***Huge deal for our Medical Director NCs***." (emphasis added.) He further commented that the legislation may "tear a gaping hole in [its] noncompete protections" though he further acknowledged that DaVita "may be able to mitigate with stronger IP language etc in [its] MDAs." Thus, as early as March 2019, DaVita leadership recognized the applicability of the new Washington legislation to their MDA noncompete covenants.

83. After the NCA went into effect in 2020, the new noncompete law remained an issue of internal discussion at DaVita. On January 8, 2020, a DaVita Recruiter wrote to the Vice President for DaVita's North Star Division about an offer she was writing up and noted that a colleague had "let me know that Washington state has had a recent change in their law that has impacted our current non-compete." The recruiter described how they were revising an unspecified noncompete in light of the new law. The email highlights how after the law went into effect, Davita's leadership and Human Resources department were aware of the new legislation.

84. But rather than comply with Washington's new legislation, which had become effective on January 1, 2020, DaVita continued inserting noncompete covenants into MDAs.

85. For example, in 2022, DaVita entered an MDA with a nephrology practice for a nephrologist to serve as the medical director of DaVita's Wenatchee Valley Dialysis center for

a 10-year term. The MDA compensation was $65,000 and contained an 18-month tail provision with a restricted geographic radius of 30-miles. The statutory compensation threshold to possibly enforce a noncompete against an independent contractor in 2022 was $268,252.59. Even though the compensation of this MDA was not even close to the minimum threshold, the noncompete purported to bind not just the medical director but two additional physicians in the director's practice group through a joinder agreement.

86. After January 1, 2020, DaVita entered into amendments that extended the length of expiring MDAs that contained noncompete covenants. Each of these amendments must meet the requirements set forth in the NCA because they purported to extend the noncompete during a new period not covered by the pre-January 1, 2020 contract. However, these noncompete covenants are void and unenforceable because they fail to meet the compensation threshold in RCW 49.62.030.

K. Fresenius Removes a Noncompete Covenant from an MDA but Keeps Using Them in Other Agreements.

87. Fresenius's internal communications highlight how it was also aware of the NCA. During an MDA renegotiation in 2020 and 2021 with a Washington nephrology practice in Walla Walla, a contract manager noted that "legal is following up on issues relating to non-compete law change in WA." When the nephrology group pushed back against the inclusion of noncompete terms in the MDA, Fresenius agreed to remove the terms. The nephrology group specifically admonished "there are many terms that are not compliant with WA State's Non-compete law that went into effect Jan 1, 2020." Fresenius indicated that counsel from both parties had reviewed the contract and "taking into consideration the changes to Washington State law, FKC decided to accept the edits and remove the non-compete and tail provisions of this MDA."

88. Despite this recognition, Fresenius continued to include noncompete covenants in Washington MDAs where the contracting party did not cite the NCA to push back on the noncompete agreement.

89. A contract negotiation that occurred in 2024 is particularly telling. Fresenius recognized there were concerns about requiring a physician in Washington to enter into a noncompete covenant. In March 2024, a Senior Director of Physician Contracting ("Senior Director") at Fresenius emailed Fresnius's President of Kidney Care to inform him that Fresenius had an MDA with a physician serving as the medical director of its Kennewick dialysis center. She noted that Fresenius had "been asking him to form a LLC so we can enforce a non-compete. He has yet to do so." The Senior Director asked if she could move forward without a noncompete and noted that he was "the ***only nephrologist*** in this market." (emphasis added.)

90. The President of Fresenius Kidney Care asked if they had any other options if the physician refused to form a LLC, but also noted "if this is the case, ***then I guess we don't have much choice but to approve***." (emphasis added.) Rather than expressing a specific concern about the inability to move forward without a noncompete agreement, he indicated a willingness to approve the MDA without a noncompete covenant if need be.

91. Nonetheless, the Fresenius team apparently convinced the physician – whom they described as the only nephrologist in the entire market – to set up an LLC so that Fresenius could enforce a noncompete. The Senior Director wrote that she had "updated the MDA and now can contract with his new LLC and have the non-competes within the agreement." The compensation for this MDA was below the 2024 statutory threshold for an independent contractor of $301,399.98.

92. Undeterred by the clear provisions of the NCA, Fresenius attempted to avoid the application of the NCA through a technicality: requiring a physician to establish a limited liability corporation. Yet, such a scheme does nothing to alter the application of the NCA to this noncompete agreement. The noncompete covenant required the medical director to sign as a "member physician" subject to the noncompete covenants next to his National Provider Number (NPI). Thus, the fact that an LLC was technically the counterparty to the contract changes

nothing, as the noncompete covenants clearly purported to bind a specific, independent contractor physician.

93. After January 1, 2020, Fresenius entered into amendments that extended the length of expiring contracts that contained noncompete provisions. Each of these amendments must meet the requirements of the NCA because they purport to extend the noncompete during a new period not covered by the pre-January 1, 2020 contract. However, these noncompete covenants are void and unenforceable because they fail to meet the compensation threshold in RCW 49.62.030.

V. ANTICOMPETITIVE AND DECEPTIVE CONDUCT

A. Defendants' Noncompete Covenants were Overly Broad and Unenforceable at Common Law.

94. Defendants' noncompete covenants are not enforceable when examined through the reasonability test employed by Washington courts at common law.

95. First, the restraint is not necessary to protect the Defendants' business or employer goodwill. Medical directors are independent contractors working part time and serving an administrative function. A nephrologist that serves as a medical director has specific responsibilities in that role. The position is centered around medical quality and safety, and thus their role is primarily related to ensuring policies and procedures are followed and that quality metrics are being met. This is not a position that is based around business development. Indeed, both federal and state law make it illegal for dialysis providers to compensate physicians for patient referrals.[4] Accordingly, Defendants reference the applicable federal statute governing this prohibition in their MDAs. Thus, when analyzing the various business interests at issue, there is no strong business justification for why a nephrologist serving in this role should be subject to burdensome noncompete covenants.

[4] 42 U.S.C. § 1320a–7b(b) (the "Anti-Kickback Statute" prohibits paying or receiving remuneration in connection with the referral of Medicare or Medicaid business); RCW 19.68.010 (the "Anti-Rebate" prohibits physicians from receiving payment for referrals for medical services).

96. Second, the restraint is far greater than necessary to secure any business interest that does exist. DaVita and Fresenius include non-solicitation provisions and covenants that protect the dissemination of confidential information or trade secrets. Those covenants protect DaVita or Fresenius to the extent they have a valid concern that any confidential information or trade secrets may be misappropriated by a medical director.

97. The exclusivity noncompete provision ties up physicians for an extended period while they are working with DaVita or Fresenius, as some medical director contracts run for a decade. In communities where there are few nephrologists, such provisions serve to lock in complete control of a market for an extended period.

98. Further, the use of tail provisions means that medical directors are restricted from working at a dialysis center even when they are no longer working as a medical director at the center. Such provisions only operate to stifle competition as the physicians are no longer serving as independent contractors to DaVita or Fresenius.

99. In addition, the joinder provisions are overbroad and not reasonable under Washington law. A joinder provision purports to restrict nephrologists within a practice that are not actually serving as medical directors. While such physicians may be able to step in when the medical director is unavailable, any protectable business interest in restricting these nephrologists is minimal when compared to the effect of the joinder provisions. These provisions greatly expand the scope of the noncompete covenants to many different physicians.

100. The injury to the public is significant. Dialysis patients are a medically vulnerable population that require treatment to prevent kidney failure and death. The lack of competition causes concrete harm to the patient population by reducing the incentive for improved quality, innovation, access to care, and convenient services such as in-home dialysis. In-home dialysis services can provide patients' privacy and dignity and save often severely ill patients from having a lengthy commute to dialysis center multiple times a week. The lack of competition means patients have less access to alternative treatment, including home dialysis, and – by

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reducing options – potentially longer drives to dialysis centers. Moreover, the lack of competition pushes prices upward for those dialysis patients with commercial health insurance resulting in higher costs for patients and employers who sponsor health insurance plans.

101. Finally, Defendants each operate as the sole dialysis provider in several markets in Washington, and the use of noncompete provisions to protect such monopolies is inconsistent with the public's interest in fair competition.

B. Defendants' Noncompete Covenants are Void and Unenforceable Under the NCA and Thus Cannot Have a Procompetitive Purpose.

102. Each of the three MDA noncompete provisions – exclusivity, tail, and joinder – are noncompetition covenants under RCW 49.62.010 because they include written terms that purport to limit the ability of a medical director (or a physician that signs a joinder) to take certain actions that might compete against DaVita or Fresenius within a specific geographic region.

103. While the compensation for medical director services varies depending on the size of the center, none of the contracts provided to the State in its investigation meet the minimum compensation threshold to subject each physician to a noncompete covenant under the NCA.

104. Regardless of whether Defendants contract with a nephrology practice or a specific physician, the MDAs contain noncompete covenants that purport to bind specific physicians (whether the medical director or a joinder physician) to noncompete covenants.

105. Defendants' use of void and unenforceable noncompete covenants cannot have a procompetitive purpose. These terms, which cannot be enforced, serve no legitimate business interest. Rather, the noncompete covenants in the MDAs can only serve a negative purpose. Indeed, the terms may deceive physicians who are unaware of the NCA or its application to independent contractors.

106. Furthermore, Defendants' own conduct demonstrates that the noncompete covenants are not necessary. Defendants at times have included exceptions to the noncompete

covenants in an MDA. For instance, DaVita granted a carveout for a Washington medical group in which different physicians serve as medical directors for both DaVita and a competitor in Bellevue.

107. The use of noncompete covenants also signals to competitors that an attempt to contract with the restricted nephrologists may result in costly legal disputes with large, well-funded companies. And the fact that many of these agreements are public in Washington because of the CN process helps to ensure that other dialysis center competitors, or possible competitors, are aware of DaVita and Fresenius's purported noncompete restrictions.

108. This conduct is particularly egregious because the Defendants have significant market share and are the dominant dialysis firms in many different geographic markets in Washington. Defendants' use of noncompete covenants are not isolated instances involving companies with little presence in Washington. Rather, these are companies with significant market power that have repeatedly used noncompete covenants to stifle competition even after they knew that the provisions were void and unenforceable in this state.

VI. CAUSES OF ACTION

The State of Washington incorporates the allegations in Paragraphs 1 through 108.

A. State's Claims Against DaVita.

1. First claim for relief: declaratory judgment under the NCA against DaVita.

109. Washington's NCA sets forth that independent contractor noncompete covenants are void and unenforceable unless the earnings from the party seeking enforcement exceed an annual earnings threshold. RCW 49.62.030.

110. The earnings threshold for independent contractor noncompete covenants was $250,000 in 2020 and has been adjusted upward on an annual basis. In 2026, the independent contractor threshold is $317,147.09.

111. If an independent contractor noncompete covenant does not meet this threshold, the noncompete covenant is void and unenforceable and no further reasonableness inquiry is required.

112. Many of DaVita's MDAs contain three forms of noncompete covenants:

a) an exclusivity provision;

b) a tail provision; and

c) a joinder provision purporting to bind additional physicians to the noncompete covenant contained in the MDA.

113. Each of these covenants constitute noncompete covenants under RCW 49.62.010.

114. These noncompete covenants are void and unenforceable under the NCA.

2. Second claim for relief: DaVita's use of noncompete covenants violates RCW 19.86.020.

115. The State of Washington incorporates the allegations in Paragraphs 1 through 108.

116. DaVita's conduct violates RCW 19.86.020 in multiple ways.

117. First, Davita engaged in unfair methods of competition affecting Washington commerce by:

a) Prior to January 1, 2020, entering into noncompete covenants related to medical director services that were overly overbroad, unnecessarily restricted competition, and were not enforceable at common law;

b) After January 1, 2020, entering into noncompete covenants related to medical director services that were void and unenforceable under RCW 49.62.030. These noncompete covenants were also overbroad, unnecessarily restricted competition, and were not enforceable at common law;

118. Second, DaVita engaged in unfair or deceptive acts or practices affecting Washington consumers, including dialysis patients and nephrologists, in violation of RCW 19.86.020 by:

a) Prior to January 1, 2020, entering into noncompete covenants in its contracts related to medical director services that violated public policy as established by common law and that caused substantial injury to Washington consumers;

b) Prior to January 1, 2020, misrepresenting, directly or indirectly, expressly, by implication, or by omission the enforceability of the noncompete covenants in its contracts related to medical director services;

c) After January 1, 2020, unfairly including void and unenforceable noncompete covenants in its contracts related to medical director services, in violation of public policy as established by RCW 49.62.030 and that caused substantial injury to Washington consumers;

d) After January 1, 2020, misrepresenting, directly or indirectly, expressly, by implication, or by omission, the enforceability of the noncompete covenants in its contracts related to medical director services; and

e) Other unfair acts or deceptive representations or omissions as set forth in the preceding paragraphs.

119. DaVita's conduct as described herein occurred in trade or commerce within the meaning of the Consumer Protection Act, RCW 19.86.010(2), directly or indirectly affecting the people of the State of Washington.

120. DaVita's unfair methods of competition and unfair or deceptive acts or practices affected the public interest in that they impacted numerous Washington consumers.

121. Based on the above unfair methods of competition and unfair or deceptive acts or practices, the State is entitled to relief under the Consumer Protection Act, including injunctive relief pursuant to RCW 19.86.080, civil penalties pursuant to RCW 19.86.140 for each and every

violation of RCW 19.86.020, and reimbursement of the costs of this action, including reasonable attorneys' fees, pursuant to RCW 19.86.080.

B. State's Claims Against Fresenius.

3. Third claim for relief: declaratory judgment under the NCA against Fresenius.

122. Washington's NCA sets forth that independent contractor noncompete covenants are void and enforceable unless the earnings from the party seeking enforcement exceed an annual earnings threshold. RCW 49.62.030.

123. The earnings threshold for independent contractor noncompete covenants was $250,000 in 2020 and has been adjusted upward on an annual basis. In 2026, the independent contractor threshold is $317,147.09.

124. If an independent contractor noncompete covenant does not meet this threshold, the noncompete covenant is void and unenforceable and no further reasonableness inquiry is required.

125. Fresenius's MDAs often contain three different forms of noncompete covenants:

a) an exclusivity provision;

b) a tail provision; and

c) a joinder provision purporting to bind additional physicians to the noncompete covenant contained in the MDA.

126. Each of these covenants constitute noncompete covenants under RCW 49.62.010.

127. These noncompete covenants are void and unenforceable under the NCA.

4. Fourth claim for relief: Fresenius's use of noncompete covenants violates RCW 19.86.020.

128. The State of Washington incorporates the allegations in Paragraphs 1 through 108.

129. Fresenius's conduct violates RCW 19.86.020 in multiple ways.

130. First, Fresenius engaged in unfair methods of competition affecting Washington commerce by:

a) Prior to January 1, 2020, entering into noncompete covenants related to medical director services that were overbroad, unnecessarily restricted competition, and were not enforceable at common law;

b) After January 1, 2020, entering into noncompete covenants related to medical director services that were void and unenforceable under RCW 49.62.030. These agreements were also overbroad, unnecessarily restricted competition, and were not enforceable at common law.

131. Second, Fresenius also engaged in unfair or deceptive acts or practices affecting Washington consumers, including dialysis patients and nephrologists, and in violation of RCW 19.86.020 by:

a) Prior to January 1, 2020, entering into noncompete covenants in its contracts related to medical director services that violated public policy as established by common law and that caused substantial injury to Washington consumers;

b) Prior to January 1, 2020, misrepresenting, directly or indirectly, expressly, by implication, or by omission the enforceability of the noncompete covenants in its contracts related to medical director services;

c) After January 1, 2020, entering into noncompete covenants in its contracts related to medical director services that violated public policy as established by RCW 49.62.030 and that caused substantial injury to Washington consumers;

d) After January 1, 2020, misrepresenting, directly or indirectly, expressly, by implication, or by omission the enforceability of the noncompete covenants in its contracts related to medical director services, in violation of public policy as established by RCW 49.62.030; and

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e) Other unfair acts or deceptive representations or omissions as set forth in the preceding paragraphs.

132. Fresenius's conduct as described herein occurred in trade or commerce within the meaning of the Consumer Protection Act, RCW 19.86.010(2), directly or indirectly affecting the people of the State of Washington.

133. Fresenius's unfair methods of competition and unfair or deceptive acts or practices affected the public interest in that they impacted numerous Washington consumers.

134. Based on the above unfair methods of competition and unfair or deceptive acts or practices, the State is entitled to relief under the Consumer Protection Act including injunctive relief pursuant to RCW 19.86.080, civil penalties pursuant to RCW 19.86.140 for each and every violation of RCW 19.86.020, and reimbursement of the costs of this action, including reasonable attorneys' fees, pursuant to RCW 19.86.080

VII. PRAYER FOR RELIEF

The State requests that the Court:

1. Enter judgment in favor of the State and against the Defendants;

2. Adjudge and decree that the Defendants engaged in the conduct alleged in this Complaint;

3. Find that Defendants' noncompete covenants entered into or extended through amendment after January 1, 2020, with a medical director or other physician (through a joinder agreement) paid less than $317,147 annually, are void and unenforceable under the NCA;

4. Declare that Defendants' noncompete covenants in effect are unenforceable and are voided with respect to all current and former medical directors and joinder physicians who signed a joinder agreement;

5. Require Defendants to provide notice to all current and former medical directors and physicians who signed a joinder agreement that the noncompete covenants in their medical director agreements are unenforceable and are voided;

6. Award civil penalties against each Defendant for each violation of RCW 19.86.020 for the maximum amount of $7,500 per violation;

7. Award an appropriate amount of costs, expenses, and attorneys' fees pursuant to RCW 49.62.080 and RCW 19.86.080; and

8. Award such other relief as the Court may deem just and proper.

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DATED this 9th day of November, 2026

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