August 20, 2019

CERTIFIED MAIL # 7016 3010 0001 0575 0105

Kerry Shannon, SVP Strategy and Business Development
Virginia Mason Medical Center
1100 Ninth Avenue
MS: GB ADM
Seattle, Washington 98101

RE: CN Application #19-18

Dear Ms. Shannon

We have completed review of the Certificate of Need application submitted by Virginia Mason Medical Center. The application proposes the approval of a 5-bed level II intermediate care nursery (ICN) located in Seattle, within King County. Enclosed is a written evaluation of the application.

For the reasons stated in this evaluation, the application submitted by Virginia Mason Medical Center proposing to establish a level II ICN in Seattle, within King County, is consistent with applicable criteria of the Certificate of Need Program, provided Virginia Mason Medical Center agrees to the following in its entirety.

**Project Description**

This certificate approves the establishment of a 5-bed level II intermediate care nursery at Virginia Mason Medical Center located in Seattle. The 5 level II intermediate care nursery beds are to come from Virginia Mason’s existing licensed capacity. Below is the configuration of acute care beds at completion of this project.

<table>
<thead>
<tr>
<th>Services Provided</th>
<th>Bed Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medical Surgical</td>
<td>313</td>
</tr>
<tr>
<td>Intermediate Care Nursery - Level II</td>
<td>5</td>
</tr>
<tr>
<td>PPS Exempt Rehabilitation</td>
<td>18</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>336</strong></td>
</tr>
</tbody>
</table>

**Conditions**

1. Approval of the project description as stated above. Virginia Mason Medical Center further agrees that any change to the project as described in the project description is a new project that requires a new Certificate of Need.
2. Virginia Mason Medical Center shall finance the project as described in the application.
3. Virginia Mason Medical Center will provide charity care in compliance with its charity care policies reviewed and approved by the Department of Health, or any subsequent
policies reviewed and approved by the Department of Health. Virginia Mason Medical Center will use reasonable efforts to provide charity care in an amount comparable to or exceeding the average amount of charity care provided by hospitals in the King County Region (less Harborview). Currently, this amount is 0.86% gross revenue and 1.88% of adjusted revenue. Virginia Mason Medical Center will maintain records of charity care applications received and the dollar amount of charity care discounts granted. The department requires these records to be available upon request.

4. Prior to completion of the project, Virginia Mason Medical Center will provide a signed agreement with an appropriate hospital for transfer of patients requiring Level III or higher neonatal intensive care services.

5. Prior to completion of the project, Virginia Mason Medical Center will provide the names and professional license numbers for key staff for the intermediate care nursery

6. Prior to completion, Virginia Mason Medical Center will provide an executed Memorandum of Agreement for Department Director consistent with the draft provided in the applicant’s January 11, 2019, screening responses.

Approved Costs
The approved capital expenditure is $3,282,500.

Please notify the Department of Health within 20 days of the date of this letter whether you accept the above project description, conditions, and capital costs for your project. If you accept these in their entirety, your application will be approved and a Certificate of Need sent to you.

If you reject any of the above provisions, your application will be denied. The department will send you a letter denying your application and provide you information about your appeal rights.

Send your written response to the Certificate of Need Program, at one of the following addresses.

Mailing Address:          Physical Address:
Department of Health      Department of Health
Certificate of Need Program  Certificate of Need Program
Mail Stop 47852           111 Israel Road SE
Olympia, WA 98504-7852     Tumwater, WA 98501

If you have any questions, or would like to arrange for a meeting to discuss our decision, please contact the Certificate of Need Program at (360) 236-2955.

Sincerely,

[Signature]
Nancy Tyson, Executive Director
Health Facilities and Certificate of Need

Enclosure
EVALUATION DATED AUGUST 20, 2019, FOR THE CERTIFICATE OF NEED APPLICATION SUBMITTED BY VIRGINIA MASON MEDICAL CENTER PROPOSING TO ESTABLISH A 5 BED LEVEL II INTERMEDIATE CARE NURSERY AT VIRGINIA MASON MEDICAL CENTER IN SEATTLE, WITHIN KING COUNTY

APPLICANT DESCRIPTION
Virginia Mason Health System (Virginia Mason) is a not-for-profit entity and the parent company of Virginia Mason Medical Center. In Washington State, Virginia Mason is an integrated health care organization, which includes a physician group practice, two hospitals, several regional clinics, a skilled nursing facility, and a research institute. For this project, Virginia Mason is the applicant.

In Washington State, Virginia Mason operates a variety of healthcare facilities. Below is a listing of the two hospitals, two skilled nursing facilities, hospice, and four ambulatory surgery centers owned or operated by Virginia Mason in Washington State. [source: CN historical files]

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Ambulatory Surgery Centers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virginia Mason Medical Center, Seattle</td>
<td>Virginia Mason Bellevue</td>
</tr>
<tr>
<td>Virginia Mason Memorial Hospital, Yakima</td>
<td>Virginia Mason Federal Way Regional Medical Center</td>
</tr>
<tr>
<td>Skilled Nursing Facilities</td>
<td>Virginia Mason Issaquah Medical Center</td>
</tr>
<tr>
<td>Bailey Boushay House, Seattle</td>
<td>Virginia Mason Lynnwood Regional Medical Center</td>
</tr>
<tr>
<td>Garden Village, Yakima</td>
<td></td>
</tr>
</tbody>
</table>

_Hospice/Hospice Care Center_  
Memorial Home Care

PROJECT DESCRIPTION
This project focuses on Virginia Mason Medical Center (VMMC) located in Seattle. The hospital has been in operation for many years and provides a variety of healthcare services to the residents of King County and surrounding communities. As of the writing of this evaluation, VMMC is licensed for a total of 336 beds located at 925 Seneca Street in Seattle [98101]. [source: CN historical files]

This project proposes to add level II intermediate care nursery and obstetric service to VMMC. Washington Administrative Code (WAC) 246-310-020(1)(d)(i)(D) defines level II intermediate care services below.

“Intermediate care nursery and/or obstetric services level II. Intermediate care nursery is defined in chapter 246-318 WAC. A level II obstetric service is in an area designed, organized, equipped, and staffed to provide a full range of maternal and neonatal services for uncomplicated patients and for the majority of complicated obstetrical problems.”

VMMC would use five of its 336 licensed beds for this service. In this evaluation, the department will refer to the services as a “level II ICN.”

The total estimated capital expenditure associated with the five ICN beds is $3,282,500. Of that amount, approximately 38% is related to construction; 36% is related to both fixed and moveable equipment, and the remaining 26% is for sales tax and fees (consulting, architect, and engineering). [source: Application, p31]

If approved, the five ICN beds would be operational in July 2020. This timeline is based on Virginia Mason’s estimation that this evaluation would be released in April 2019. Given the delay of this evaluation, the estimated operational date could change. [source: January 11, 2019, screening response, p4]
APPLICABILITY OF CERTIFICATE OF NEED LAW
Virginia Mason’s application is subject to Certificate of Need review as the establishment of a new tertiary service under the provisions of Revised Code of Washington (RCW) 70.38.105(4)(f) and Washington Administrative Code (WAC) 246-310-020(1)(d)(B).

EVALUATION CRITERIA
WAC 246-310-200(1)(a)-(d) identifies the four determinations that the department must make for each application. WAC 246-310-200(2) provides additional direction in how the department is to make its determinations. It states:

“Criteria contained in this section and in WAC 246-310-210, 246-310-220, 246-310-230, and 246-310-240 shall be used by the department in making the required determinations.

(a) In the use of criteria for making the required determinations, the department shall consider:

(i) The consistency of the proposed project with service or facility standards contained in this chapter;

(ii) In the event the standards contained in this chapter do not address in sufficient detail for a required determination the services or facilities for health services proposed, the department may consider standards not in conflict with those standards in accordance with subsection (2)(b) of this section; and

(iii) The relationship of the proposed project to the long-range plan (if any) of the person proposing the project.”

In the event WAC 246-310 does not contain service or facility standards in sufficient detail to make the required determinations, WAC 246-310-200(2)(b) identifies the types of standards the department may consider in making its required determinations. Specifically WAC 246-310-200(2)(b) states:

“The department may consider any of the following in its use of criteria for making the required determinations:

(i) Nationally recognized standards from professional organizations;

(ii) Standards developed by professional organizations in Washington State;

(iii) Federal Medicare and Medicaid certification requirements;

(iv) State licensing requirements;

(v) Applicable standards developed by other individuals, groups, or organizations with recognized expertise related to a proposed undertaking; and

(vi) The written findings and recommendations of individuals, groups, or organizations with recognized expertise related to a proposed undertaking, with whom the department consults during the review of an application.”

To obtain Certificate of Need approval, the applicant must demonstrate compliance with the criteria found in WAC 246-310-210 (need); 246-310-220 (financial feasibility); 246-310-230 (structure and process of care); 246-310-240 (cost containment). Where applicable, meeting the February 2013 Perinatal Level of Care Guidelines established by the Washington State Perinatal Advisory Committee assists in demonstrating compliance with the criteria.

TYPE OF REVIEW
This application was reviewed under the regular review timeline outlined in WAC 246-310-160, which is summarized on the following page.
### APPLICATION CHRONOLOGY

<table>
<thead>
<tr>
<th>Action</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Letter of Intent Submitted</td>
<td>September 17, 2018</td>
</tr>
<tr>
<td>Application Submitted</td>
<td>October 18, 2018</td>
</tr>
<tr>
<td><strong>Department’s pre-review activities</strong></td>
<td></td>
</tr>
<tr>
<td>• DOH 1st Screening Letter</td>
<td>November 15, 2018</td>
</tr>
<tr>
<td>• Applicant's Responses Received</td>
<td>January 11, 2019</td>
</tr>
<tr>
<td><strong>Beginning of Review</strong></td>
<td>January 18, 2019</td>
</tr>
<tr>
<td><strong>End of Public Comment/No Public Hearing Conducted</strong></td>
<td>February 22, 2019</td>
</tr>
<tr>
<td>• Public comments accepted through end of public comment</td>
<td></td>
</tr>
<tr>
<td><strong>Rebuttal Comments Received</strong></td>
<td>March 15, 2019</td>
</tr>
<tr>
<td><strong>Department's Anticipated Decision Date</strong></td>
<td>April 22, 2019</td>
</tr>
<tr>
<td><strong>Department’s Anticipated Decision Date with 120-day Extension</strong></td>
<td>August 22, 2019</td>
</tr>
<tr>
<td><strong>Department's Actual Decision Date</strong></td>
<td>August 20, 2019</td>
</tr>
</tbody>
</table>

### AFFECTED PERSONS

Washington Administrative Code 246-310-010(2) defines “affected person” as:
“...an “interested person” who:

(a) Is located or resides in the applicant's health service area;
(b) Testified at a public hearing or submitted written evidence; and
(c) Requested in writing to be informed of the department's decision.”

WAC 246-310-010(2) requires an affected person to first meet the definition of an ‘interested person.’ WAC 246-310-010(34) defines “interested person” as:

(a) The applicant;
(b) Health care facilities and health maintenance organizations providing services similar to the services under review and located in the health service area;
(c) Third-party payers reimbursing health care facilities in the health service area;
(d) Any agency establishing rates for health care facilities and health maintenance organizations in the health service area where the proposed project is to be located;
(e) Health care facilities and health maintenance organizations which, in the twelve months prior to receipt of the application, have submitted a letter of intent to provide similar services in the same planning area;
(f) Any person residing within the geographic area to be served by the applicant; and
(g) Any person regularly using health care facilities within the geographic area to be served by the applicant.

During the review of this project, five persons or health care providers sought interested person status. A brief description of each is below.

**MultiCare Health System**

MultiCare Health System is a not-for-profit health care organization that owns and operates five hospitals in King and Pierce counties. All five hospitals provide a variety of healthcare services to residents of King and Pierce counties and surrounding communities. MultiCare Health System also owns and operates a variety of healthcare clinics located in King, Kitsap, Pierce, Snohomish, and Thurston counties. [source: MultiCare Health System website] MultiCare Health System did not provide public comment on this project and does not qualify as an affected person.
Providence St. Joseph Health
Providence Health & Services Washington submitted a request for interested and affected person status for this application. In Washington State, Providence Health & Services operates a variety of healthcare facilities, including Swedish Medical Center – First Hill, Swedish – Cherry Hill, and Swedish - Issaquah, within King County. Providence Health & Services did not provide public comment on this project. As a result, Providence Health & Services does not qualify as an affected person for this project.

Providence Regional Medical Center – Everett
Providence Regional Medical Center – Everett is a subsidiary of Providence St. Joseph Health located in Everett, in Snohomish County. Providence Regional Medical Center – Everett did not provide public comment on this project and does not qualify as an affected person.

Swedish Health Services
Swedish Health Services is a subsidiary of Providence Health & Services. Swedish Health Services operates a variety of healthcare facilities in King County, including Swedish Medical Center – First Hill, which operates both a level II ICN and level III and IV neonatal intensive care unit (NICU) in the Central King planning area. Swedish Health Services provided written comments on this project. Swedish Health Services meets the affected person qualifications identified above.

Seattle Children’s Hospital
Seattle Children’s Hospital is a not-for-profit organization that operates a hospital and several clinics in King and neighboring counties. [source: Seattle Children’s website] Seattle Children’s requested interested person status. As a healthcare facility providing similar services in the health service area, Seattle Children’s meets the definition of an ‘interested person,’ but did not provide written comments on this project. Seattle Children’s does not meet the definition of an affected person for this project.

SOURCE INFORMATION REVIEWED
• Virginia Mason Medical Center’s Certificate of Need application received October 18, 2018
• Virginia Mason Medical Center’s screening responses received January 11, 2019
• Public comments received from community members by the close of business on February 22, 2019
• Virginia Mason Medical Center public comment received on February 15 and February 21, 2019
• Washington State Health Care Authority public comment received on February 14, 2019
• CHI Franciscan Health public comment received on February 21, 2019
• Premera Blue Cross public comment received February 20, 2019
• Regence public comment received February 21, 2019
• Swedish Health Services public comment received February 22, 2019
• Virginia Mason Medical Center’s rebuttal documents received March 18, 2019
• Department of Health’s Hospital and Patient Data Systems’ Comprehensive Hospital Abstract Reporting System data for years 2013 through 2017
• Hospital/Finance and Charity Care (HFCC) Financial Review dated August 1, 2019
• Department of Health Integrated Licensing and Regulatory System database [ILRS]
• Licensing and/or survey data provided by the Department of Health’s Office of Health Systems Oversight
• Licensing data provided by the Medical Quality Assurance Commission, Nursing Quality Assurance Commission, and Health Systems Quality Assurance Office of Customer Service
• Washington State Perinatal and Neonatal Level of Care 2018 Guidelines
• Virginia Mason’s website at virginiamason.org
• CHI Franciscan Health System’s website at www.chifranciscan.org
CONCLUSIONS
For the reasons stated in this evaluation, the application submitted by Virginia Mason Health System proposing to establish a 5-bed level II intermediate care nursery at Virginia Mason Medical Center is consistent with applicable review criteria of the Certificate of Need Program, provided that Virginia Mason Health System agrees to the following in its entirety.

Project Description
This certificate approves the establishment of a 5-bed level II intermediate care nursery at Virginia Mason Medical Center located in Seattle. The 5 level II intermediate care nursery beds are to come from Virginia Mason’s existing licensed capacity. Below is the configuration of acute care beds at completion of this project.

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4. Prior to completion of the project, Virginia Mason Medical Center will provide a signed agreement with an appropriate hospital for transfer of patients requiring Level III or higher neonatal intensive care services.
5. Prior to completion of the project, Virginia Mason Medical Center will provide the names and professional license numbers for key staff for the intermediate care nursery.
6. Prior to completion, Virginia Mason Medical Center will provide an executed Memorandum of Agreement for Department Director consistent with the draft provided in the applicant’s January 11, 2019, screening responses.

Approved Costs:
The total estimated capital expenditure associated this project is $3,282,500.
CRITERIA DETERMINATIONS

A. Need (WAC 246-310-210)

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department determines that Virginia Mason met the applicable need criteria in WAC 246-310-210.

(1) The population served or to be served has need for the project and other services and facilities of the type proposed are not or will not be sufficiently available or accessible to meet that need.

WAC 246-310-020 states (in summary) that a level II obstetric service is to be in an area designed, organized, equipped, and staffed to provide a full range of maternal and neonatal services for uncomplicated patients and for the majority of complicated obstetrical problems. WAC 246-310 does not contain an ICN need methodology. As a result, the evaluation of the need criterion for ICN projects begins with an evaluation of the methodology provided by the applicant.

Virginia Mason

Virginia Mason provided a three step numeric need methodology for its level II bed addition. The methodology is restated below. [source: application, pp-29]

"To estimate planning area Level II nursery bed need, Virginia Mason employed a three-step methodology that parallels the methodology used by other applicants requesting Level II bed expansions as well as by the CN Program in its evaluation of these applications.

"The planning area for Virginia Mason’s Level II NICU is defined as Central King. In Step 1, ten years of historical Level II resident patient days were identified and a use rate, based on the female population age 15-44, was calculated.

Applicant’s Numeric Methodology

**STEP 1: Identify 10-Year Historic Planning Area Resident Days and Use Rate**

<table>
<thead>
<tr>
<th>Year</th>
<th>Level II Patient Days</th>
<th>Females 15-44 (pop.)</th>
<th>Use Rate per 1,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level II Patient Days</td>
<td>3,956</td>
<td>3,858</td>
<td>3,926</td>
</tr>
<tr>
<td>Females 15-44 (pop.)</td>
<td>68,939</td>
<td>69,470</td>
<td>70,005</td>
</tr>
<tr>
<td>Use Rate per 1,000 Population</td>
<td>57.38</td>
<td>55.53</td>
<td>56.08</td>
</tr>
</tbody>
</table>

Source: CHARS for Level II Patient Days (defined as DRGs 791-794), Population: 2017 Claritas Estimates

"In Step 2, Virginia Mason calculated a market share of planning area resident days and in-migration based on actual 2017 experience.

**STEP 2: Calculate Planning Area Provider Level II Patient Origin, In-migration Ratio, and Market Share**

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Level II Central King Planning Area Resident Days</td>
<td>4,912</td>
</tr>
<tr>
<td>Total Planning Provider Days from Planning Area Residents</td>
<td>3,208</td>
</tr>
<tr>
<td>Planning Area Providers’ Market Share</td>
<td>65.3%</td>
</tr>
<tr>
<td>Total Level II Patient Days to Planning Area Providers</td>
<td>13,838</td>
</tr>
<tr>
<td>Level II Patient Days to Planning Area Providers Generated from Outside the Planning Area</td>
<td>10,630</td>
</tr>
<tr>
<td>In-migration Ratio</td>
<td>3.314</td>
</tr>
</tbody>
</table>

Source: Source: CHARS for Level II Patient Days (defined as DRGs 791-794)
“In Step 3, Level II days generated by Planning Area residents for the period of 2018-2024 were calculated using the use rate established in Step 1.

“The days were then adjusted to account for market share and in-migration as well as estimated patient days at Swedish/Ballard. Consistent with previous applications, Virginia Mason used a targeted provider occupancy of 65% and subtracted existing beds. The net bed need is 13 beds in 2017; fully supporting the five beds requested in this application.”

**STEP 3: Projected Need for Central King Providers (at Current Market Share and In-Migration)**

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>2024</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Resident Patient Days</strong></td>
<td>5,018</td>
<td>5,016</td>
<td>5,014</td>
<td>5,012</td>
<td>5,011</td>
<td>5,009</td>
<td>5,007</td>
</tr>
<tr>
<td><strong>Planning Area Providers’ Market Share</strong></td>
<td>65.3%</td>
<td>65.3%</td>
<td>65.3%</td>
<td>65.3%</td>
<td>65.3%</td>
<td>65.3%</td>
<td>65.3%</td>
</tr>
<tr>
<td><strong>Estimated Days from Planning Area Residents</strong></td>
<td>3,277</td>
<td>3,275</td>
<td>3,274</td>
<td>3,273</td>
<td>3,272</td>
<td>3,271</td>
<td>3,270</td>
</tr>
<tr>
<td><strong>Out of Area Days to Planning Area Providers</strong></td>
<td>10,859</td>
<td>10,855</td>
<td>10,851</td>
<td>10,846</td>
<td>10,844</td>
<td>10,840</td>
<td>10,835</td>
</tr>
<tr>
<td><strong>Estimated Total Days including In-migration</strong></td>
<td>14,136</td>
<td>14,130</td>
<td>14,125</td>
<td>14,119</td>
<td>14,116</td>
<td>14,111</td>
<td>14,105</td>
</tr>
<tr>
<td><strong>ADC</strong></td>
<td>38.7</td>
<td>38.7</td>
<td>38.7</td>
<td>38.7</td>
<td>38.7</td>
<td>38.7</td>
<td>38.6</td>
</tr>
<tr>
<td><strong>Occupancy</strong></td>
<td>65%</td>
<td>65%</td>
<td>65%</td>
<td>65%</td>
<td>65%</td>
<td>65%</td>
<td>65%</td>
</tr>
<tr>
<td><strong>Gross Bed Need</strong></td>
<td>59.5</td>
<td>59.5</td>
<td>59.5</td>
<td>59.5</td>
<td>59.5</td>
<td>59.5</td>
<td>59.5</td>
</tr>
<tr>
<td><strong>Bed Supply</strong></td>
<td>46</td>
<td>46</td>
<td>46</td>
<td>46</td>
<td>46</td>
<td>46</td>
<td>46</td>
</tr>
<tr>
<td><strong>Net Bed Need</strong></td>
<td>13.6</td>
<td>13.6</td>
<td>13.5</td>
<td>13.5</td>
<td>13.5</td>
<td>13.5</td>
<td>13.5</td>
</tr>
</tbody>
</table>

*Source: Applicant*

**Public Comments**

During the review of this project, Swedish Health Services provided comments related to the planning area used in the numeric methodology provided by Virginia Mason. Swedish Health Services’ comments are below. [source: February 21, 2019, public comment]

**Birth Rate**

“On page 5 of their application, VM states that only 16% of their patients have historically resided in the Central King planning area. They appropriately identify the rest of King County as their secondary service area. As outlined on their web site (www.virginiamason.org), VM indeed has the majority of their primary care clinics located outside of the Central King planning area in the following locations: Bainbridge Island, Bellevue, Edmonds, Federal Way, Issaquah, Kirkland, Lynnwood, and University Village.
Although 84% of VM’s patients reside outside of the Central King planning area, in their application, they utilize a derived birth rate for Central King versus the actual documented birth rate of King County as a whole. According to the health statistics reports on the Department of Health web site (www.doh.wa.gov), the birth rates for King County have been:

<table>
<thead>
<tr>
<th>Year</th>
<th>Birth Rate/1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>12.4</td>
</tr>
<tr>
<td>2015</td>
<td>12.4</td>
</tr>
<tr>
<td>2014</td>
<td>12.6</td>
</tr>
<tr>
<td>2013</td>
<td>12.6</td>
</tr>
<tr>
<td>2012</td>
<td>12.8</td>
</tr>
<tr>
<td>2011</td>
<td>12.7</td>
</tr>
<tr>
<td>2010</td>
<td>12.7</td>
</tr>
</tbody>
</table>

As is clear in this data, the actual birth rate in King County as a whole is decreasing, not increasing. As a result, given their patient origin, VM should not assume a higher birth rate than that of King County (12.4/1,000) in their forecast methodology otherwise their projections will be inflated.

**LOS and Volume**

Table 3 on page 9 of the VM application outlines the following projections for their level II admissions and patient days.

<table>
<thead>
<tr>
<th>Virginia Mason Level II Nursery Admissions and Patient Days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Year 1-Partial Year (2020)</td>
</tr>
<tr>
<td>----------------------------</td>
</tr>
<tr>
<td>Level II Admissions(^5)</td>
</tr>
<tr>
<td>Level II Patient Days(^6)</td>
</tr>
</tbody>
</table>

Source: Applicant

\(^5\) Washington State Perinatal and Neonatal Level of Care (LOC) Guidelines, March 2018

\(^6\) Nursery admissions represent 28% of the total deliveries within the obstetrics program.

\(^7\) Assumes actual 2017 CHARS Length of Stay in King County (2017) of 4.5 days.
“Table 13 on page 29 of the application provides further details related to the projected admissions and patient days:

<table>
<thead>
<tr>
<th>Table 13</th>
<th>Virginia Mason Level II Nursery Admissions and Patient Days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year 1 (2020)</td>
</tr>
<tr>
<td>Projected OB Discharges</td>
<td>500</td>
</tr>
<tr>
<td>Admissions @ 28% of OB discharges</td>
<td>140</td>
</tr>
<tr>
<td>Patient Days @ 4.5 days per admission</td>
<td>630</td>
</tr>
<tr>
<td>ADC</td>
<td>1.7</td>
</tr>
<tr>
<td>Occupancy on 5 beds</td>
<td>34.5%</td>
</tr>
</tbody>
</table>

Source: Applicant

“We believe that the data represented in the above tables have some critical errors. First, in our extensive experience, 28% of OB discharges is a very high projection for babies requiring level II care. The Swedish experience in 2018 at our four campuses where delivery services were provided was:

- Swedish Edmonds had a 16% Level II admission rate
- Swedish Issaquah had a 12.4% Level II admission rate
- Swedish First Hill, had an admission rate of 25% when Level III and IV babies were included, but only 12.6% if we limit the data to only Level II admits
- Swedish Ballard had a 15% Level II admission rate, which included all patients requiring that level of care from the Addiction Recovery Service.

“Second, the VM projections are overstated since, as outlined in footnote 9 on page 18 of their application, they are using DRG’s 791 -794 to form their projection. In our experience this is an inaccurate definition to utilize to project Level II volume, since DRG 794 encompasses a large number of neonates who would be appropriately cared for in a postpartum environment. As an example, DRG 794 is assigned to babies who are delivered by cesarean section, those who are multiples, and those with a risk of chorioamnionitis necessitating observation but not treatment. By including DRG 794, the projected admissions, patient days and therefore ADC in the VM application are overstated.

“If we assume that VM would have a more common number of Level II admissions at 15% of OB discharges, equal to that of Swedish Ballard in 2018, their projected number of Level II admissions, patient days and ADC would actually be at the levels outlined in yellow in the table below:
Utilizing the more realistic projections, the resulting Level II ADC for VM would only be 0.3-0.9 in the first 2 years and these levels are only achieved if VM is able to attain their aggressive delivery volumes. At these low census levels, it would be reasonable to expect quality concerns. As noted in WA DOH Perinatal Guidelines included on page 60 of the VM application, level II facilities caring for babies greater than 34 weeks and 2000g should maintain an ADC of at least 1-2 level II patients. Those caring for babies greater than 32 weeks and 1500g should maintain an ADC of 2-4. Nursing and provider competency is difficult to maintain in low ADC environments.

The delivery volumes projected by VM are also unrealistic as is their anticipated growth rate in their delivery volumes. As outlined above, VM gets the majority of its patients from King County where the birth rates are decreasing. The 40-70% growth rates assumed by VM in their application are not realistic in a market with several established providers and where birth rates are declining. It is also not realistic for VM to assume that their patients from East, North and South King County will drive to VM’s Seattle hospital for delivery when they have great delivery providers closer to home which have been well established for many years such as those at the University of Washington including their locations at UW, Northwest Hospital and Valley, the Swedish locations at First Hill, Edmonds and Issaquah, as well as the robust delivery programs at Highline, Evergreen and Overlake. The delivery volumes for these established programs were provided on page 18 of the VM application.

Given the low ADC of 0.3 to 2.2 projected above, if VM does not achieve their aggressive delivery rates - over 850 deliveries/year, they would never achieve the ADC needed to meet the WA DOH Perinatal Guidelines. Therefore, approving this new program is not in the best interest of the residents of King County when there are numerous other facilities meeting these guidelines that have a strong history of serving VM patients. If VM is able to re-open their program, their volumes would directly impact the volumes these established facilities which have supported the needs of VM’s patients for the many years following their program closure in the 1990’s.

**Swedish Capacity**

“On page 25 of their application, VM makes numerous assumptions related to the Level II capacity of Swedish First Hill and Ballard. The actual volumes of Swedish are as follows:

- Swedish bed capacity in 2018 for FH/Ballard was 84. Of those beds, 30 were designated level IV. The additional 54 were level II, but all were used flexibly.
- In 2018, the total number of NICU patient days for Swedish FH/Ballard was 20,070. This resulted in a total NICU ADC for Swedish FH/Ballard of 55. With a total NICU bed capacity of 84, Swedish FH/Ballard campuses were only running at 65.45% capacity for NICU patients in 2018.
Although Swedish FH/Ballard had plenty of NICU capacity in 2018, we continue to make changes to our program and care models that will continue to increase our capacity in the future. Two significant examples include:

- **Closure of Ballard Level II NICU** - the Swedish Ballard Level II NICU was closed in 2018. This was mainly due to low volumes; representing higher costs and difficulty with maintenance of staff competency. We were able to easily accommodate the Ballard volume at the First Hill campus as it exists today. Adding the Ballard Level II NICU volume to First Hill only increased our capacity from 64.45% to an average of 72%. This level of 72% more than accommodates for fluctuations in census resulting from seasonal volume trends.

- **Management of Neonatal Abstinence Syndrome (NAS)** - the historical length of stay for NICU patients with NAS at Swedish has been 19 days. We are currently working on care delivery model changes to introduce a more current and clinically validated eat, sleep, console model which we anticipate will reduce the average length of stay for this patient population to less than or equal to 6 days. In a recent pilot of this program at Providence Everett (PRMCE), they saw a reduction in length of stay from an average of 21 days to an average of 5.6. On average there are 9 babies with a NAS diagnosis at Swedish FH at any given time so implementing this new program will result in further capacity in the NICU at Swedish FH.

“Our information provided above the assertion by VM that Swedish First Hill is running a NICU occupancy rate of over 82% are unfounded. Swedish First Hill has plenty of capacity and will continue to have capacity to accommodate any future market growth in the Central King Planning Area.”

**Rebuttal Comments**

Virginia Mason provided the following rebuttal comments related to this sub-criterion. [source: Virginia Mason, March 8, 2019, rebuttal comments]

**1. Virginia Mason’s projections of Level II births are reasonable: they are based on actual CHARS data and consistent with past CN decisions.**

“Related to Need, Swedish suggests that 1) the appropriate planning area should be King County, not Central King, 2) that the birth rate is declining in King County, 3) and that the definition of Level II included in our CN application is erroneous, and that therefore, admissions and patient days are overstated.

**a) The Planning Area**

“As Swedish noted, Virginia Mason operates clinics throughout the County; and in fact, the majority of our tertiary hospital patients reside outside of Central King. When we held a technical assistance consultation with the CN Program prior to submitting the CN application, we were advised to use Central King as the planning area for this project. This is in accordance with prior Level II applications, including two applications submitted by Swedish. For example, in its 2011 CN application for the establishment of a Level II service at Swedish Issaquah, Swedish proposed East King (the hospital planning area in which its Issaquah hospital is located) as the planning area and for purposes of determining the use rate. In addition, and more recently, in its 2013 application for the establishment of an eight bed Level II service at Swedish Ballard, the planning area was defined as North King (the hospital planning area in which Swedish Ballard is located).

“In its evaluations on both of these projects, the CN Program concurred that the appropriate planning area for the Level II services was the Hospital Planning Area (East King or North King), not King in total. Specifically, the CN Program’s 2011 analysis stated:
“The number of females within the age cohort of 15-44 (childbearing age) were compiled from Claritas population data for the east King planning area for each year 2000-2009.

And in its 2013 analysis of the proposed Swedish Ballard Level II, the Program concluded:

The department concludes that numeric need for 8 level II ICN beds in the north King planning area is demonstrated. (Emphasis added.)

Given the CN Program’s past practice, and further based on the Program’s advice provided during the technical assistance meeting, Virginia Mason’s planning area of Central King is appropriate.

b) Swedish alludes that if a King County use rate were used, there would be no need. This is not accurate. While Virginia Mason appropriately calculated the use rate for Central King, if a correctly calculated King County use rate (the birth rate) was applied, the need would be greater, because the use rate is 20 percent higher.

Swedish suggests that the planning area should be the entirety of King County. We have demonstrated above that the correct planning area is Central King (this statement is supported by our rationale which was based on the majority of births originating from Central King). Swedish also states that the King County birth rate is declining.

“Virginia Mason cannot replicate Swedish’s birth rate calculations. The birth rate is typically calculated as births per one thousand women age 15-44 (women of childbearing age). Table 1 compares the population of females in Central King to total King and calculates a birth rate. When the birth rate is appropriately calculated, and as depicted in Table 1, the rate in the County is flat. However, because of the strong growth in the number of women of childbearing age, the actual number of births in King County increased by six percent (approximately 1,400 births) between 2010 and 2017.

**Applicant’s Table**

**Table 1**

<table>
<thead>
<tr>
<th>Area</th>
<th>Population</th>
<th>2010 Birth Rate</th>
<th>2017 Est. Birth Rate</th>
<th>% Change</th>
<th>% Change</th>
<th>Increase in No. of Births (2010-2017)</th>
<th>2022 Projection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central King County Females age 15-44</td>
<td>70,005</td>
<td>75,395</td>
<td>3,339</td>
<td>11.5%</td>
<td>3.5%</td>
<td>344</td>
<td>457,562</td>
</tr>
<tr>
<td>Births</td>
<td>2,995</td>
<td>42.78</td>
<td>44.29</td>
<td></td>
<td></td>
<td>344</td>
<td>NA</td>
</tr>
<tr>
<td>Total King County Females age 15-44</td>
<td>422,615</td>
<td>450,869</td>
<td>53.65</td>
<td>6.0%</td>
<td>-0.7%</td>
<td>1,367</td>
<td>NA</td>
</tr>
</tbody>
</table>


“As Table 1 indicates, in 2017 there were approximately 75,000 women of childbearing age (15-44) within Central King and a total of 450,000 in King County. In all of King County, the number of females ages 15-44 is projected to increase by 1.5 percent to 457,562 by 2022.

Contrary to Swedish’s public comment, birth rates in King County are not declining and the total number of births has increased.
c) DRG Definition of Level II and Percentage of Level II admissions of Total OB Deliveries

Definition of Level II
Swedish states that Virginia Mason used an incorrect definition of Level II but did not state the definition it used. Swedish neglects to acknowledge that the definition of Level II was “set” by the CN Program more than a decade ago and has been consistently used by the CN Program since that time.

Of particular interest is the fact that the 2011 CN application of Swedish to establish a 14-bed intermediate care nursery within space at its not yet operational Issaquah Hospital Campus and its 2013 CN to establish an eight-bed intermediate care nursery within space at the Ballard Hospital Campus each put forth the very same DRG definition that we propose in our current application. Specifically, the Swedish Issaquah application stated:

Thus, in order to provide a complete picture of Planning Area utilization and hospital market share, utilizations statistics for levels I, II and III have been included....

This analysis uses the Department's definition for level I (DRG 795), level II (DRGs 791-794) and level III (DRGs 789 and 790).

And, the Swedish Ballard Application stated:

This application relies upon the Department's definition for level I (DRG 795), level II (DRGs 791-794) and level III (DRG 789 and 790).

These definitions were also ‘accepted and approved’ by the CN Program in the evaluations of these applications. In the CN Program’s evaluation of the Swedish Issaquah Level II application, the CN Program wrote:

The majority of level II patients are included in DRGs 791, 792, 793, and 794. Both applicants used data from DRGs 791, 792, 793, and 794 for level II calculations.

In the Swedish Ballard application, the CN Program stated:

The majority of level II patients are included in DRGs 791, 792, 793, and 794.

SHS used data from DRGs 791, 792, 793, and 794 for its Level II calculations and focused on a ‘north king’ planning area.

Percentage of Total Births that Result in a Level II Admission:

Swedish also states, and once again with no data that is available to either Virginia Mason or the CN Program, that we overstated the percentage of neonates that require Level II care. As noted on page 29 of our application, we assumed that 28 percent of the OB deliveries would be Level II and that this was ‘consistent with actual King County experience’. Table 2 provides additional data, for King County. As Table 2 indicates, the actual 2016 and 2017 data suggests, that under the definition of DRGs 791 to 794, the percent of neonates meeting a Level II definition averaged nearly 36 percent over the 2016-2017 timeframe.
Given the above, and the lack of challenge to our projected ALOS, Virginia Mason’s projected admissions and patient days are both reasonable and achievable.”

**Department’s Evaluation**

Level II intermediate care nursery services are considered tertiary services as defined by WAC 246-310-010. For some tertiary services, such as open heart surgery, the department uses an established methodology to assist in its evaluation of need for the services. For other tertiary services, including level II services, no such methodology exists. Given that the department has not developed an established methodology for level II services, an evaluation of the need criterion begins with an evaluation of the methodology provided by the applicant.

Virginia Mason’s need methodology is based on three main factors:

- planning area and use rate;
- patient origin, in-migration ratio, and market share; and
- current capacity.

A more extensive discussion of each factor used by Virginia Mason is below.

**Planning Area**

Virginia Mason used Central King County as its designated planning area. Virginia Mason stated it used this planning area based on historical CN decisions, including projects proposed by Swedish (First Hill/Ballard and Issaquah) and Overlake Hospital Medical Center.

In public comment Swedish Health Services contended that Virginia Mason should have based its need projections on a use rate calculated for King County as a whole, not Central King, because 84% of VMMC’s patients reside outside of Central King.

To address this concern, the department reviewed similar applications reviewed by the program in the last ten years. That review included a range of application types – new Level II programs, new Level III or IV programs, and expansions of existing Level II and III programs. Among those reviews, the department has allowed applicants some flexibility in designating the appropriate planning areas for their particular applications. As level of service increases, the department allows wider geographic regions. For Level II-only applications, the department has generally relied on hospital planning areas that align with the planning areas used for acute care bed additions. For Level III and IV evaluations,
the department has allowed larger geographic planning areas. The department concludes that Virginia Mason’s use of the Central King planning area for establishment of a new Level II ICN program is consistent with standard practice and appropriate for this project.

Table 3 below shows the listing of Central King County zip codes used in the application.

<table>
<thead>
<tr>
<th>Zip</th>
<th>City</th>
<th>Zip</th>
<th>City</th>
<th>Zip</th>
<th>City</th>
</tr>
</thead>
<tbody>
<tr>
<td>98101</td>
<td>Seattle</td>
<td>98118</td>
<td>Seattle</td>
<td>98141</td>
<td>Seattle</td>
</tr>
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<td>98102</td>
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<tr>
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<td>Seattle</td>
<td>98139</td>
<td>Seattle</td>
<td>98199</td>
<td>Seattle</td>
</tr>
</tbody>
</table>

Population Projections
Virginia Mason based its population projections on females between the ages of 15-44 years of age residing in King County. Claritas population data was used because it is the most reliable population data that provides a breakdown of Washington Counties by zip code. For Central King County, Virginia Mason used the populations associated with the zip codes identified in Table 1. This approach is also reasonable.

Current Capacity
The applicant determined that there are 46 existing ICN level II beds operating in the planning area, all located at Swedish First Hill. Swedish asserted in its written comment, “Swedish bed capacity in 2018 for FH/Ballard was 84. Of those beds, 30 were designated level IV. The additional 54 were level II, but all were used flexibly.”

The department reviewed its available internal data. A 2018 ICN bed inventory noted a total of 54 Level II beds for the combined Swedish First Hill/Ballard license, with 46 located at First Hill and 8 at the Ballard location. Swedish stated in its comment that it has closed its Ballard ICN. No information was submitted showing the department had authorized relocation of those 8 beds to the First Hill campus. In addition, Swedish’s statement that its 30 Level IV and 46 level II ICN beds “…all were used flexibly” is confusing and potentially misleading. Swedish First Hill/Ballard’s Level III/IV NICU bed capacity is approved at 30, and Level II capacity is 46. While the Level III/IV beds may be used to treat lower acuity patients, the Level II beds may not be used for Level III and IV patients. The department can only conclude from this information that Virginia Mason reasonably estimated First Hill capacity at 46 Level II beds.

In summary, the department concludes that the three factors used in the applicant’s numeric methodology are reasonable.
Numeric Need Methodology
Using the three main factors above, Virginia Mason provided a numeric need methodology that is summarized in three steps:

- **In Step 1**, 10 years (2008 – 2017) of historical Level II ICN patient days were determined and a use rate, based on the female population age 15-44 was established.
- **In Step 2**, Virginia Mason calculated a market share of planning area resident days and in-migration based on actual 2017 experience.
- **In Step 3**, ICN days generated by Planning Area residents for the period of 2018-2024 were calculated using the use rate established in Step 1. The days were then adjusted to account for market share and in-migration. Virginia Mason used a targeted provider occupancy of 65% and subtracted the existing supply of 46 ICN beds.

Table 4 below is an excerpt from the third and final step of Virginia Mason’s numeric methodology. While the numeric methodology projected for years 2018 through 2024, only years 2020 through 2023 are shown below.

<table>
<thead>
<tr>
<th>Department’s Table 4</th>
<th>Virginia Mason Numeric Methodology Step Three</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year 2020</td>
</tr>
<tr>
<td>Total Resident Patient Days</td>
<td>5,014</td>
</tr>
<tr>
<td>Planning Area Provider Market Share</td>
<td>65.3%</td>
</tr>
<tr>
<td>Estimated Days from Planning Area Residents</td>
<td>3,274</td>
</tr>
<tr>
<td>Estimated Days Including In-migration</td>
<td>14,125</td>
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<tr>
<td>Average Daily Census</td>
<td>38.7</td>
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<tr>
<td>Occupancy</td>
<td>65%</td>
</tr>
<tr>
<td>Bed Need</td>
<td>59.5</td>
</tr>
<tr>
<td>Minus Current Supply</td>
<td>46</td>
</tr>
<tr>
<td><strong>Net Bed Need</strong></td>
<td><strong>13.5</strong></td>
</tr>
</tbody>
</table>

As shown in Table 4 above, Virginia Mason’s numeric methodology projected need for an additional 14 level II ICN beds in year 2020, which remains stable through the end of year 2023. The department notes that, given Swedish’s previously un-announced closure of the Ballard ICN, is it likely that the estimated patient days in Table 4 are understated. Virginia Mason is not seeking to fill the entire projected need. Based on its assumptions about in-migration and retention of patients currently served by Virginia Mason providers, facilities and affiliates, it is requesting only five Level II ICN beds. In previous evaluations for level II ICN services, the department has concluded that 65% occupancy is reasonable to allow for flexibility and to accommodate for peak usage of the ICN.

Based on the information above, the department concludes that the applicant’s methodology is reasonable and can be substantiated with the available data.

In addition to a demonstration of numeric need, the Virginia Mason and supporters of this project identified a strong preference for an additional provider of Level II ICN services in the planning area.

**Public Comment**
During the review of this project, the department received letters focusing on the desirability of the proposed level II ICN services at VMMC.
Susan E. Birch, MBA, BSN, RN, Director, Washington State Health Care Authority [source: February 14, 2019, public comment]

“The Washington State Health Care Authority (HCA) is committed to whole-person care, integrating physical health and behavioral health services for better results and healthier residents. HCA purchases health care for more than two million Washington residents through Washington Apple Health (Medicaid), the Public Employees Benefits Board (PEBB) program, and, beginning in 2020, the School Employees Benefits Board (SEBB) program. As the largest health care purchaser in the state, we lead the effort to transform health care, helping ensure Washington residents have access to better health and better care at a lower cost.

“I understand that Virginia Mason intends to establish a new obstetrics service at its Seattle hospital, and that prior to opening it must secure approval from the state's Certificate of Need Program for a Level II Special Care Nursery. This letter is written in support of Virginia Mason's Certificate of Need request. HCA is committed to offering high quality, low-cost maternity care to Washington residents through Apple Health. We are excited at the prospect of Virginia Mason offering maternity care services to Apple Health members, over 400,000 of which live in King County. We look forward to working with Virginia Mason along with other providers and hospitals to improve maternal and child outcomes as we decrease unnecessary C-sections and inductions. Our partners in these efforts include the Washington State Perinatal Advisory Committee, the Department of Health, the Department of Social and Health Services, the Dr. Robert Bree Collaborative, Washington State Hospital Associations Safe Deliveries Roadmap, and the Foundation for HealthCare Quality’s Obstetrical Clinical Outcomes Assessment program.

“A level II nursery is essential to providing timely care for neonates 32 weeks and older born with problems that are expected to resolve rapidly and generally without need for assisted ventilation. Using CHARs data, Virginia Mason's application showed that more than one of every four neonates born to a King County resident experiences some portion of their newborn stay in a Level II nursery. Opening a service where in more than 25 percent of neonates are transferred to another provider and the mother-newborn dyad if disrupted would fragment care, dissatisfy patients, and add significant costs to the health care delivery system. Virginia Mason is nationally recognized for transforming health care by designing care processes around patients, increasing quality, and reducing the cost of care. HCA would be pleased to have those we purchase care for have Virginia Mason’s obstetrics and level II service available and encourage the Department to approve their project.”

John Espinola, MD, MPH, Executive Vice President, Premera Blue Cross [source: February 19, 2019, public comment]

“Please accept this letter as Premera's support of Virginia Mason Medical Center's pending Certificate of Need application requesting approval to establish a Level II neonatal service. As the largest health plan in the Pacific Northwest, Premera works closely with Virginia Mason and offers several plans in conjunction with Virginia Mason including the Premera Personal Care Partner System. Enrollees in these plans choose a primary care provider from Virginia Mason but have to go outside of the Virginia Mason system for obstetrical and neonatal care. Being able to provide comprehensive, high quality and cost-effective services within a network of providers would be a huge benefit to our enrollees.

“The current c-section rate in Central King is about 30% and the early elective delivery rate is 1.1 %. Virginia Mason has indicated that its proposed new obstetrics unit and Level II will deliver care that exceeds these current levels by utilizing evidence-based care standards, educating providers and patients about the risks of unnecessary interventions and continuing its demonstrated commitment to the most appropriate and highest quality clinical care. The employers that select Premera and the patients that have deductibles and out of pocket costs will benefit by the addition of these services at Virginia Mason.”
John Partin, Vice President of Network Management, Regence BlueShield [source: February 5, 2019, public comment]

“Regence supports the Certificate of Need (CN) application submitted by Virginia Mason Medical Center proposing to establish a five-basinet Level II neonatal service. Regence takes seriously its responsibility for ensuring that our members have access to efficient providers that offer high quality outcomes at affordable prices, and to this end, we have enjoyed a long and very positive working relationship with Virginia Mason.

“For Regence members in general, and Central King County members in particular, there are currently a fairly limited number of options for obstetrical services. The proposed Level II service will support a new obstetrical/birth center that will increase access, provide options and enhance continuity of care for our members who choose to have their care provided by Virginia Mason.

“Virginia Mason consistently demonstrates and has been nationally recognized for delivering quality outcomes efficiently and cost effectively. With the rising cost of deductibles, coinsurances and other out of pocket expenses, Regence expects our members will benefit with the addition of this service to our network.”

Lloyd David, Chief Executive Officer, The Polyclinic [source: February 20, 2019, public comment]

“The Polyclinic is a multispecialty group with more than 240 physicians and advance practice clinicians and more than 240,000 patients in 17 Clinic locations throughout the Puget Sound. The Polyclinic is pleased to provide this letter in support of Virginia Mason's Certificate of Need application to establish a Level II Neonatal Program.

“As you are no doubt aware, one result of City of Seattle and King County land use and zoning changes, is that beginning in about 2005, there has, in fact, been strong growth in the population of females age 15-44 in Central King, and, as noted in the Virginia Mason CN application, a more than 20% increase in births. Additionally, the market has changed such that payers, purchasers and patients are actively seeking out proven quality, cost-effective alternatives. The Polyclinic obstetrics providers have been challenged, at times, when their usual site for obstetrics care is not available to their patients; due to changing network configurations.

“From the Polyclinic's perspective, it is important to have a selection of providers to ensure that we can meet our patients' needs. As a leader in both quality and patient experience in the region and State, the Polyclinic actively participates with purchasers, other providers, consumers, and payers in efforts to improve health care quality and costs. It is with this lens and with the interests of our patients and providers that we lend our full support.”

In addition to the letters of support from the payers and providers above, staff from Virginia Mason and CHI Franciscan also provided supporting comments related to this sub-criterion.

Ingrid Gerbino, MD, Chief of Primary Care, Virginia Mason Medical Center [source: February 11, 2019, public comment]

“As the Chief of the Department of Primary Care at Virginia Mason, I am very pleased to submit this letter of support for Virginia Mason's Certificate of Need application proposing the establishment of a five bed Level II Neonatal Service. The Level II is a necessary support service for the highly needed obstetrics program that Virginia Mason proposes to open in 2020.

“Virginia Mason has nearly 150 primary care providers (adult medicine, family medicine, pediatrics, behavioral health and specialized services) located in nine medical centers throughout the Puget Sound
region. Based on zip code and proximity to our hospital we estimate at least 300 current patients need obstetrical care annually and would choose to deliver at Virginia Mason Medical Center. I hear regularly from our providers about the dissatisfaction of patients who, once becoming pregnant, are transitioned to a provider outside of Virginia Mason. In addition to current patients, CHI Franciscan and Virginia Mason employees, the Puget Sound High Value Network (PSHVN) and the general community regularly express an interest in additional option for obstetrics and neonatal services in the Central King/downtown Seattle area. The Certificate of Need will provide this quality, accessible option.

“As described in the Certificate of Need application, the service will be licensed and operated by Virginia Mason and the day-to-day management of the service will be provided, under a services agreement, by CHI Franciscan, which performs more than 8,000 deliveries annually in its system and operates three Level II Special Care Nurseries as well as a Level III NICU. Our primary care providers are assured that this relationship will assure high quality, be standard of practice for the community and will enhance continuity of care and patient satisfaction.”

Michael Dudas, MD, Chief of Pediatrics, Virginia Mason Medical Center [source: February 6, 2019, public comment]

“Please accept this letter as my strong support of Virginia Mason's application for a Level II service. Since 2007, I have served as Chief of the Department of Pediatrics at Virginia Mason Medical Center. Prior to Virginia Mason, I served in a number of positions at Seattle Children's including President of the Medical Staff. Virginia Mason's plans to add obstetrical services has generated high interest and support from both patients and staff. There is widespread clinical consensus that a Level II Special Care Nursery is an essential component of an urban obstetrical program.

“Data produced by Washington State demonstrates that about 25% of all neonates born to King County mothers spend some portion of their newborn stay in a Level II nursery. Neonates admitted to a Level II are typically born at 32-34 weeks+ gestation and weigh 2,000 grams or more. They tend to be moderately-ill or have problems that are expected to resolve rapidly and generally without need for assisted ventilation. It would be a disservice to obstetrical patients if the new Virginia Mason program did not have the ability to provide Level II services. Transferring a newborn for Level II services disrupts the mother-newborn dyad, reduces patient satisfaction, delays care initiation, typically extends length of stay and adds costs. Virginia Mason is well qualified to offer this service, and the partnership between Virginia Mason and CHI Franciscan related to this service will assure even higher quality, more efficient care. Need has been demonstrated, and options will be improved. For these reasons, I urge your timely approval.”

Rebecca Okelo, RN, MBA, Program and Projects Director, Virginia Mason [source: February 19, 2019, public comment]

“I am a Program and Projects Director at Virginia Mason Medical Center, historically providing nursing care to patients in the intensive care unit, outpatient plastic and reconstructive surgery and now supporting Virginia Mason's population health and patient access initiatives. It is my understanding that Virginia Mason proposes to open a birthing center to provide obstetrics and nursery services in the First Hill neighborhood of Seattle. As a mother of two children and a third due in the next four weeks, I offer my support for the proposed Level II Special Care Nursery that is needed to offer an alternative to Virginia Mason employees and prospective mothers in the Seattle area.

“Having the option to deliver at Virginia Mason's proposed facility would allow our family to receive a fully integrated care experience including primary, maternity and pediatric care within the same system. In working at Virginia Mason for ten years now, I can attest to the proven quality, efficient care they provide for the entire Pacific Northwest community. Offering an additional option of providers in Seattle
is critical for current patients, employees and others throughout Seattle, and I urge your timely approval of Virginia Mason's proposed Level II nursery."

Jerry Anderson, MD, FACOG, Regional Medical Director – Gynecology/COEMIGS, CHI Franciscan Women’s & Children’s Services [source: February 4, 2019, public comment]

“I am a King County based Franciscan Medical Group board-certified obstetrician/ gynecologist providing comprehensive care for women including high-risk pregnancy care. I understand that Virginia Mason proposes to open a delivery service to provide additional access in downtown Seattle and I am pleased to offer my strong support for the proposed Level II Special Care Nursery that is needed to assure the delivery program provides the support services necessary to producing optimal outcomes.

“Many factors go into safely delivering healthy babies. While we are increasingly able to identify maternal and perinatal risk issues that are best managed by assuring the mother deliver in a tertiary or quaternary setting, many neonates are born at 32-34 weeks + gestation that are moderately-ill or have problems that are expected to resolve rapidly and generally without need for assisted ventilation. In fact, data provided in Virginia Mason’s application showed that more than one of every four neonates born to a King County resident experiences some portion of their newborn stay in a Level II nursery. Research demonstrates that high-quality care delivered close to home produces the best outcomes and the data also demonstrates that the clinical standard of care in the greater Puget Sound is for OB providers to operate a level II service. Opening a service wherein more than 25% of neonates are transferred to another provider and the mother-newborn dyad is disrupted would fragment care, dissatisfy patients and add significant costs to the health care delivery system.

“Virginia Mason is a proven quality, efficient provider. Having a selection of providers in Central King is beneficial, and I urge your timely approval of its proposed Level II nursery.”

Swedish Health Services provided the following information (also quoted on page 11), above.

Swedish Health Services

“Swedish Capacity

On page 25 of their application, VM makes numerous assumptions related to the Level II capacity of Swedish First Hill and Ballard. The actual volumes of Swedish are as follows:

- “Swedish bed capacity in 2018 for FH/Ballard was 84. Of those beds, 30 were designated level IV. The additional 54 were level II, but all were used flexibly.
- “In 2018, the total number of NICU patient days for Swedish FH/Ballard was 20,070. This resulted in a total NICU ADC for Swedish FH/Ballard of 55. With a total NICU bed capacity of 84, Swedish FH/Ballard campuses were only running at 65.45% capacity for NICU patients in 2018.

Although Swedish FH/Ballard had plenty of NICU capacity in 2018, we continue to make changes to our program and care models that will continue to increase our capacity in the future. Two significant examples include:

- Closure of Ballard Level II NICU - The Swedish Ballard Level II NICU was closed in 2018. This was mainly due to low volumes; representing higher costs and difficulty with maintenance of staff competency. We were able to easily accommodate the Ballard volume at the First Hill campus as it exists today. Adding the Ballard Level II NICU volume to First Hill only increased our capacity from 64.45% to an average of 72%. This level of 72% more than accommodates for fluctuations in census resulting from seasonal volume trends.
Management of Neonatal Abstinence Syndrome (NAS) - the historical length of stay for NICU patients with NAS at Swedish has been 19 days. We are currently working on care delivery model changes to introduce a more current and clinically validated eat, sleep, console model which we anticipate will reduce the average length of stay for this patient population to less than or equal to 6 days. In a recent pilot of this program at Providence Everett (PRMCE), they saw a reduction in length of stay from an average of 21 days to an average of 5.6. On average there are 9 babies with a NAS diagnosis at Swedish FH at any given time so implementing this new program will result in further capacity in the NICU at Swedish FH.

Per the information provided above the assertion by VM that Swedish First Hill is running a NICU occupancy rate of over 82% are unfounded. Swedish First Hill has plenty of capacity and will continue to have capacity to accommodate any future market growth in the Central King Planning Area.”

Rebuttal Comments
Virginia Mason provided the following rebuttal comments related to this sub-criterion. No other affected persons offered rebuttal comments. [source: Virginia Mason, March 8, 2019, rebuttal comments]

Virginia Mason
“The public record on our application contains a number of letters suggesting that there is a desire for expanding the number of obstetric and neonatal service providers in Central King...

Virginia Mason is well known in the state, nationally and internationally to be a low cost, high quality, cost-effective provider. In 2018, the Washington Health Alliance recognized Virginia Mason as one of only four hospitals in the state that were among the top ten in quality and patient experience while also having a gross charge index lower than the state average. Clearly, our state’s health care purchasers and insurers recognize the benefits to payers and patients that will result from the establishment of a Level II service at Virginia Mason”

Department Evaluation
Virginia Mason demonstrated that numeric need for additional level II ICN capacity is demonstrated in the planning area. Virginia Mason also demonstrated desire for additional providers in the planning area among entities that pay for childbirth services. Virginia Mason did not, however, provide convincing evidence that the services provided at Swedish First Hill are not sufficiently available or accessible to patients who need those services now or in the future.

Instead, Virginia Mason demonstrated that there is sufficient likelihood that an additional provider in an area with only one hospital providing ICN services would be well positioned to meet the needs of those planning area patients whose parents or physicians choose not to use the existing provider. The department further concludes that the strong preference for an additional provider, especially as voiced by physicians in the area and insurers, are evidence that the existing provider may not be sufficiently available and accessible to meet forecast need.

Based on the information provided in the application and in the public comment process, the department concludes that this sub-criterion is met.

(2) All residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly are likely to have adequate access to the proposed health service or services.
To evaluate this sub-criterion, the department evaluates an applicant’s admission policies, willingness to serve Medicare and Medicaid patients, and to serve patients that cannot afford to pay for services.
The admission policy provides the overall guiding principles of the facility as to the types of patients that are appropriate candidates to use the facility and assurances regarding access to treatment. The admission policy must also include language to ensure all residents of the planning area would have access to the proposed services. This is accomplished by providing an admission policy that states patients would be admitted without regard to race, ethnicity, national origin, age, sex, pre-existing condition, physical, or mental status.

Medicare certification is a measure of an applicant’s willingness to serve the elderly. With limited exceptions, Medicare is coverage for individuals age 65 and over. It is also recognized that women live longer than men and therefore more likely to be on Medicare longer.

Medicaid certification is a measure of an applicant’s willingness to serve low income persons and may include individuals with disabilities.

Charity care shows a willingness of a provider to provide services to individuals who do not have private insurance, do not qualify for Medicare, do not qualify for Medicaid, or are under insured. ¹

**Virginia Mason**

Virginia Mason provided copies of the following policies currently in used at VMMC. [source: Application, Exhibit 10]
- Admission Policy – Approved February 2017
- Non-Discrimination Policy – Approved March 2014
- Charity Care Policy – Approved December 2017

VMMC is currently Medicare and Medicaid certified. VM provided its current source of revenues by payer for VMMC and stated that the establishment of the Level II and obstetrical (OB) services changes the payer mix slightly at VMMC. [source: January 11, 2019, screening response, p2]

Current and projected hospital-wide payer mix is shown below.

<table>
<thead>
<tr>
<th>Revenue Source</th>
<th>Current</th>
<th>With OB/ICN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>51.5%</td>
<td>47.4%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>2.8%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Commercial</td>
<td>43.5%</td>
<td>45.7%</td>
</tr>
<tr>
<td>Other</td>
<td>2.2%</td>
<td>2.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

In addition to the policies and payer mix information, Virginia Mason provided the following information related to uncompensated care provided by VMMC. [source: Application, p21]

“For hospital charity care reporting purposes, the Department of Health (Department) divides Washington State into five regions. Virginia Mason is located in King County. According to 2014-2016 charity care data produced by the Department (the latest data currently available), the three-year charity care average for King County, excluding Harborview, is 0.93% of gross revenue and 1.98% of adjusted revenue. During this same time period, the three-year percentage of charity care for Virginia Mason was .67% of total revenue and 1.31% of adjusted revenue. Virginia Mason’s actual 2017 charity care level was 0.85% of total revenue. While there are very concrete reasons for Virginia Mason’s

¹ WAC 246-453-010(4)
charity care being slightly less than the regional average (including the fact that we do not currently provide inpatient obstetrics or pediatrics, which have significantly higher rates of charity care, and that our emergency room does not have a trauma designation and is therefore is “bypassed” by EMS), for the purposes of this application, charity care was budgeted to be consistent with the most recent King County three year percentage, not including Harborview.”

Public Comments
During the review of this project, Swedish Health Services provided comments related to this sub-criterion. Those comments are below. [source: May 3, 2018, public comment]

Swedish Health Services
“Additionally, on page 10 of their application, VM states that currently only 2.8% of their patients were insured by Medicaid in 2017. Their application also states on page 21 that their charity care average was only 0.67% during 2014-2016 and 0.85% in 2017. This makes the level of charity care provided by VM consistently well below the King County average (excluding Harborview) of 0.93%. The percentage of Medicaid patients seen at VM is also far lower than the average seen at other King County hospitals. VM cites the lack of OB, pediatrics and trauma designation as the rationale for their low rates of charity care and Medicaid patients, yet only project their Medicaid rate to increase from 2.8% to 4.8% if their project is approved and that their charity rate would only increase to the King County average of 0.93%. If the Department elects to approve the application, we request that it impose conditions on the CN that require VM to provide charity care at a level commensurate with the King County average (excluding Harborview). The Department also should impose a condition requiring VM to provide care to Medicaid patients at a rate that is consistent with the payer mix in the Central King Planning Area.”

Rebuttal Comments
In response to the comments above, Virginia Mason provided the following rebuttal comments. [source: Virginia Mason, March 8, 2019, rebuttal comments]

Virginia Mason
“Regarding Swedish’s request that the DOH mandate our organization’s future payer mix, we assure you that the Level II Nursery will serve all patients without regard for their ability to pay (in accordance with our charity care policy) and fully expect the charity care to be in line with the Central King Planning Area. Virginia Mason would respect such a condition on these requested beds. Virginia Mason notes for the record that Swedish First Hill has, since at least 2013, been below the King County charity care average.”

Department Evaluation
Virginia Mason has been providing healthcare services to the residents of Washington through its hospitals and medical clinics for many years. Healthcare services are stated to be available to low-income, racial and ethnic minorities, handicapped and other underserved groups. [source: Virginia Mason Patient Nondiscrimination Policy]

The Admission Policy describes the process VMMC uses to admit a patient but does not outline the rights and responsibilities of the patient and the hospital. Those rights and responsibilities are referenced by, but not included with the admission policy. The Patient Nondiscrimination Policy includes the following non-discrimination language: “The VMMC Workforce will treat all patients and visitors receiving services from or participating in other programs of Virginia Mason Medical Center including its clinics with equality in a welcoming manner that is free from discrimination based on age, race, color, creed, ethnicity, religion, national
origin, marital status, sex, sexual orientation, gender identity or expression, disability, veteran or military status, or any other basis prohibited by federal, state, or local law.”

VMMC currently provides services to both Medicare and Medicaid patients. Virginia Mason anticipates slight increases in the proportion of patients covered by Medicaid and a small decrease in the proportion of Medicare patients after establishing OB and ICN services, because those patients generally are covered by Medicaid and commercial insurers, but not by Medicare.

VMMC’s current Medicare revenues are approximately 51.5% of total revenues, which may decrease to 47.4%; likewise, Medicaid revenues are currently 2.8%, which may increase to 4.81%. Commercial revenues are expected to increase from 43.5% to 45.7%. Other payer revenues are expected to remain at 2.2%. Financial data provided in the application also shows both Medicare and Medicaid revenues.

The Financial Assistance Policy (Charity Care) provided in the application has been reviewed and approved by the Department of Health’s Hospital Financial/Charity Care Program (HFCCP). The policy outlines the process one would use to obtain financial assistance or charity care. The policy was approved in October 2018. This is the same policy posted to the department’s website for VMMC. The pro forma financial documents provided in the application include a charity care 'line item' as a deduction of revenue.

Charity Care Percentage Requirement
For charity care reporting purposes, Washington State is divided into five regions: King County, Puget Sound (less King County), Southwest, Central, and Eastern. Virginia Mason proposes to establish Level II ICN service at Virginia Mason Medical Center located in the King County Region. Currently there are 22 hospitals operating within the region. All 22 hospitals provided charity care information for 2017.

Table 5 below compares the three-year historical average of charity care provided by the hospitals currently operating in the King County Region, less Harborview² and VMMC’s historical charity care percentages for years 2015-2017. The table also compares the projected percentage of charity care. [source: January 11, 2019, screening response, Attachment 5 and HFCCP 2015-2017 charity care summaries]

<table>
<thead>
<tr>
<th></th>
<th>Percentage of Total Revenue</th>
<th>Percentage of Adjusted Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>King County Region</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Historical 3-Year Average</td>
<td>0.86%</td>
<td>1.88%</td>
</tr>
<tr>
<td>Virginia Mason Medical Center</td>
<td>0.59%</td>
<td>1.16%</td>
</tr>
<tr>
<td>Historical 3-Year Average</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Virginia Mason Medical Center</td>
<td>Projected Average</td>
<td>0.85%</td>
</tr>
</tbody>
</table>

As noted in Table 5 above, the three-year historical average shows VMMC has been providing charity care below both the total and adjusted regional averages. For this project, Virginia Mason projects that

² Harborview Medical Center is subsidized by the state legislature to provide charity care services. Charity care percentages for Harborview make up almost 50% of the total percentages provided in the King County Region. Therefore, for comparison purposes, the department excluded Harborview Medical Center's percentages.
VMMC would provide charity care at nearly the regional average for total revenues and adjusted revenues.

Virginia Mason has been providing health care services at VMMC for many years. Charity care is health care provided through the hospital at no cost or reduced cost to low income patients. Charity care is a state-mandated and partially state-funded program that allows uninsured or underinsured people to receive inpatient and outpatient care at a reduced cost. Only people who meet certain income and asset criteria are eligible to receive charity care.

The focus of this sub-criterion is charity care percentages specific to VMMC. Swedish Health Services expressed concerns regarding the historical percentages of charity care provided at VMMC. Swedish Health Services suggested a charity care condition if this project is approved; Virginia Mason stated it is willing to agree to such a condition. In past hospital CN applications, the department has been attaching a charity care condition to the approvals, based, in part, on the fluctuation of charity care percentages since the passage of the Affordable Care Act in March 2010.

For these reasons, if this project is approved, the department concurs that Virginia Mason must agree to the charity care condition stated below.³

Virginia Mason Medical Center will provide charity care in compliance with its charity care policies reviewed and approved by the Department of Health, or any subsequent policies reviewed and approved by the Department of Health. Virginia Mason Medical Center will use reasonable efforts to provide charity care in an amount comparable to or exceeding the average amount of charity care provided by hospitals in the King County Region, less Harborview. Currently, this amount is 0.86% gross revenue and 1.88% of adjusted revenue. Virginia Mason Medical Center will maintain records of charity care applications received and the dollar amount of charity care discounts granted. The department requires these records to be available upon request.

Based on the information provided in the application and with Virginia Mason’s agreement to the condition, the department concludes this sub-criterion is met.

(3) The applicant has substantiated any of the following special needs and circumstances the proposed project is to serve.

(a) The special needs and circumstances of entities such as medical and other health professions schools, multidisciplinary clinics and specialty centers providing a substantial portion of their services or resources, or both, to individuals not residing in the health service areas in which the entities are located or in adjacent health service areas.

(b) The special needs and circumstances of biomedical and behavioral research projects designed to meet a national need and for which local conditions offer special advantages.

(c) The special needs and circumstances of osteopathic hospitals and non-allopathic services.

Department Evaluation
This sub-criterion is not applicable to this application.

³ The condition related to the percentage of charity care and its impact on VMMC’s revenue and expense statement is further addressed in the financial feasibility section of this evaluation.
(4) The project will not have an adverse effect on health professional schools and training programs. The assessment of the conformance of a project with this criterion shall include consideration of:

(a) The effect of the means proposed for the delivery of health services on the clinical needs of health professional training programs in the area in which the services are to be provided.

(b) If proposed health services are to be available in a limited number of facilities, the extent to which the health professions schools serving the area will have access to the services for training purposes.

Department Evaluation
This sub-criterion is not applicable to this application.

(5) The project is needed to meet the special needs and circumstances of enrolled members or reasonably anticipated new members of a health maintenance organization or proposed health maintenance organization and the services proposed are not available from nonhealth maintenance organization providers or other health maintenance organizations in a reasonable and cost-effective manner consistent with the basic method of operation of the health maintenance organization or proposed health maintenance organization.

Department Evaluation
This sub-criterion is not applicable to this application.

B. Financial Feasibility (WAC 246-310-220)
Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department determines that Virginia Mason met the applicable financial feasibility criteria in WAC 246-310-220.

(1) The immediate and long-range capital and operating costs of the project can be met.
WAC 246-310 does not contain specific WAC 246-310-220(1) financial feasibility criteria as identified in WAC 246-310-200(2)(a)(i). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that directs what the operating revenues and expenses should be for a project of this type and size. Therefore, using its experience and expertise the department evaluates if the applicant’s pro forma income statements reasonably project the proposed project is meeting its immediate and long-range capital and operating costs by the end of the third complete year of operation.

Virginia Mason
Virginia Mason provided the following assumptions to determine the projected number of admissions, patient days, and average length of stay for VMMC’s level II ICN cost center. [source: Application, pp28-29]

“To estimate internal census, Virginia Mason first calculated total births expected from its primary care clinic system, employees (CHI Franciscan and Virginia Mason Health System), the PSHVN and the general community. Table 12 details the number and assumptions for each of the above patient categories:
Applicant’s Table 12
Virginia Mason Projected Patient Census and Assumptions

<table>
<thead>
<tr>
<th></th>
<th>Annual Births</th>
<th>% Assumed to Choose Virginia Mason</th>
<th>Estimated Unique OB Discharges to Virginia Mason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virginia Mason primary care patients</td>
<td>515</td>
<td>60%</td>
<td>309</td>
</tr>
<tr>
<td>PSHVN5</td>
<td>80</td>
<td>60%</td>
<td>48</td>
</tr>
<tr>
<td>Virginia Mason/CHI Franciscan Employees Residing in King County</td>
<td>130</td>
<td>70%</td>
<td>91</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>448</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central King Planning Area residents</td>
<td></td>
<td>Assumes 25% outmigration</td>
<td>182</td>
</tr>
<tr>
<td>Estimated In-migration (70% per current Central King OB providers)</td>
<td></td>
<td>Assumes 40% in-migration</td>
<td>420</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,050</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Applicant

“After total births were projected, Virginia Mason calculated Level II admissions and days. Consistent with actual King County experience, Level II patient admissions were assumed to be 28% of total OB discharges and average length of stay (ALOS) was assumed to be 4.5. Table 13 details the projected utilization for the proposed Level II nursery. In an effort to be conservative, Virginia Mason assumed fewer than the 1,050 2017 OB discharges it could have expected (had it offered OB services) during the first two years of operation. By 2022, the third year of the project, Virginia Mason has assumed that it would have approximately 1,200 OB discharges per year.”

Applicant’s Table 13
Virginia Mason Level II Intermediate Care Nursery
Admissions and Patient Days

<table>
<thead>
<tr>
<th></th>
<th>Year 1 (2020)</th>
<th>Year 2 (2021)</th>
<th>Year 3 (2022)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projected OB Discharges</td>
<td>500</td>
<td>850</td>
<td>1,200</td>
</tr>
<tr>
<td>Admissions @ 28% of OB discharges</td>
<td>140</td>
<td>238</td>
<td>336</td>
</tr>
<tr>
<td>Patient Days @ 4.5 days per admission</td>
<td>630</td>
<td>1,071</td>
<td>1,512</td>
</tr>
<tr>
<td>ADC</td>
<td>1.7</td>
<td>2.9</td>
<td>4.1</td>
</tr>
<tr>
<td>Occupancy on 5 beds</td>
<td>34.5%</td>
<td>58.7%</td>
<td>82.8%</td>
</tr>
</tbody>
</table>

Source: Applicant

The assumptions Virginia Mason used to project revenue, expenses, and net income for VMMC’s level II ICN cost center with 5 bassinets for projection years 2020 through 2022 are below. [source: January 11, 2019, screening response, Attachment 5]

“Revenues
- Gross revenues are based on relatively conservative assumptions on volume and reimbursement. Volume assumptions include percentages from Virginia Mason’s primary care patient base, which includes its employees; CHI-Franciscan employees who live proximate to Virginia Mason and have indicated a desire to use its clinical services; Virginia Mason’s ACO members; and the First Hill and

4 Based on convenience, choice, payer patient preference, etc.
5 2017 covered lives was approximately 15,000
adjacent community. Reimbursement assumptions are based on anticipated remuneration from commercial payors and Medicaid.

- Deductions from revenue are calculated based on best available market estimates by payer. Contractual allowances, by payer are included in Attachment 5.
- Bad debt is assumed constant at Virginia Mason’s average of 0.57% of gross revenues.
- Charity care is assumed constant using the three-year charity care

| Applicant’s Table
| Revenue Sources by Payer |
|--------------------------|-------------------------|
| Payer                    | Percentage |
| Medicaid                 | 27.2%       |
| Commercial/HMO           | 70.3%       |
| Other                    | 2.5%        |
| Total                    | 100.0%      |

**Expenses**

Staffing requirements are based on the anticipated hours of operation of the program, number of ORs in operation and estimated program volumes. The number of FTEs, by type is included in Table 16.

- Wage and salary figures are specific to each group of FTEs, and are calculated on an hourly basis, based on Virginia Mason’s current wage structure. It is assumed a FTE works 2,080 hours per year.
- Benefits were calculated as 22% of total wages and salaries for all staff.
- Professional fees include costs associated with neonatology support and medical director payments.
- Medical supplies were based on an average per procedure based on CHI Franciscan’s current experience.
- Purchased services: include items such as Ancillary Service Costs including Patient Financial Services, Computer Equipment & Installation, Telecom Allocation, Linen Transfers, and Janitorial Services.
- Depreciation expenses were based on a straight line and assumed an average useful life of 8 years.
- Rent expense is calculated consistent with fair market value.”

Based on the assumptions above, Virginia Mason provided the following revenue and expense statement for VMMC’s level II ICN cost center. The statement shows projected years 2020 through 2022. [source: January 11, 2019, screening response, Attachment 5]

| Department’s Table 6
| Virginia Mason Medical Center Level II ICN Cost Center Projections for Years 2020 through 2022 |
|--------------------------|---------------------------------------------------------------------------------|
| # of ICN Beds            | CY 2020 | CY 2021 | CY 2022 |
|                         | 5       | 5       | 5       |
| Net Revenue             | $1,090,346 | $1,880,543 | $2,692,380 |
| Total Expenses          | $1,823,154 | $2,135,559 | $2,424,000 |
| Net Profit / (Loss)     | $(732,808) | $(255,015) | $268,380 |

In addition to providing the level II cost center revenue and expense statement, Virginia Mason also provided a projected revenue and expense statement for VMMC as a whole with the 5 level II ICN beds. Below are the assumptions used by Virginia Mason used to project the hospital-wide statement. [source: January 11, 2019, screening responses, Attachment 8]
Virginia Mason Medical Center Financial Assumptions

“No inflation is assumed in either the revenue or expense assumptions.

“Revenues
- Operating revenues and deductions for the hospital are estimated and held constant using Virginia Mason’s FS – 3 Revenue and Expense projection submitted to the Department of Health. For the proposed SCN and obstetrics program, Virginia Mason developed the assumptions for gross revenues based on relatively conservative assumptions on volume and reimbursement. Volume assumptions include percentages from its primary care patient base, which includes its employees; CHI-Franciscan employees who live proximate to Virginia Mason and have indicated a desire to use its clinical services; Virginia Mason’s ACO members; and the First Hill and adjacent community.

Reimbursement assumptions are based on anticipated remuneration from commercial payors and Medicaid.
- Bad debt is assumed constant at Virginia Mason’s average of 0.57% of gross revenues.
- Charity care is assumed constant using Virginia Mason’s current experience at 0.85% of total patient services revenues.

Expenses
- All hospital expenses are estimated based on Virginia Mason’s FS – 3 Revenue and Expense projection submitted for 2017 to the Department of Health.

“For the Special Care Nursery and Obstetrics Program Specifically:
- Staffing requirements are based on the anticipated hours of operation of the program, number of ORs in operation and estimated program volumes.
- Wage and salary figures are specific to each group of FTEs, and are calculated on an hourly basis, based on Virginia Mason’s current wage structure. It is assumed a FTE works 2,080 hours per year.
- Benefits are calculated as 22% of total wages and salaries for all staff.
- Professional fees include costs associated with anticipated neonatology support.
- Medical supplies are based on an average per procedure.
- Purchased services: include items such as Ancillary Service Costs including Patient Financial Services, Computer Equipment & Installation, Telecom Allocation, Linen Transfers, and Janitorial Services.
- Depreciation expenses are based on straight line and assumed an average useful life of 8 years.
- Rent expense is calculated consistent with fair market value.”

The revenue is based on the current VMMC payer mix and charges and projected payer mix after initiating OB and NICU services. Current and projected hospital-wide payer mix are shown below.

<table>
<thead>
<tr>
<th>Revenue Source</th>
<th>Current</th>
<th>With NICU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>51.5%</td>
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<td>Medicaid</td>
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</tr>
<tr>
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<td>2.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>
Virginia Mason provided the following explanation for the expected change in payer mix shown above. [source: January 11, 2019, screening response, p3]

“…the differences between the payers reflect that OB and SCN services are generally not provided to individuals insured by Medicare but are primarily provided to Medicaid and commercially insured populations. Therefore, those categories are expected to increase and Medicare is expected to decrease (as a percentage of total revenue).”

Based on the assumptions Virginia Mason used to project revenue, expenses, and net income for VMMC as a whole with the 5-bed level II ICN for projection year 2020 through projection year 2022 are below. [source: Applicant’s January 11, 2019, screening response, Attachment 5]

<table>
<thead>
<tr>
<th>Department’s Table 7</th>
<th>Virginia Mason Medical Center</th>
<th>Most Recent Year 2017 and Projection Years 2019 through 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CY 2017</td>
<td>CY 2020</td>
</tr>
<tr>
<td>Net Revenue</td>
<td>$1,057,525,048</td>
<td>$1,092,283,463</td>
</tr>
<tr>
<td>Total Expenses</td>
<td>$1,044,984,661</td>
<td>$1,081,088,743</td>
</tr>
<tr>
<td>Net Profit / (Loss)</td>
<td>$25,617,804</td>
<td>$24,010,588</td>
</tr>
</tbody>
</table>

The ‘Net Revenue’ line item is gross inpatient and outpatient hospital revenue, plus any non-operating revenue. The ‘Total Expenses’ line item includes all expenses related to hospital operations, including all staff salaries/wages and allocated costs.

Public Comments
During the review of this project, Swedish Health Services provided comments related to this sub-criterion. Swedish Health Services’ comments are below. [source: February 22, 2019, public comment]

Swedish Health Services
“As noted in the section above, we do not believe that VM will be able to achieve the volume projections and therefore ADC outlined in their application. As a result, it is unlikely that they will meet the financial projections outlined in their application.

“Additionally, on page 10 of their application, VM states that currently only 2.8% of their patients were insured by Medicaid in 2017. Their application also states on page 21 that their charity care average was only 0.67% during 2014-2016 and 0.85% in 2017. This makes the level of charity care provided by VM consistently well below the King County average (excluding Harborview) of 0.93%. The percentage of Medicaid patients seen at VM is also far lower than the average seen at other King County hospitals. VM cites the lack of OB, pediatrics and trauma designation as the rationale for their low rates of charity care and Medicaid patients, yet only project their Medicaid rate to increase from 2.8% to 4.8% if their project is approved and that their charity rate would only increase to the King County average of 0.93%. If the Department elects to approve the application, we request that it impose conditions on the CN that require VM to provide charity care at a level commensurate with the King County average (excluding Harborview). The Department also should impose a condition requiring VM to provide care to Medicaid patients at a rate that is consistent with the payer mix in the Central King Planning Area.”
Rebuttal Comments

Virginia Mason

“Given the lack of substantiation of Swedish’s stated concerns regarding projected admissions and use rate information, Virginia Mason regards these arguments as moot. Virginia Mason is confident that the utilization projections will be realized, and the project will be financially feasible.

“Regarding Swedish’s request that the DOH mandate our organization’s future payer mix, we assure you that the Level II Nursery will serve all patients without regard for their ability to pay (in accordance with our charity care policy) and fully expect the charity care to be in line with the Central King Planning Area. Virginia Mason would respect such a condition on these requested beds. Virginia Mason notes for the record that Swedish First Hill has, since at least 2013, been below the King County charity care average.” [source: Virginia Mason rebuttal comments, pp4-5]

Department Evaluation
To evaluate this sub-criterion, the department first reviewed the assumptions used by Virginia Mason to determine the projected number of admissions, patient days, and occupancy of VMMC’s level II ICN. Virginia Mason provided its patient days and discharge projections beginning with year 2019 through year 2022. When compared to historical data [years 2015, 2016, and 2017] obtained from the Department of Health’s Hospital and Patient Data Systems’ Hospital Census and Charges Report, the projections are reasonable. The department can reasonably substantiate Virginia Mason’s assumptions. After reviewing Virginia Mason’s admission and patient day assumptions for VMMC, the department concludes they are reasonable.

Virginia Mason based its revenue and expenses for VMMC on the assumptions referenced above. Virginia Mason also used its current operations as a base-line for the revenue and expenses projected for VMMC as a whole with the ICN. A review of VMMC’s fiscal year historical data reported to the Department of Health shows that Virginia Mason operated VMMC at a profit for fiscal years 2015 through 2017. [source: DOH Hospital year-end financial reports, 20165-2017]

To assist in the evaluation of this sub-criterion, the Department of Health’s Hospital/Finance and Charity Care Program (HFCCP) reviewed the pro forma financial statements submitted by Virginia Mason. To determine whether Virginia Mason would meet its immediate and long range capital costs, HFCCP reviewed the 2017 historical balance sheet for VMMC. The information is shown in Table 8 below. [source: HFCCP analysis, p2]

<table>
<thead>
<tr>
<th>Department’s Table 8</th>
<th>Virginia Mason Medical Center Balance Sheet for 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assets</strong></td>
<td><strong>Liabilities</strong></td>
</tr>
<tr>
<td>Current Assets</td>
<td>$ 230,410,534</td>
</tr>
<tr>
<td>Board Designated Assets</td>
<td>$ 354,572,524</td>
</tr>
<tr>
<td>Property/Plant/Equipment</td>
<td>$ 550,810,969</td>
</tr>
<tr>
<td>Other Assets</td>
<td>$ 10,239,473</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td><strong>$ 1,146,033,500</strong></td>
</tr>
<tr>
<td>Current Liabilities</td>
<td>$ 139,808,739</td>
</tr>
<tr>
<td>Other Liabilities</td>
<td>$ 0</td>
</tr>
<tr>
<td>Long Term Debt</td>
<td>$ 504,949,140</td>
</tr>
<tr>
<td><strong>Equity</strong></td>
<td><strong>$ 501,275,621</strong></td>
</tr>
<tr>
<td><strong>Total Liabilities and Equity</strong></td>
<td><strong>$ 1,146,033,500</strong></td>
</tr>
</tbody>
</table>

For hospital projects, HFCCP provides a financial ratio analysis assesses the financial position of an applicant, both historically and prospectively. The financial ratios typically analyzed are 1) long-term debt to equity; 2) current assets to current liabilities; 3) assets financed by liabilities; 4) total operating expense to total operating revenue; and 5) debt service coverage. Historical and projected balance sheet
data is used in the analysis. VMMC’s 2017 balance sheet was used to review applicable ratios and pro forma financial information.

Table 9 compares statewide data for historical year 2017, VMMC historical year 2017, and projected years 2020 through 2022. [source: HFCCP analysis, p3]

<table>
<thead>
<tr>
<th>Category</th>
<th>Trend *</th>
<th>State 2017</th>
<th>VMMC 2017</th>
<th>VMMC 2020</th>
<th>VMMC 2021</th>
<th>VMMC 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Term Debt to Equity</td>
<td>B</td>
<td>0.442</td>
<td>1.007</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Current Assets/Current Liabilities</td>
<td>A</td>
<td>3.320</td>
<td>1.648</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Assets Funded by Liabilities</td>
<td>B</td>
<td>0.372</td>
<td>0.563</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Operating Expense/Operating Revenue</td>
<td>B</td>
<td>0.980</td>
<td>0.988</td>
<td>0.990</td>
<td>0.989</td>
<td>0.987</td>
</tr>
</tbody>
</table>

**Definitions:**
- **Long Term Debt to Equity**: Long Term Debt/Equity
- **Current Assets/Current Liabilities**: Current Assets/Current Liabilities
- **Assets Funded by Liabilities**: Current Liabilities + Long term Debt/Assets
- **Operating Expense/Operating Revenue**: Operating expenses / operating revenue
- **Debt Service Coverage**: Net Profit+Depr and Interest Exp/Current Mat. LTD and Interest Exp

* A is better if above the ratio; and B is better if below the ratio.

After reviewing the financial ratios above, staff from HFCCP provided the following statements. [source: HFCCP analysis, p3]

“Each of the ratios for VM is outside the preferred range in FY 2017. CON year 3, (third year following addition of the beds) fiscal year end ratios for VM (for those that can be calculated with the available data) are below the state average, but within acceptable bounds and demonstrating an improving trend. The hospital is breaking even in each year of the projections. VM revenue and expense ratios are generally near the desired range for this project.

The debt-related ratios for VM are outside the p range for 2017 and cannot be calculated for future years because the applicant did not provide pro-forma balance sheets. Because the project is not using any debt financing and represents a very small portion of the facility’s reserves, review of these ratios is not crucial to this evaluation.

Review of the financial and utilization information show that the immediate and long range capital expenditure as well as the operating costs can be met. This criterion is satisfied.”

Based on the information above, the department concludes that the immediate and long-range operating costs of the project can be met. **This sub-criterion is 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.**

WAC 246-310 does not contain specific WAC 246-310-220(2) financial feasibility criteria as identified in WAC 246-310-200(2)(a)(i). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that directs what an unreasonable impact on costs and charges would be for a project of this type and size. Therefore, using its experience and expertise the department compared the proposed project’s costs with those previously considered by the department.
Virginia Mason
The capital expenditure associated with the addition of 5 level II ICN beds is $3,282,500. The table below shows the breakdown of the costs. [source: Application, p31]

<table>
<thead>
<tr>
<th>Item</th>
<th>Total Cost</th>
<th>Percentage of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building Construction</td>
<td>$1,260,000</td>
<td>38.4%</td>
</tr>
<tr>
<td>Moveable Equipment/Furniture</td>
<td>$1,180,000</td>
<td>35.9%</td>
</tr>
<tr>
<td>Architect &amp; Engineering Fees</td>
<td>$440,000</td>
<td>13.4%</td>
</tr>
<tr>
<td>Consulting Fees</td>
<td>$40,000</td>
<td>1.2%</td>
</tr>
<tr>
<td>Supervision &amp; Inspection</td>
<td>$25,000</td>
<td>0.8%</td>
</tr>
<tr>
<td>Other Project Costs</td>
<td>$81,300</td>
<td>2.5%</td>
</tr>
<tr>
<td>Sales Tax</td>
<td>$256,200</td>
<td>7.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$3,282,500</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Virginia Mason provided a letter from its senior vice president and hospital administrator attesting that, based on VM’s experience, the costs identified above are reasonable. [source: Application, Exhibit 11]

Although VMMC is not currently providing level II ICN or obstetric services, the only start-up costs in addition to the capital expenditure are $337,421. [source: Application, p33]

Public Comments
None

Rebuttal Comments
None

Department Evaluation
Virginia Mason provided a letter from an administrator, attesting that the construction estimate within the application is reasonable. The costs in the application apply only to the requested 5-bed ICN, and do not include other costs related to the establishment of general labor and delivery services at VMMC.

In its financial review, the HFCCP provided the following information and review regarding the rates proposed by Virginia Mason. [source: HFCCP Program analysis pp3-4]

“*There are several ways to review hospital newborn cost information. Hospitals report data to DOH through the financial format and the hospital inpatient format. In the financial reporting system, hospitals can report all newborn revenue and expense for delivery and post-partum care under account 6100 Alternative Birth Center or they can report it under 6170 Nursery for the baby only and 6070 Acute Care for the mother. Newborns that need intensive care are reported under 6010 Intensive Care, which also includes Adult and Pediatric patients.*

*Newborn days in Intensive Care are usually a small percent of the total. I reviewed the hospital inpatient database (CHARS) for comparison data. Revenue Code 0172 is Level II Nursery care , 0173 is Level III Nursery Care, and 0174 is Level IV Nursery Care in the CHARS database. I examined the average charges per day for those discharges that included Revenue Code 0172, 0173, and 0174. The average charge per day in 2017 in CHARS for discharges containing revenue code 0172 was higher than the applicant’s*
average, but varied too much among different facilities to conclude that the applicant’s charges are unreasonable.”

Virginia Mason stated under WAC 246-310-220(1) that the payer mix is expected to change slightly with the addition of 5 level II ICN beds. With the addition of childbirth services, VM’s proportion of Medicaid and commercial insurance revenue will rise in comparison with Medicare revenue.

Based on the above information, the department concludes that VMMC’s establishment of a level II ICN would probably not have an unreasonable impact on the costs and charges for healthcare services in King County and surrounding communities. **This sub-criterion is met.**

(3) **The project can be appropriately financed.**

WAC 246-310 does not contain specific source of financing criteria as identified in WAC 246-310-200(2)(a)(i). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that directs how a project of this type and size should be financed. Therefore, using its experience and expertise the department compared the proposed project’s source of financing to those previously considered by the department.

**Virginia Mason**
The total estimated capital expenditure associated with the 5-bed level II ICN is $3,282,500. Of that amount, approximately 38% is related to construction; 36% is related to both fixed and moveable equipment, and the remaining 16% is for sales tax and fees (consulting, architect, and engineering). [source: Application, p31]

Virginia Mason intends to fund the project using Virginia Mason reserves and provided a letter of financial commitment for the project. There are no start-up costs associated with this project. [source: Application, p33 and Exhibit 12]

**Public Comments**
None

**Rebuttal Comments**
None

**Department Evaluation**
After reviewing the balance sheet, the HFCCP provided the following statements. [source: HFCCP analysis, p4]

“The CN project capital expenditure is $63,252,500. Virginia Mason will use existing reserves. This investment represents 0.3% of total assets of the hospital itself as of 2017. The financing methods used are appropriate business practice. This criterion is satisfied.”

If this project is approved, the department would attach a condition requiring Virginia Mason to finance the project consistent with the financing description in the application. With the financing condition, the department concludes **this sub-criterion is met.**

C. **Structure and Process (Quality) of Care (WAC 246-310-230)**

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department determines that Virginia Mason met the applicable structure and process of care criteria in WAC 246-310-230.
(1) A sufficient supply of qualified staff for the project, including both health personnel and management personnel, are available or can be recruited.

WAC 246-310 does not contain specific WAC 246-310-230(1) criteria as identified in WAC 246-310-200(2)(a)(i). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that directs what specific staffing patterns or numbers of FTEs [full time equivalents] that should be employed for projects of this type or size. Therefore, using its experience and expertise the department concludes that the planning would allow for the required coverage.

**Virginia Mason**

VMMC does not currently provide obstetric or level II ICN services. Table 11 provides a breakdown of projected FTEs [full time equivalents] for the level II ICN through the third year following completion of the project. [source: Application, p37]

<table>
<thead>
<tr>
<th>FTE by Type</th>
<th>CY 2019 Increase</th>
<th>CY 2020 Increase</th>
<th>CY 2021 Increase</th>
<th>CY 2022 Increase</th>
<th>Total FTEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing FTEs</td>
<td>5.6</td>
<td>4.6</td>
<td>0.0</td>
<td>1.0</td>
<td>11.2</td>
</tr>
<tr>
<td>Unit Director</td>
<td>1.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Total FTEs</strong></td>
<td><strong>6.6</strong></td>
<td><strong>4.6</strong></td>
<td><strong>0.0</strong></td>
<td><strong>1.0</strong></td>
<td><strong>12.2</strong></td>
</tr>
</tbody>
</table>

In addition to the table above, Virginia Mason provided the following statements related to this sub-criterion. [source: Application, p38]

“For an organization the size of Virginia Mason, staffing the Level II nursery requires less than a one percent overall increase. Virginia Mason offers a competitive wage and benefit package and has been very successful in recruiting and retaining staff. In addition, this service will be one of the first clinical service lines offered as part of the 2016 CHI Franciscan-Virginia Mason strategic and clinical affiliation, discussed earlier. This affiliation is designed to expand access and improve care quality and safety across the Puget Sound region. Employees of both Virginia Mason and CHI Franciscan have expressed interest in the affiliation, and we expect to attract others as well to this exciting new service line. As noted in earlier sections of this application, some of the key clinical staff will be provided by CHI Franciscan through the services agreement; the Department Director’s scope of services is outlined in the MOA, provided in Exhibit 5. Specifically, CHI Franciscan will provide a full time Department Director and clinical expertise. As a result of all of the above, Virginia Mason does not foresee any difficulties in obtaining additional staff as needed.”

**Public Comments**
None

**Rebuttal Comments**
None

**Department Evaluation**

VMMC is currently licensed for 336 acute care beds. When 5 of those beds are designated as level II ICN beds, staff of the unit would increase by approximately 12 FTEs. The increase in staff coincides with the increase in admissions and patient days for the level II ICN.
For this project, Virginia Mason intends to use the strategies for recruitment and retention of staff it has successfully used in the past. The strategies identified by Virginia Mason are consistent with those of other applicants reviewed and approved by the department.

Information provided in the application demonstrates that Virginia Mason is a well-established provider of healthcare services King County and surrounding areas. Information provided in the application demonstrates that Virginia Mason has the ability and expertise to recruit and retain a sufficient supply of qualified staff for this project.

**Washington State Perinatal Levels of Care Guidelines**
The department also uses the standards of care guidelines outlined in the Washington State Perinatal Levels of Care Guidelines in evaluating this project. The guidelines, adopted by the Perinatal Advisory Committee, offer recommendations on facility and staffing standards for perinatal and neonatal services within a hospital. The guidelines were initially developed in 1988, and revised in years 1993, 2001, 2005, 2010, 2013, and 2018.

**Public Comment**
Swedish Health Services questioned whether Virginia Mason’s volume projections would allow it to be compliant with the guidelines: [source: February 21, 2019 comments, p21]

“Given the low ADC of 0.3 to 2.2 projected above, if VM does not achieve their aggressive delivery rates - over 850 deliveries/year, they would never achieve the ADC needed to meet the WA DOH Perinatal Guidelines. Therefore, approving this new program is not in the best interest of the residents of King County when there are numerous other facilities meeting these guide lines that have a strong history of serving VM patients. If VM is able to re-open their program, their volumes would directly impact the volumes these established facilities which have supported the needs of VM’s patients for the many years following their program closure in the 1990’s.”

**Rebuttal Comment**
Virginia Mason did not directly rebut this observation, rather this was addressed in its discussion defending the volume projections.

**Department Evaluation**
This issue is addressed in the department’s review of Virginia Mason’s volume projections earlier in the evaluation. The department notes that Virginia Mason’s volume projections are reasonable and provide reasonable assurance that the guidelines will be met.

(2) *The proposed service(s) will have an appropriate relationship, including organizational relationship, to ancillary and support services, and ancillary and support services will be sufficient to support any health services included in the proposed project.*

WAC 246-310 does not contain specific WAC 246-310-230(2) as identified in WAC 246-310-200(2)(a)(i). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that directs what relationships, ancillary and support services should be for a project of this type and size. Therefore, using its experience and expertise the department assessed the materials contained in the application.

**Virginia Mason**
Virginia Mason provided the following statements related to this sub-criterion. [source: Application, p39]

“As discussed in earlier sections of this application, at least a Level II nursery is “standard” for urban obstetrical programs in Western Washington, and as CHARS data demonstrates, more than one of every four neonates born in King County spends some part of their newborn stay in a Level II environment.
This establishment of a Level II nursery along with the OB service at Virginia Mason will assure family-centered care principles are realized and will also support the mother-newborn dyad and the physical safety, and emotional well-being of both the mother and the neonate. Having an on-site Level II nursery will avoid patient transfers and reduce fragmentation of care.”

Virginia Mason provided the information about vendors with whom VMMC currently contracts for services. [source: January 11, 2019, screening responses, p9]

“All typical ancillary and support services will be provided in-house by Virginia Mason. These services include, but are not limited to: anesthesiology, laboratory, dietary, pharmacy, radiology, lactation, Information Systems, housekeeping, perioperative services, respiratory therapy, sterile processing, security, patient relations, patient financial services, clinical engineering, courier services and pathology.”

Public Comments
Swedish Health Services provided the following information to address this criterion: [source: Swedish comments, p6]

“On page 9 of the application, one of the types of patients expected to be served by the proposed project is for stabilization of infants born before 32 weeks gestation and weighing less than 1500g until transfer to a neonatal intensive care facility. But, in the application, VM does not discuss where these neonates will be transferred to for advanced care. Length of transfer should be highly considered, given clinical outcomes associated with transfer to higher level of care. The Swedish FH campus is two blocks from VM, and the NICU’s at UW and Children’s are also nearby. Since the application is silent on patient transfers, it is our hope that transfers of neonates would be to one of these close providers of care instead of the longer distance to one of CHI’s facilities farther away since neonates who require transfer have poorer outcomes than those who do not (American Academy of Pediatrics (AAP) levels of neonatal care, 2004).

In addition, AAP has extensive research that shows that babies born in tertiary centers have better outcomes than those born in sites with level I and II nurseries. The most appropriate use of Level I and II nurseries are to address low risk deliveries where a tertiary center is not readily available. That is not the case in Seattle where there are three advanced care NICU’s available nearby VM, including Swedish which is located less than a mile from VM. This is noted by the fact that there have been two Level II NICU closures in Seattle over the past few years – Group Health in 2015 and Swedish Ballard in 2018. In addition, access to a skilled transport team is essential for excellent outcomes, and is omitted from VM's application for a level II NICU.”

Rebuttal Comments
Virginia Mason provided the following rebuttal comments: [source: Virginia Mason rebuttal comments, p7]

“As was discussed in the CN application, at least a Level II nursery is the minimal “standard” for urban obstetrical programs in Western Washington, and as CHARS data demonstrates, more than one of every three neonates born in King County spends some part of their newborn stay in a Level II environment. The establishment of a Level II nursery along with the OB service at Virginia Mason will assure family-centered care principles are realized and will also support the mother-newborn dyad and the physical safety and emotional well-being of both the mother and the neonate.

“Swedish stated that we did not note the facility to which neonates would be transferred. Virginia Mason already has several transport agreements in place, and, consistent with our notable quality track record, we always act in the best interest of our patients. Related to the Level II nursery, we fully intend to have a transport agreement that supports quality care and the mother-newborn dyad. Should the Program
desire, Virginia Mason would be amenable to a condition requiring that we submit a signed transfer agreement prior to opening the Level II nursery.”

**Department Evaluation**

Virginia Mason provided a comparison chart as verification and documentation that the VMMC meets or exceeds the advisory committee's recommended guidelines. [source: Application, Exhibit 6] Among the requirements of the guidelines are demonstrations that the hospital can initiate transport of patients to higher level care facilities according to the patient’s need. Virginia Mason notes that it will “Continue current transport agreements to provide transport services to other facilities when care outside of our designated level of care is required.” [source: application, Exhibit 6] Virginia Mason did not provide copies of any draft or executed transfer agreements for newborns, nor did it identify any hospitals with which it has or intends to have such transfer agreements.

Based on the information reviewed in the application, the department concludes that there is not reasonable assurance that Virginia Mason will establish or continue to maintain the necessary relationships with ancillary and support services with the addition of ICN services absent a transfer agreement with a provider of higher level ICN services and any approval must be conditioned upon the submission of such an agreement. Contingent on such an agreement, this sub-criterion is met.

(3) *There is reasonable assurance that the project will be in conformance with applicable state licensing requirements and, if the applicant is or plans to be certified under the Medicaid or Medicare program, with the applicable conditions of participation related to those programs.*

WAC 246-310 does not contain specific WAC 246-310-230(3) criteria as identified in WAC 246-310-200(2)(a)(i). There are known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that a facility must meet when it is to be Medicare certified and Medicaid eligible. Therefore, using its experience and expertise the department assessed the applicant’s history in meeting these standards at other facilities owned or operated by the applicant.

**Virginia Mason**

Virginia Mason provided the following statements related to this sub-criterion. [source: Application, p40] “Virginia Mason has no history with respect to the actions described in CN criterion referenced above. Virginia Mason operates in conformance with all applicable federal laws, rules and regulations for the operation of a health care facility.”

**Public Comments**

None

**Rebuttal Comments**

None

**Department Evaluation**

As part of this review, the department must conclude that the proposed services provided by an applicant would be provided in a manner that ensures safe and adequate care to the public.6 To accomplish this task, the department reviewed the quality of care compliance history for the healthcare facilities owned, operated, or managed by Virginia Mason or its subsidiaries.

Virginia Mason Medical Center is part of Virginia Mason Health System, which is a not-for-profit healthcare system. Virginia Mason operates two hospitals – VMMC and Virginia Mason Memorial

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6 WAC 246-310-230(5).
Hospital – a network of clinics, and two skilled nursing facilities. [sources: Application, pdf5 and Exhibit 1]

Washington State Survey Data
The two Virginia Mason hospitals are Virginia Mason Medical Center, located in Seattle, and Virginia Mason Memorial Hospital located in Yakima. Both hospitals are accredited by the Joint Commission. [source: Joint Commission website, CN historical files]

In addition to the two hospitals, department also reviewed the compliance history for the four ambulatory surgery centers, one hospice care center, one hospice agency, and two nursing homes owned and operated by Virginia Mason and its affiliates. All of these Virginia Mason facilities are operational. Using its own internal database, the survey data showed that 6 surveys have been conducted and completed by Washington State surveyors on the non-nursing home facilities since year 2016. All surveys resulted in no significant non-compliance issues. Both nursing homes had recent survey activity with issues typical of the facility type. The reports indicated that the issues had been corrected to the satisfaction of the survey agency. [source: ILRS survey data, Department of Health Office of Health System Oversight, and Centers for Medicare and Medicaid Services]

In addition to the facility review above, Virginia Mason provided the name and provider credential numbers for its designated ICN medical director, Dr. Eric Demers. A review of Dr. Demers’ credential revealed no sanctions. Because VMMC does not yet offer obstetric or ICN services, it has not identified other staff that will be attached to the project. If this project is approved, the department would attach a condition requiring Virginia Mason to provide the name and credential number of key staff for the ICN.

Based on the above information and provided the applicant’s agrees with the staff condition referenced above, the department concludes that Virginia Mason demonstrated reasonable assurance that VMMC would continue to operate in compliance with state and federal requirements if this project is approved. This sub criterion is met.

(4) The proposed project will promote continuity in the provision of health care, not result in an unwarranted fragmentation of services, and have an appropriate relationship to the service area’s existing health care system.

WAC 246-310 does not contain specific WAC 246-310-230(4) criteria as identified in WAC 246-310-200(2)(a)(i). There are also no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b) that directs how to measure unwarranted fragmentation of services or what types of relationships with a services area’s existing health care system should be for a project of this type and size. Therefore, using its experience and expertise the department assessed the materials in the application.

Virginia Mason
Virginia Mason provided the following statements related to this review criterion. [source: Application, p39]

“As discussed in earlier sections of this application, at least a Level II nursery is “standard” for urban obstetrical programs in Western Washington, and as CHARS data demonstrates, more than one of every four neonates born in King County spends some part of their newborn stay in a Level II environment. This establishment of a Level II nursery along with the OB service at Virginia Mason will assure family-centered care principles are realized and will also support the mother-newborn dyad and the physical safety, and emotional well-being of both the mother and the neonate. Having an on-site Level II nursery will avoid patient transfers and reduce fragmentation of care.”
“For all Virginia Mason patients, including Level II nursery patients, discharge planning is initiated shortly after admission. It will be the goal of the Level II nursery to ensure that the newborns are discharged home as soon as it is medically and clinically appropriate. For those families who may have additional needs, a care manager will be assigned to help coordinate post-discharge services and ensure that parents are provided with the training and education that they need to manage their infant at home.”

Public Comments
Swedish Health Services offered the following comment on this sub-criterion: [source: Swedish Health Services February 21, 2019, public comment. Pp6-7]
“On page 9 of the application, one of the types of patients expected to be served by the proposed project is for stabilization of infants born before 32 weeks gestation and weighing less than 1500g until transfer to a neonatal intensive care facility. But, in the application, VM does not discuss where these neonates will be transferred to for advanced care. Length of transfer should be highly considered, given clinical outcomes associated with transfer to higher level of care. The Swedish FH campus is two blocks from VM, and the NICU’s at UW and Children’s are also nearby. Since the application is silent on patient transfers, it is our hope that transfers of neonates would be to one of these close providers of care instead of the longer distance to one of CHI’s facilities farther away since neonates who require transfer have poorer outcomes than those who do not (American Academy of Pediatrics (AAP) levels of neonatal care, 2004).

“In addition, AAP has extensive research that shows that babies born in tertiary centers have better outcomes than those born in sites with level I and II nurseries. The most appropriate use of Level I and II nurseries are to address low risk deliveries where a tertiary center is not readily available. That is not the case in Seattle where there are three advanced care NICU’s available nearby VM, including Swedish which is located less than a mile from VM. This is noted by the fact that there have been two Level II NICU closures in Seattle over the past few years – Group Health in 2015 and Swedish Ballard in 2018. In addition, access to a skilled transport team is essential for excellent outcomes, and is omitted from VM’s application for a level II NICU.”

Rebuttal Comments
Virginia Mason provide the following rebuttal to Swedish’s assertions above: [source: Virginia Mason rebuttal comments, p8]
“As was discussed in the CN application, at least a Level II nursery is the minimal “standard” for urban obstetrical programs in Western Washington, and as CHARS data demonstrates, more than one of every three neonates born in King County spends some part of their newborn stay in a Level II environment. The establishment of a Level II nursery along with the OB service at Virginia Mason will assure family-centered care principles are realized and will also support the mother-newborn dyad and the physical safety and emotional well-being of both the mother and the neonate.

“Swedish stated that we did not note the facility to which neonates would be transferred. Virginia Mason already has several transport agreements in place, and, consistent with our notable quality track record, we always act in the best interest of our patients. Related to the Level II nursery, we fully intend to have a transport agreement that supports quality care and the mother-newborn dyad. Should the Program desire, Virginia Mason would be amenable to a condition requiring that we submit a signed transfer agreement prior to opening the Level II nursery.”
**Department Evaluation**

This sub-criterion encompasses three concepts: that a project, 1. promote continuity in the provision of health care, 2. not result in an unwarranted fragmentation of services, and 3. have an appropriate relationship to the service area’s existing health care system.

Virginia Mason has demonstrated that this project does promote continuity in the provision of health care for patients currently served by Virginia Mason providers for other health needs, for members of the Puget Sound High Value Network, and for patients whose health insurers direct them to providers other than the current sole provider, Swedish First Hill. All such patients would be required to either leave their accustomed healthcare system or leave the planning area to obtain services without this project.

Swedish Health Services correctly identifies that some fragmentation of services may occur because Virginia Mason is only proposing to provide level II ICN services and not Levels III and IV. The criterion, however, is *unwarranted fragmentation*. As noted earlier in the need section of this evaluation, a significant number of newborns require the level II services proposed to be provided at VMMC. A far smaller number require higher levels of care. The department concludes that the fragmentation caused by transferring level III and IV patients to other providers is not unwarranted when viewed against the benefits of this project.

Finally, Virginia Mason has demonstrated that this project will have an appropriate relationship to the service area’s existing health care system. Virginia Mason’s physicians already treat many of the patients who will have children at VMMC and whose babies will use the ICN. Existing payers and health care providers already have relationships with Virginia Mason that will continue after completion of this project. Virginia Mason has not, however, identified any providers of level III or IV NICU services to which it would transfer babies needing those levels of care. In order to fully comply with this sub criterion, approval of this project is conditioned upon Virginia Mason providing transfer agreements with hospitals able to provide appropriate levels of care.

Based on the information provided in the application, the department concludes there is reasonable assurance that this project will continue to promote continuity in the provision of health care services in the community with the new level II ICN. **This sub-criterion is met.**

(5) *There is reasonable assurance that the services to be provided through the proposed project will be provided in a manner that ensures safe and adequate care to the public to be served and in accord with applicable federal and state laws, rules, and regulations.*

This sub-criterion is addressed in sub-section (3) above and is **met.**

**D. Cost Containment (WAC 246-310-240)**

Based on the source information reviewed and agreement to the conditions identified in the conclusion section of this evaluation, the department determines that Virginia Mason met the applicable cost containment criteria in WAC 246-310-240.

(1) *Superior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable.*

To determine if a proposed project is the best alternative, in terms of cost, efficiency, or effectiveness, the department takes a multi-step approach. First the department determines if the application has met the other criteria of WAC 246-310-210 thru 230. If the project has failed to meet one or more of these criteria then the project cannot be considered to be the best alternative in terms of cost, efficiency, or effectiveness as a result the application would fail this sub-criterion.
If the project has met the applicable criteria in WAC 246-310-210 through 230 criteria, the department then assesses the other options considered by the applicant. If the department determines the proposed project is better or equal to other options considered by the applicant and the department has not identified any other better options this criterion is determined to be met unless there are multiple applications.

If there are multiple applications, the department’s assessment is to apply any service or facility superiority criteria contained throughout WAC 246-310 related to the specific project type. The adopted superiority criteria are objective measures used to compare competing projects and make the determination between two or more approvable projects which is the best alternative. If WAC 246-310 does not contain any service or facility type superiority criteria as directed by WAC 246-310-200(2)(a)(i), then the department would look to WAC 246-310-240(2)(a)(ii) and (b) for criteria to make the assessment of the competing proposals. If there are no known recognized standards as identified in WAC 246-310-200(2)(a)(ii) and (b), then using its experience and expertise, the department would assess the competing projects and determine which project should be approved.

**Virginia Mason**

**Step One**
For this project, Virginia Mason met the applicable review criteria under WAC 246-310-210, 220, and 230. Therefore, the department moves to step two below.

**Step Two**
Before submitting this application, Virginia Mason considered several alternatives to the proposed project. The options and Virginia Mason’s rationale for rejecting each option is below. [source: Application, p41]

- **Reopen OB with only Level I services**
  Virginia Mason rejected this option because the transferring the significant number of babies needing Level II services would create fragmentation of care and add unnecessary costs.

- **Reopen OB with Level I and submit a subsequent Level II application**
  The second option was rejected for the same reasons for the first. Virginia Mason did not identify any advantages to re-initiating OB services and requesting Level II ICN authorization at a later date.

- **Establish a Level II ICN without collaboration with CHI Franciscan**
  This third option was not explored in the initial application, rather it was discussed at the request of the department in response to screening questions. Virginia Mason decided collaboration with CHI Franciscan allowed it to establish Level II services at lower cost by avoiding consulting expenses and other planning and implementation expenses that it would have incurred without relying on the expertise of an established provider of Level II ICN and higher NICU services. Virginia Mason further concluded that proceeding without CHI Franciscan would give it a higher level of control and simplicity in operations, but that those benefits were outweighed by the cost savings and expertise offered by CHI Franciscan.

The option selected, to simultaneously re-initiate OB services and open a Level II ICN was selected to meet the demand for additional Level II ICN services and to avoid unnecessary transfers out of VMMC.

**Step Three**
This step is applicable only when there are two or more approvable projects. Virginia Mason’s application is the only application under review to add level II ICN beds in Seattle, within King County. Therefore, this step does not apply.
Public Comments
Swedish Health Services provided the following comments related to this sub-criterion.

“Per the VM CN application, CHI and VM plan to create a regional health network throughout the Puget Sound, and cite that employees have requested an alternative in Central King for obstetric and neonatal care. As noted above, there are several providers in King County providing both obstetrics and NICU care at a high quality. There are also no documented capacity concerns for any of these locations, including at Swedish First Hill. A new program at VM will dilute the staffing resources available to other providers in the area. Approving the proposed VM project would be an unnecessary duplication of service for the residents of King County. When VM closed their obstetrics program in the 1990’s the other providers in the area expanded their capacity to care for those VM patients. At no point in the application process has VM said anything negative regarding the quality of care provided by any of these other locations, including Swedish. Given the current model has been effective for 20 years, there is no reason why VM cannot explore continued ways to partner with other providers in the area on the provision of obstetrical and neonatal care for their population of patients. Swedish would be open to these discussions as we were with Group Health when they closed their obstetrical and Level II service at their Capital Hill Campus in 2015. Since that time Group Health obstetrical providers have been well served by the facilities at Swedish First Hill, including our extensive neonatal care services.

Rebuttal Comments
Virginia Mason provided the following rebuttal comments related to this sub-criterion.

The public record on our application contains a number of letters suggesting that there is a desire for expanding the number of obstetric and neonatal service providers in Central King. For example, the Health Care Authority wrote:

“HCA purchases health care for more than two million Washington residents through Washington Apple Health (Medicaid), the Public Employees Benefits Board (PEBB) program, and, beginning in 2020, the School Employees Benefits Board (SEBB) program. As the largest health care purchaser in the state, we lead the effort to transform health care, helping ensure Washington residents have access to better health and better care at a lower cost.

“This letter is written in support of Virginia Mason’s Certificate of Need request. HCA is committed to offering high quality, low-cost maternity care to Washington residents through Apple Health. We are excited at the prospect of Virginia Mason offering maternity care services to Apple Health members, over 400,000 of which live in King County. We look forward to working with Virginia Mason along with other providers and hospitals to improve maternal and child outcomes as we decrease unnecessary C-sections and inductions.”

Susan E. Birch, MBA, BSN, RN, Director

The two largest statewide insurers’ comments are below.
Premera Blue Cross John Espinola, MD, MPH, Executive Vice President Healthcare Services

“Premera works closely with Virginia Mason and offers several plans in conjunction with Virginia Mason including the Premera Personal Care Partner System. Enrollees in these plans choose a primary care provider from Virginia Mason but have to go outside of the Virginia Mason system for obstetrical and neonatal care. Being able to provide comprehensive, high quality and cost-effective services within a network of providers would be a huge benefit to our enrollees.

“The current c-section rate in Central King is about 30% and the early elective delivery rate is 1.1%. Virginia Mason has indicated that its proposed new obstetrics unit and Level II will deliver care that exceeds these current levels by utilizing evidence-based care standards, educating providers and patients about the risks of unnecessary interventions and continuing its demonstrated commitment to
the most appropriate and highest quality clinical care. The employers that select Premera and the
patients that have deductibles and out of pocket costs will benefit by the addition of these services at
Virginia Mason.”

**Regence** John Partin, Vice President of Network Management

“Regence takes seriously its responsibility for ensuring that our members have access to efficient
providers that offer high quality outcomes at affordable prices, and to this end, we have enjoyed a long
and very positive working relationship with Virginia Mason.

“For Regence members in general, and Central King County members in particular, there are currently
a fairly limited number of options for obstetrical services. The proposed Level II service will support a
new obstetrical/birth center that will increase access, provide options and enhance continuity of care
for our members who choose to have their care provided by Virginia Mason.

“Virginia Mason consistently demonstrates and has been nationally recognized for delivering quality
outcomes efficiently and cost effectively. With the rising cost of deductibles, co-insurances and other out
of pocket expenses, Regence expects our members will benefit with the addition of this service to our
network.”

“Virginia Mason is well known in the state, nationally and internationally to be a low cost, high
quality, cost-effective provider. In 2018, the Washington Health Alliance recognized Virginia Mason as one of
only four hospitals in the state that were among the top ten in quality and patient experience while also
having a gross charge index lower than the state average. Clearly, our state’s health care purchasers
and insurers recognize the benefits to payers and patients that will result from the establishment of a
Level II service at Virginia Mason.”

**Department Evaluation**

Information provided in the Virginia Mason application and within public comments demonstrates that
that the level II ICN services are needed at VMMC. Virginia Mason discussed the additional staff
required to operate an ICN and demonstrated its ability to recruit and retain necessary staff. The
application and public comments support that a “do nothing” option was appropriately ruled out by the
applicant.

The department concludes that the project as submitted by Virginia Mason is the best available option
for the planning area and surrounding communities. **This sub-criterion is met.**

(2) **In the case of a project involving construction:**

(a) **The costs, scope, and methods of construction and energy conservation are reasonable:**

**Virginia Mason**

“The design process is focused on maximizing value leading to lower lifecycle costs. In addition, we
intend to reduce cost by prefabricating mechanical, electrical and plumbing. As planned, prefabrication
will allow for higher quality construction while reducing cost, safety concerns, and project
duration.”[source: Application, p42]

Public Comments

None

Rebuttal Comments

None
Department Evaluation
As part of its analysis, HFCCP provided the following statements regarding the construction costs, scope, and method. [source: HFCCP analysis, p5]

“The costs of the project are the cost for construction, planning and process. VM’s projections are below.”

<table>
<thead>
<tr>
<th>Total Capital</th>
<th>$3,282,500</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beds/Stations/Other (Unit)</td>
<td>5</td>
</tr>
<tr>
<td>Total Capital per Unit</td>
<td>$656,500</td>
</tr>
</tbody>
</table>

“The costs shown are within past construction costs reviewed by this office. Also construction cost can vary quite a bit due to type of construction, quality of material, custom vs. standard design, building site and other factors. VM is remodeling existing space and will construct the facility to the latest energy and hospital standards.”

Based on the information provided in the application and the analysis from HFCCP, the department concludes this sub-criterion is met.

(b) The project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.

Virginia Mason
“In addition, Virginia Mason is known to be a cost attentive provider. In 2018, the Washington Health Alliance recognized Virginia Mason as one of only three hospitals in the state among the top ten in quality and patient experience while also having a gross charge index lower than the state average.”[source: Application, p22]

Public Comments
None

Rebuttal Comments
None

Department Evaluation
As part of its analysis, HFCCP provided the following statements related to this sub-criterion. [source: HFCCP analysis, p5]

“Staff is satisfied that, contingent on a demonstration of need for additional services, adding NICU bassinets to the existing facility will not have an unreasonable impact of the costs and charges to the public of providing services by other persons. Staff is satisfied the project is appropriate. This criterion is satisfied.”

The department concludes this sub-criterion is met.
The project will involve appropriate improvements or innovations in the financing and delivery of health services which foster cost containment and which promote quality assurance and cost effectiveness.

**Virginia Mason**

“The proposed Virginia Mason Level II nursery will provide a high value, system efficient alternative. For example, as shown in Table 18, the 2017 C-section rate in Central King is 30.3% and the early elective delivery rate is 1.1%. CHI Franciscan’s overall C-section rate is 27.46% and early elective delivery rate is 0.76% meaning that it is reasonable to expect improved (decreased rates) outcomes.

“Virginia Mason’s proposed nursery program intends to deliver obstetrics and nursery care that exceeds these performance levels by utilizing evidence-based care standards and educating providers and patients about the risks of unnecessary interventions and continuing our commitment to the most appropriate and highest quality clinical care to King County residents.” [source: Application, p42]

Public Comments
None

Rebuttal Comments
None

**Department Evaluation**

As noted earlier in this evaluation, this project has the potential to improve delivery of acute care services to the residents of King County and surrounding communities with the addition of level II ICN beds at VMMC. The department is satisfied the project is appropriate and needed. **This sub-criterion is met.**