PCI Rulemaking

Updates, Recommendations, & Proposed Next Steps
from the External PCI Group Collaboration Sessions

December 17, 2024

PCI Rulemaking | External Group Collaboration

Participants To-Date:

- Alex Burton, Virginia Mason Franciscan Health
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Please note that this remains an open offer for anyone who would like to partner between the Department's PCI Workgroup meetings to discuss key topics and offer questions and/or recommendations. We are glad to invite others into these optional touch-base meetings.

Agenda Topics

- **PCI Rulemaking: What We've Covered & What Remains**
- **Updates & Recommendations for Eight Key Topics**
  - Non-numeric need
  - Concurrent review (WAC 246-310-710)
  - General requirements (WAC 246-310-715)
  - Hospital volume standards (WAC 246-310-720)
  - Physician volume standards (WAC 246-310-725)
  - Staffing requirements (WAC 246-310-730)
  - Partnering agreements (WAC 246-310-735)
  - Quality assurance (WAC 246-310-740)
  - Other miscellaneous items
- **Proposed Next Steps & Future Topics for Discussion**
  - Need forecasting methodology (WAC 246-310-745)
  - Tiebreaker (WAC 246-310-750)
  - Ongoing compliance with standards (WAC 246-310-755)

PCI Rulemaking: What We've Covered & What Remains

WAC	Name of Section	Status	Next Steps
246-310-700	Adult elective percutaneous coronary interventions (PCI) without on-site cardiac surgery	Revisions proposed	None at this time. Revisit after other sections have been reviewed
246-310-705	PCI definitions	Revisions proposed	None at this time. Revisit after other sections have been reviewed
246-310-710	Concurrent review	In progress	Share options & discuss at PCI Workshop (12/17)
246-310-715	General requirements	In progress / Revisions proposed	Share recommendations at PCI Workshop (12/17)
246-310-720	Hospital volume standards	In progress / Revisions proposed	Share recommendations at PCI Workshop (12/17)
246-310-725	Physician volume standards	In progress / Revisions proposed	Share recommendations at PCI Workshop (12/17)
246-310-730	Staffing requirements	In progress / Revisions proposed	Share recommendations at PCI Workshop (12/17)
246-310-735	Partnering agreements	In progress / Revisions proposed	Share recommendations at PCI Workshop (12/17)
246-310-740	Quality assurance	In progress / Revisions proposed	Share recommendations at PCI Workshop (12/17)
246-310-745	Need forecasting methodology	In progress / Additional edits needed	Share recommendations for non-numeric need at PCI Workshop. Work on edits to incorporate numeric & non-numeric need recommendations
246-310-750	Tiebreaker	Not yet reviewed	Discuss at External PCI Workgroup (12/19)
246-310-755	Ongoing compliance with standards	Not yet reviewed	Discuss at External PCI Workgroup (12/19)

Topic #1. Non-numeric Need
Recommendations

Recommendation: Non-Numeric Need

(1) The Department may grant a certificate of need for a new elective percutaneous coronary intervention program in a planning area where there is not numeric need.

(a) The Department will consider if the applicant meets the following criteria:

(i) All applicable review criteria and standards with the exception of numeric need have been met;

(ii) The applicant commits to serving Medicare and Medicaid patients;

(iii) Approval under these non-numeric need will not cause existing CN-approved provider(s) to fall below 200 PCIs; and

(iv) The applicant demonstrates the ability to address at least one of the following non-numeric criteria. Applicants must include empirical data that supports their non-numeric need application. This information must be publicly available and replicable. The non-numeric need criteria are:

(1) Demonstration an applicant's request would substantially improve access to communities with documented barriers to access and/or higher disease burdens which result in poorer cardiovascular health outcomes. These communities include low-income and uninsured populations, as well as demographics with higher rates of identifiable risk factors for cardiovascular disease. These measures would be compared to Statewide or National averages as appropriate.

(2) Demonstration an applicant's request would improve access in a PCI Planning Area that lacks a CN-approved elective PCI provider.

(3) An existing emergent-only provider has operated for at least the last three (3) consecutive years and seeks to add elective.

(4) Demonstration an applicant's request is consistent with a significant change in PCI treatment practice and promotes cost containment through a reduction in facility-based reimbursement by at least 30%.

(5) Demonstration an applicant's request will improve cost-effectiveness and efficiency by alleviating capacity constraints at an affiliate hospital's catheterization laboratory (ies) and/or inpatient beds where PCIs are currently performed. The applicant must also demonstrate the cumulative annual planning area resident PCI volumes performed by the applicant and any affiliate PCI program(s) will be sufficient to support the minimum volume standard for the applicant and its affiliate PCI program(s). An affiliate PCI program is defined as a health care facility's CN-approved PCI program that is owned and operated by the same system as the applicant.

NOTES ABOUT HIGHLIGHTED PASSAGE

- The External PCI Workgroup members have not reached consensus about the highlighted passage.
- The highlighted criteria are a placeholder and are only applicable if a PCI site of care change is implemented as a result of PCI rulemaking.
- While some workgroup members prefer to have the site of care-related text listed, others have noted that many WACs will need to be updated if a site of care change is adopted and that it is cleanest if the highlighted passage is not included in the recommendations at this time.
- Based on the Dec. 5 Workshop, we also note that UW/Harborview has proposed edits that differ from the External PCI Workgroup and will require further discussion.

Topic #2. Concurrent review (WAC 246-310-710)

Discussion of two options

WAC 246-310-710 Concurrent review

The department shall review new adult elective percutaneous coronary intervention (PCI) services using the concurrent review cycle according to the following table:

(see image to the right …)

(1) If the department is unable to meet the deadline for making a decision on the application, it will notify applicants fifteen days prior to the scheduled decision date. In that event, the department will establish a new decision date.

(2) The department may not accept new applications for a planning area if there are any pending applications in that planning area filed under a previous concurrent review cycle, or applications submitted prior to the effective date of these rules that affect any of the new planning areas, unless the department has not made a decision on the pending applications within the review timelines of nine months for a concurrent review and six months for a regular review.

(3) If the department determines that an application does not compete with another application, it may convert the review of an application that was initially submitted under a concurrent review cycle to a regular review process.

Concurrent Review Cycle:

Application Submission Period	Letters of Intent Due	First working day through last working day of January of each year.	
	Receipt of Initial Application	First working day through last working day of February of each year.	
	End of Screening Period	Last working day of March of each year.	
	Applicant Response	Last working day of April of each year.	
Department Action	Beginning of Review Preparation	May 1 through May 15	
Application Review Period	Public Comment Period (includes public hearing if requested)	60-Day Public Comment Period	Begins May 16 of each year or the first working day after May 16.
	Rebuttal Period	30-Day Rebuttal period	Applicant and affected party response to public comment.
	Ex parte Period	45-Day Ex parte period	Department evaluation and decision.

WAC 246-310-710 Concurrent review

Current State: There are seven types of CN projects that have concurrent review cycles, although most (if not all) of these project types do not attract a high volume of applications.

Examples of Questions Discussed by External Workgroup

- Are there any advantages to eliminating the elective PCI concurrent application cycle and allow applicants to have the flexibility to apply at any time? What are the disadvantages?
- If the concurrent cycle is maintained and we anchor to COAP as a single data source, should the timing shift to earlier in the year since we'd no longer be waiting on the annual PCI survey results?
- We've requested that we receive access to COAP data on a quarterly basis. If the concurrent review cycle were eliminated, would it be acceptable for applicants to utilize the most recent 12 months of data to apply?

WAC 246-310-710 Concurrent review

	Option 1. Change Timing of Concurrent Cycle	Option 2. Eliminate Concurrent Cycle
Description	**Maintain** the annual concurrent review cycle for elective PCI CN applications but move the timing of the cycle to earlier in the year (LOI: June 30, CN Application: July 31).	**Eliminate** the annual concurrent review cycle for elective PCI CN applications, allowing applicants to apply at any time during the year.
Considerations	• Timing of cycle is moved to coincide with the availability of the full-year of COAP data and numeric need model by the Department. Also helpful to move the annual cycle away from the holidays • Continues to create predictability for when elective PCI applications will be considered State-wide, yet improves the timeliness of addressing access by anchoring to when new annual data is available • A drawback remains that significant time can be spent on a potential CN project before it is known whether numeric need is shown, as potential applicants often begin working well in advance of the concurrent review cycle to prepare for the once-a-year window	• Provides flexibility for applicants to submit applications when they're ready. This could be especially beneficial for those utilizing non-numeric need. • With the recommendation to receive COAP data on a quarterly basis, applicants could utilize the most recent 12 months of available data for their need model. (Question: Going forward, would the Department need to produce the need models, or can the models be produced by the applicants?) • Like other CN projects that do not have an annual concurrent review cycle, there would still be the ability of other applicants submit a competing proposal prior to BOR being declared and trigger a concurrent review cycle. Note: It would be important for the Department to post LOIs & applications to Box on-time so that interested / affected parties could determine if they want to apply, as well. • Allows for improved timeliness in addressing community need & access, as opposed to waiting for an annual concurrent review cycle to open

*Note: Both options assume that COAP is selected as the single data source for the PCI need models.

Topic #3: General requirements (WAC 246-310-715)

Review of Redlines & Recommendations

WAC 246-310-715 General Requirements

Summary of Proposed Changes

- Remove verbiage that is duplicative of other WACs and include WAC references for alignment purposes, as needed
- Update verbiage so that it is more timeless and won't have to be updated as frequently (or as extensively) in the future

WAC 246-310-715 General Requirements

Redline	With Changes Accepted
The applicant hospital must: (1) Submit an ~~detailed~~ analysis of the impact that their new adult elective PCI services will have on ~~the~~ Cardiovascular Disease and Interventional Cardiology Fellowship Training programs within the state of Washington ~~at the University of Washington~~ and allow the programs an opportunity to respond. ~~New programs may not reduce current volumes at the University of Washington fellowship training program.~~	The applicant hospital must: (1) Submit an analysis of the impact that their new adult elective PCI services will have on Cardiovascular Disease and Interventional Cardiology Fellowship Training programs within the state of Washington and allow the programs an opportunity to respond.

NOTE: Discussion remains under way with clinicians about whether (1) is still needed or whether it is their preferred recommendation to remove it altogether.

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WAC 246-310-715 General Requirements

Redline	With Changes Accepted
(2) Submit a detailed analysis of the projected volume of adult elective PCIs that it anticipates it will perform in years one, two and three after it begins operations. All new elective PCI programs must comply with the state of Washington ~~annual~~ PCI volume standards in WAC 246-310-720 and WAC 246-210-725. ~~of (two hundred) by the end of year three. The projected volumes must be sufficient to assure that all physicians working only at the applicant hospital will be able to meet volume standards of fifty PCIs per year.~~ If an applicant hospital fails to meet annual volume standards set forth in WAC 246-310-720 and WAC 246-310-725, the department ~~may~~ shall conduct a review of certificate of need approval for the program under WAC 246-310-755.	(2) Submit a detailed analysis of the projected volume of adult elective PCIs that it anticipates it will perform in years one, two and three after it begins operations. All new elective PCI programs must comply with the state of Washington PCI volume standards in WAC 246-310-720 and WAC 246-210-725. If an applicant hospital fails to meet annual volume standards set forth in WAC 246-310-720 and WAC 246-310-725, the department shall conduct a review of certificate of need approval for the program under WAC 246-310-755.

NOTE: The reference to WAC 246-310-725 can be eliminated if the volume standards are combined into a single WAC.

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WAC 246-310-715 General Requirements

Redline	With Changes Accepted
(3) Submit a plan detailing how they will effectively recruit and staff the new program with qualified nurses, catheterization laboratory technicians, and interventional cardiologists. ~~without negatively affecting existing staffing at PCI programs in the same planning area~~.	(3) Submit a plan detailing how they will effectively recruit and staff the new program with qualified nurses, catheterization laboratory technicians, and interventional cardiologists.
(4) Maintain one catheterization lab used primarily for cardiology. The lab must be a fully equipped cardiac catheterization laboratory with all appropriate devices, optimal digital imaging systems, life sustaining apparati, intra-aortic balloon pump assist device (IABP). ~~The lab must be staffed by qualified, experienced nursing and technical staff with documented competencies in the treatment of acutely ill patients.~~	(4) Maintain one catheterization lab used primarily for cardiology. The lab must be a fully equipped cardiac catheterization laboratory with all appropriate devices, optimal digital imaging systems, life sustaining apparati, intra-aortic balloon pump assist device (IABP).

NOTE: The aqua highlights identify the text that is still being evaluated in partnership with clinicians.

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WAC 246-310-715 General Requirements

Redline	With Changes Accepted
(5) Be prepared and staffed to perform emergent PCIs twenty-four hours per day, seven days per week in addition to the scheduled PCIs.	(5) Be prepared and staffed to perform emergent PCIs twenty-four hours per day, seven days per week in addition to the scheduled PCIs.
(6) Have a partner agreement consistent with WAC 246-310-735.	(6) Have a partner agreement consistent with WAC 246-310-735.
~~(6)~~ (7)If an existing CON approved heart surgery program relinquishes the CON for heart surgery, the facility must apply for an amended CON to continue elective PCI services. The applicant must demonstrate ability to meet the elective PCI standards in this chapter.	(7) If an existing CON approved heart surgery program relinquishes the CON for heart surgery, the facility must apply for an amended CON to continue elective PCI services. The applicant must demonstrate ability to meet the elective PCI standards in this chapter.

NOTE: The aqua highlights identify the text that is still being evaluated in partnership with clinicians.

NOTES ABOUT YELLOW HIGHLIGHTED PASSAGE

- The External PCI Workgroup members have not reached consensus about the yellow highlighted passage (5).
- Some workgroup members prefer to eliminate (5), as they would like to make site of care-related changes to the WACs now. Others have noted that many WACs will need to be updated if a site of care change is adopted and that it is cleanest if the highlighted passage is not included in the recommendations at this time.

Topic #4: Hospital volume standards (WAC 246-310-720)

Review of Redlines & Recommendations

WAC 246-310-720 Hospital volume standards

Summary of Proposed Changes

- Consolidate WAC 246-310-720 Hospital volume standards and WAC 246-310-725 Physician volume standards into a single WAC for all applicable volume standards
- Based on prior recommendations to introduce non-numeric need criteria, remove verbiage that pertains to CNs being granted for numeric need only
- Other minor edits, as needed

WAC 246-310-720 Hospital volume standards

Recommendation: Combine WAC 246-310-720 and WAC 246-310-725 into a single set of volume standards. Retitle as WAC 246-310-720 Volume standards.

Redline	With Changes Accepted
(1) Hospitals with an elective PCI program must perform a minimum of two hundred adult PCIs per year by the end of the third year of operation and each year thereafter. ~~(2) The department shall only grant a certificate of need to new programs within the identified planning area if:~~ ~~(a) The state need forecasting methodology projects unmet volumes sufficient to establish one or more programs within a planning area; and~~ ~~(b) All existing PCI programs in that planning area are meeting or exceeding the minimum volume standard.~~ (2) Physicians performing adult elective PCI procedures ~~at the applying hospital~~ must perform a minimum of fifty PCIs per year. Applicant hospitals must provide an attestation ~~documentation~~ that physicians performed fifty PCI procedures per year for the previous three years prior to the applicant's CON request.	(1) Hospitals with an elective PCI program must perform a minimum of two hundred adult PCIs per year by the end of the third year of operation and each year thereafter. (2) Physicians performing adult elective PCI procedures must perform a minimum of fifty PCIs per year. Applicant hospitals must provide an attestation that physicians performed fifty PCI procedures per year for the previous three years prior to the applicant's CON request.

Topic #5: Physician volume standards (WAC 246-310-725)
Review of Redlines & Recommendations

WAC 246-310-725 Physician volume standards

Summary of Proposed Changes

- Consolidate WAC 246-310-720 Hospital volume standards and WAC 246-310-725 Physician volume standards into a single WAC for all applicable volume standards
- Other minor edits, as needed

WAC 246-310-725 Physician volume standards

Recommendation: Combine WAC 246-310-720 and WAC 246-310-725 into a single set of volume standards. Retitle as WAC 246-310-720 Volume standards.

Redline	With Changes Accepted
Physicians performing adult elective PCI procedures ~~at the applying hospital~~ must perform a minimum of fifty PCIs per year. Applicant hospitals must provide an attestation ~~documentation~~ that physicians performed fifty PCI procedures per year for the previous three years prior to the applicant's CON request.	Physicians performing adult elective PCI procedures must perform a minimum of fifty PCIs per year. Applicant hospitals must provide an attestation that physicians performed fifty PCI procedures per year for the previous three years prior to the applicant's CON request.

Topic #6: Staffing requirements (WAC 246-310-730)

Review of Redlines & Recommendations

WAC 246-310-730 Staffing requirements

Summary of Proposed Changes

- Recommend eliminating WAC 246-310-730

WAC 246-310-730 Staffing requirements

Recommendation: Eliminate WAC 246-310-730. The staffing requirements are referenced in WAC 246-310-715(3) and also covered by Structure and Process of Care (WAC 246-310-230). The current details in WAC 246-310-730 are not needed.

Redline	With Changes Accepted
~~The applicant hospital must:~~ ~~(1) Employ a sufficient number of properly credentialed physicians so that both emergent and elective PCIs can be performed.~~ ~~(2) Staff its catheterization laboratory with a qualified, trained team of technicians experienced in interventional lab procedures.~~ ~~(a) Nursing staff should have coronary care unit experience and have demonstrated competency in operating PCI related technologies.~~ ~~(b) Staff should be capable of endotracheal intubation and ventilator management both on-site and during transfer if necessary.~~	

Topic #7: Partnering agreements (WAC 246-310-735)

Review of Redlines & Recommendations

WAC 246-310-735 Partnering agreements

Redline	With Changes Accepted
The applicant hospital must have a signed written agreement with a hospital providing on-site cardiac surgery. This agreement must include, at minimum, these provisions ~~for~~:	The applicant hospital must have a signed written agreement with a hospital providing on-site cardiac surgery. This agreement must include, at minimum, these provisions:
(1) ~~Coordination between~~ The nonsurgical hospital shall coordinate with the backup ~~and~~ surgical hospital~~'s~~ about the availability of its surgical teams and operating rooms. ~~The hospital with on-site surgical services is not required to maintain an available surgical suite twenty-four hours, seven days a week.~~	(1) The nonsurgical hospital shall coordinate with the backup surgical hospital about the availability of its surgical teams and operating rooms.
(2) ~~Assurance~~ The backup surgical hospital ~~can~~ shall provide an attestation that it can perform ~~provide~~ cardiac surgery during ~~all~~ the hours that elective PCIs are being performed at the applicant hospital.	(2) The backup surgical hospital shall provide an attestation that it can perform cardiac surgery during the hours that elective PCIs are being performed at the applicant hospital.
(3) ~~Transfer of~~ In the event of a patient transfer, the nonsurgical hospital shall provide access to all clinical data, including images and videos, ~~with the patient~~ to the backup surgical hospital.	(3) In the event of a patient transfer, the nonsurgical hospital shall provide access to all clinical data, including images and videos, to the backup surgical hospital.

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WAC 246-310-735 Partnering agreements

Redline	With Changes Accepted
(4) ~~Communication by~~ The physician(s) performing the elective PCI shall communicate to the backup surgical hospital cardiac surgeon(s) about the clinical reasons for urgent transfer and the patient's clinical condition.	(4) The physician(s) performing the elective PCI shall communicate to the backup surgical hospital cardiac surgeon(s) about the clinical reasons for urgent transfer and the patient's clinical condition.
(5) ~~Acceptance of all referred patients by~~ The backup surgical hospital shall accept referred patients.	(5) The backup surgical hospital shall accept referred patients.
(6) ~~The applicant hospital's mode of emergency transport for patients requiring urgent transfer. The hospital must have~~ The applicant hospital shall have a signed transportation agreement with a vendor who will ~~expeditiously~~ transport by air or land all patients ~~who experience complications during elective PCIs~~ that require transfer to a backup surgical hospital ~~with on-site cardiac surgery~~. Emergency transportation shall begin within twenty minutes of the initial identification of a complication.	(6) The applicant hospital shall have a signed transportation agreement with a vendor who will transport by air or land all patients that require transfer to a backup surgical hospital. Emergency transportation shall begin within twenty minutes of the initial identification of a complication.
~~(7) Emergency transportation beginning within twenty minutes of the initial identification of a complication.~~	

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WAC 246-310-735 Partnering agreements

Redline	With Changes Accepted
~~(8)~~ (7) ~~Evidence~~ The transportation vendor shall provide an attestation that its emergency transport staff are ~~certified. These staff must be~~ advanced cardiac life support (ACLS) certified and have the skills, experience, and equipment to monitor and treat the patient en route~~. and to manage an intra-aortic balloon pump (IABP).~~	(7) The transportation vendor shall provide an attestation that its emergency transport staff are advanced cardiac life support (ACLS) certified and have the skills, experience, and equipment to monitor and treat the patient en route.
~~(9)~~ (8) ~~The hospital documenting~~ The applicant hospital shall maintain quality reporting of the total transportation time, calculated as the time that lapses from the decision to transfer the patient ~~with an elective PCI complication~~ to arrival in the operating room of the backup surgical hospital. The total transportation time must be less than one hundred twenty minutes.	(8) The applicant hospital shall maintain quality reporting of the total transportation time, calculated as the time that lapses from the decision to transfer the patient to arrival in the operating room of the backup surgical hospital. The total transportation time must be less than one hundred twenty minutes.
~~(10)~~ (9) The applicant hospital, transportation vendor, and backup surgical hospital shall perform a minimum of ~~At least~~ two annual timed emergency transportation drills with outcomes reported to the applicant hospital's quality assurance program.	(10) The applicant hospital, transportation vendor, and backup surgical hospital shall perform a minimum of two annual timed emergency transportation drills with outcomes reported to the applicant hospital's quality assurance program.

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WAC 246-310-735 Partnering agreements

Redline	With Changes Accepted
~~(11)~~ (10) ~~Patient signed informed consent for adult elective (and emergent) PCIs.~~ The applicant hospital shall provide a patient consent form that ~~must explicitly~~ communicates ~~to the patients~~ that the intervention is being performed without on-site ~~surgery~~ surgical backup. The patient consent form shall ~~and~~ address the risks and mitigations, including but not limited to, emergent patient transfer, surgery by a backup surgical hospital, ~~and urgent surgery,~~ and the established emergency transfer agreements.	(10) The applicant hospital shall provide a patient consent form that communicates that the intervention is being performed without on-site surgical backup. The patient consent form shall address the risks and mitigations, including but not limited to, emergent patient transfer, surgery by a backup surgical hospital, and the established emergency transfer agreements.
~~(l2)~~ (11) The applicant hospital and backup surgical hospital shall conduct a quarterly quality conference to review ~~Conferences between representatives from the heart surgery program(s) and the elective coronary intervention program. These conferences must be held at least quarterly, in which a significant number of preoperative and post-operative cases are reviewed, including~~ all transport cases.	(11) The applicant hospital and backup surgical hospital shall conduct a quarterly quality conference to review all transport cases.

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WAC 246-310-735 Partnering agreements

Redline	With Changes Accepted
~~(13) Addressing peak volume periods (such as joint agreements with other programs, the capacity to temporarily increase staffing, etc.).~~	

Topic #8: Quality assurance (WAC 246-310-740)

Review of Redlines & Recommendations

WAC 246-310-740 Quality assurance

Redline	With Changes Accepted
(1) The applicant hospital must submit a written quality assurance/quality improvement plan specific to the elective PCI program as part of its application. ~~At minimum, the plan must include:~~ ~~(1) A process for ongoing review of the outcomes of adult elective PCIs. Outcomes must be benchmarked against state or national quality of care indicators for elective PCIs.~~ ~~(2) A system for patient selection that results in outcomes that are equal to or better than the benchmark standards in the applicant's plan.~~ ~~(3) A process for formalized case reviews with partnering surgical backup hospital(s) of preoperative and post-operative elective PCI cases, including all transferred cases.~~	(1) The applicant hospital must submit a written quality assurance/quality improvement plan specific to the elective PCI program as part of its application.

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WAC 246-310-740 Quality assurance

Redline	With Changes Accepted
~~(4) A description of the hospital's cardiac catheterization laboratory and elective PCI quality assurance reporting processes for information requested by the department or the department's designee. The department of health does not intend to require duplicative reporting of information.~~	
(2) All certificate of need approved PCI programs must submit PCI statistics, adhering to COAP PCI data submittal timelines. PCI data shall include with each PCI the date the procedure, provider name, patient age, and patient zip code.	(2) All certificate of need approved PCI programs must submit PCI statistics, adhering to COAP PCI data submittal timelines. PCI data shall include with each PCI the date the procedure, provider name, patient age, and patient zip code.

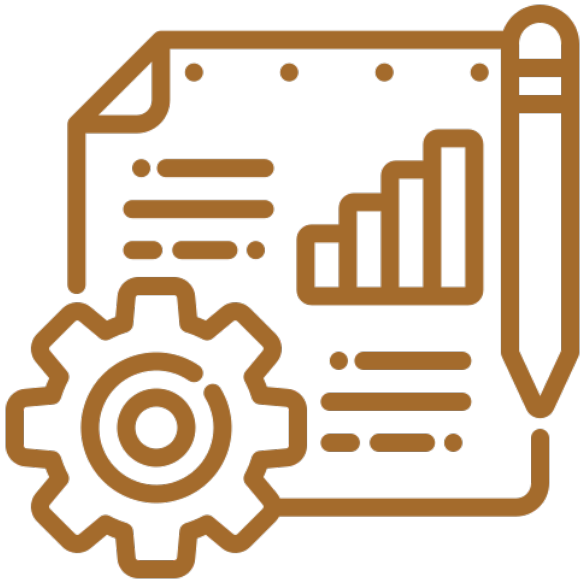
Other miscellaneous items
Recommendations

Projected Need for Programs

Current State: For example, if the projected need for an elective PCI program is 0.95 in a Planning Area, the need model will say there is no need for a new program.

<u>Examples of Questions Discussed</u>

- Within the numeric need methodology, should rounding be utilized when calculating the # of new programs?
- Are no changes needed if we are able to adopt revisions to the numeric need methodology and non-numeric need?



Recommendation
No additional edits to the WACs should be made to allow for rounding of projected need, provided that the proposed changes to the numeric need methodology and non-numeric need are adopted.

State Health Plan

Current State: The Department continues to reference and rely upon portions of the 1989 Washington State Health Plan, even though this plan was sunset decades ago.

Examples of Questions Discussed

- Are there any “PCI remnants” that remain in the State Health Plan that need to be migrated to the WACs and RCWs?
- How do we want to complete our due diligence to identify any remnants and pull forward those pieces into the current rulemaking efforts?

Closing the Loop

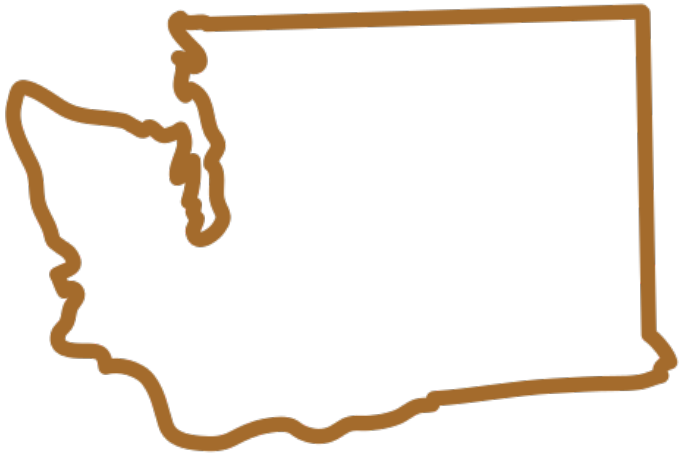
The External PCI Workgroup has reviewed the 1989 Washington State Health Plan and did not identify any additional information that need to be migrated to the WACs or RCWs.

Border Communities

Current State: Limitations exist in the current numeric need model to account for in-migration / outmigration, which is observed to a greater extent in border communities.

<u>Examples of Questions Discussed</u>

- Are there any additional refinements needed to the proposed alternatives for the Numeric Need Methodology?
- Are the issues adequately addressed if Non-numeric Need is codified into the WACs?



Recommendation
No additional edits to the WACs are needed, provided that the proposed changes to the numeric need methodology and non-numeric need are adopted.

Proposed Next Steps & Future Topics for External PCI Group Collaboration Sessions

Proposed Next Steps & Future Topics

Request for the Department

- **Schedule additional PCI Rule Workshops.** The timeline will help the External PCI Collaboration Group establish the cadence of our meeting schedule to continue make ongoing, meaningful progress on working through key issues and drafting recommendations and questions for discussion.

External PCI Group Collaboration Sessions: Proposed Next Topics

- Need forecasting methodology (WAC 246-310-745)
- Tiebreaker (WAC 246-310-750)
- Ongoing compliance with standards (WAC 246-310-755)

PCI Rulemaking

Questions?