# Sacred Heart Response to CHS' Public Comment on Proposed Certificate of Need Settlement

## 1. Introduction And Summary Of Response To CHS Public Comment.

The Department of Health has been presented with the ongoing challenge of how to preserve patient choice in a time of rapid change in the Spokane health care market, while at the same time ensuring that quality of care is maintained for those who can pay, as well as for those who cannot. Rapid change arrived in Spokane when two venerable not for profit institutions, Deaconess and Valley hospitals, were acquired by the nation's largest, publicly traded hospital company, Community Health Systems, Inc. ("CHS"). These acquisitions raise serious and immediate questions about whether regional cooperation through Inland Northwest Health Services will continue, whether CHS will maintain service lines or drop them, as it did with trauma care, and whether CHS will provide its share of charity care.[1]

In its proposed settlement, the Department has crafted a fair solution that will, if approved, ensure patients and their doctors have the right to choose where they receive care. The proposed settlement also ensures that critical care not available at a CHS hospital or anywhere else in Eastern Washington remains available at Sacred Heart to all who need it. It allows Sacred Heart to lower the cost of care and to improve quality.

The proposed settlement is supported by the Spokane community, including by medical, business and civic groups. (See comments attached as Exhibit A). Premera and SEIU, who opposed Sacred Heart's original application, have not opposed the proposed settlement.

By opposing the settlement, CHS is asking the Department to trust that CHS alone will meet the incremental growth in patient needs in Spokane for the next decade. CHS in effect asks the Department to place a bet that a for profit hospital system, controlled in Tennessee and whose shares are traded on the New York Stock Exchange, will be a reliable substitute to the not for profit hospitals that have served Spokane for generations.

Sacred Heart's mission is to provide compassionate care and service for all, especially the poor and vulnerable. Because there are no public hospitals in Spokane, Providence hospitals serve as the safety net for the poor and vulnerable who are injured or sick. Sacred Heart must achieve a careful operational balance to ensure sufficient resources are available to meet the needs of an expanding underserved population. Growing a full range of services is essential to maintaining the financial health and balance necessary for Sacred Heart to provide vital safety net services to Eastern Washington residents.

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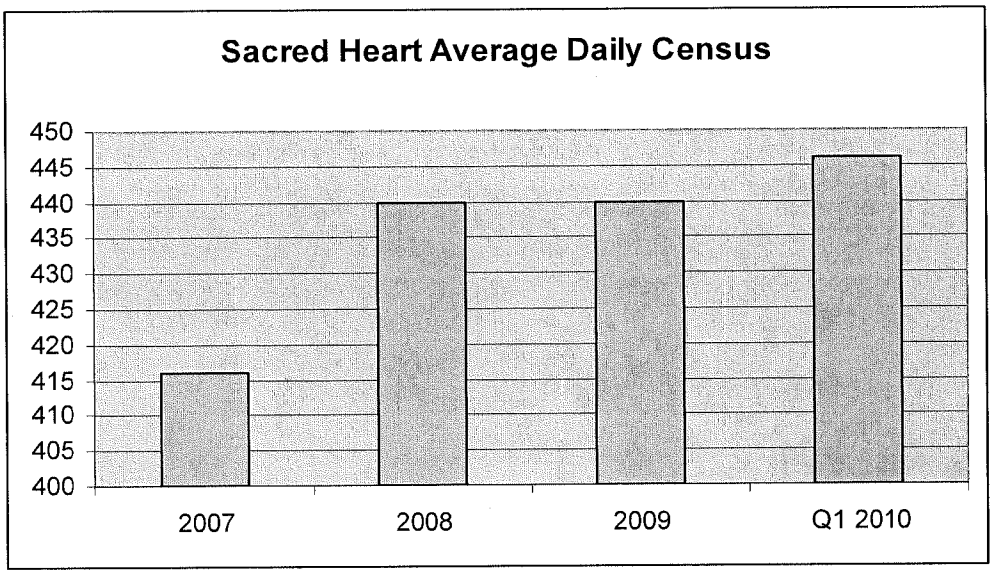
[1] Sacred Heart refers to Deaconess and Valley as "CHS" because both hospitals are owned by that publicly traded company. *See* CHS' Form 10-K filed February 25, 2010 with the Securities and Exchange Commission. CHS also owns a majority interest in Rockwood Clinic. *Id.*

CHS' effort to seize control over the incremental growth in the Spokane health care market could undermine Sacred Heart's ability to fulfill its safety net role. These efforts began early in this proceeding when CHS purported to "discover" more than 100 set up and available beds that had never been previously reported. The Department denied Sacred Heart's request for 152 adult acute care beds largely because these newly "found" CHS beds skewed the bed need forecast. The Department and Sacred Heart spent several months negotiating a solution that would assume, for the purposes of argument, that CHS had as many beds as it claimed, while allowing Sacred Heart an opportunity to expand to help meet the projected need in the region.

The reason CHS so aggressively opposes the settlement is simple: Sacred Heart is the highest quality, lowest cost tertiary care hospital in Eastern Washington. Doctors and patients will continue to choose Sacred Heart for their care, unless denied that choice because the hospital is full and must turn them away. If the settlement is not approved, CHS will have more patient revenue not because it offers better or lower cost care, but because it has no competition for this incremental business.

There is nothing in the settlement that affects CHS' ability to continue its aggressive efforts to transform the Spokane health care market. CHS' suggestion that its financial viability is threatened is simply not credible, given that it has access to billions of dollars of capital through public financial markets, and that it has shown a willingness to use these funds in Spokane with its $54 million acquisition of Rockwood Clinic.

In the four months since CHS acquired Rockwood, physicians and their patients have continued to choose Sacred Heart for their care. The Rockwood physicians were a significant source of referrals to Sacred Heart. And yet, as these physicians were directed to send patients to Deaconess and Valley, Sacred Heart's average daily census has remained steady (as shown by the chart below and further discussed in section 2.b. below), a remarkable fact given the impact the Great Recession has had on health care volumes across the nation. When given the option, physicians and patients choose Sacred Heart. The proposed settlement will ensure that they continue to have this choice.



This memorandum, including the attached statement of health care expert Professor Glenn Melnick, responds to CHS' public comment opposing the proposed settlement between the Department and Sacred Heart.[2] It addresses the contention that the Rockwood acquisition obviates the need for additional beds at Sacred Heart; confirms that the Department has the authority to exercise its judgment when determining whether there is bed need under the State Health Plan; that the proposed 75 bed expansion is financially feasible; and that expanding Sacred Heart will lower the cost of care and increase quality, while an expansion of CHS' Spokane hospitals will increase the costs of care.[3]

## 2. The Proposed Settlement Is Necessary To Allow Sacred Heart to Meet CHS' Efforts To Limit Patient Choice In The Spokane Health Care Market.

CHS has launched an aggressive campaign to reshape the Spokane health care market. CHS is attempting to block Sacred Heart's expansion by challenging its certificate of need application. CHS argues that its recent purchase of Rockwood Clinic will result in a shift in patient volumes that it says will make Sacred Heart's planned expansion unnecessary.

The Rockwood acquisition has resulted in a reshuffling of patient volumes, but despite CHS' efforts, Sacred Heart's volumes remain high. As CHS requires its Rockwood physicians to refer patients to Deaconess and/or Valley, other physicians in the region are choosing Sacred Heart and filling its beds with increased referrals. Sacred Heart is the highest quality, lowest cost hospital in the region and provides services not available at Deaconess, Valley or other hospitals in the region. For these reasons, Sacred Heart will continue to attract new patients as additional beds become available.

Patients and their physicians in Spokane deserve the opportunity to choose whether they receive care at Sacred Heart or at a CHS hospital; whether they receive care at a not for profit hospital that invests in the community and serves as its safety net, or at a for profit hospital system that answers to investors. CHS' arguments about the impact of the Rockwood

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[2] CHS' assertion that Sacred Heart and the Department engaged in secret settlement negotiations is inconsistent with the record. On December 31, 2009, Sacred Heart communicated the possibility of settlement to counsel for CHS. *See* Intervenors' Mot. to Compel Discovery page 6 (Jan. 29, 2010). In January 2010, Sacred Heart provided CHS with the general terms of its proposed settlement. *Id.* at page 6, n.7. In February 2010, the Department provided CHS with copies of materials related to the tentative settlement agreement. On or about February 17, 2010, the Department met with CHS to receive input from CHS on the proposed settlement before it was made public. CHS Opposition Letter page 3; Prehearing Order No. 3: Order of Continuance page 1 (Feb. 12, 2010).

[3] Before settling this certificate of need appeal, the Department must inform CHS of the Department's decision and "afford them an opportunity to comment, in advance, on the proposed settlement." RCW 70.38.115(10)(c); WAC 246-310-610(4). On March 17, 2010, the Department publicly-released the proposed settlement and invited health care facilities meeting the criteria set forth in the certificate of need statute, including CHS, to comment on it by April 16, 2010. *See* Notice of Proposed Settlement and Opportunity to Comment page 2. CHS' assertion that the Department did not give adequate and valid notice of the proposed settlement is thus unfounded, as evidenced by the fact that CHS submitted comments on the proposed settlement on April 16, 2010.

acquisition should be seen for what they are, an effort to gain a competitive advantage through a regulatory process over Sacred Heart, a higher quality, lower cost competitor.[4]

### a. The Rockwood Acquisition Is Part Of CHS' Aggressive Effort To Transform The Spokane Health Care Market.

On January 4, 2010, Community Health Systems, Inc., announced that it had purchased Rockwood Clinic, PS. *Community Health System buys Rockwood Clinic, deepens entry into Spokane market,* NASHVILLE BUS. J., Jan. 4, 2010. CHS, which in 2008 purchased Empire Health Services, owner of Deaconess and Valley, is the largest publicly traded hospital company in the United States and currently owns, leases or operates 122 hospitals in 29 states representing about 18,000 licensed beds.

Almost immediately after it closed the acquisition, CHS instructed Rockwood physicians to begin referring patients to Deaconess and Valley rather than Sacred Heart and Holy Family. CHS has indicated that within five years it will shift the majority of Rockwood's patients to CHS hospitals. *See* John Stucke, *Clinic sale details released,* SPOKESMAN-REVIEW, Feb. 19, 2010.

In response to federal healthcare reform and changes in the Spokane market, Providence is building its service line programs and services that are vital to the community through development of numerous physician alignment opportunities. Providence's strategy is confidential and will be made public only as relationships are formalized. That strategy includes: agreements with some Rockwood physicians who have chosen to align their practices with Sacred Heart; acquisitions of medical groups; and other types of physician alignment relationships. These initiatives will result in further growth in demand for Sacred Heart's services.

Providence has for nearly 125 years sought to be a good steward for the health care needs of the Spokane community. Providence seeks to provide the highest quality, most efficient care while also serving as the safety net for those patients who cannot afford to pay for it. Providence has successfully balanced the costs of serving as the safety net with its goal of investing in providing high quality tertiary care. Sacred Heart's expansion, which would be allowed by the proposed settlement, is an important component of Providence's efforts to balance all aspects of its healing mission.

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[4] CHS repeatedly implies that Sacred Heart's project is a response to CHS' efforts to restore the vitality of Deaconess and Valley. CHS Opposition Letter pages 1, 6, 13. Sacred Heart began the planning and expansion process as early as mid-2007, when it engaged Kurt Salmon and Associates, a nationally recognized hospital facility planning firm, and Mahlum Architects, an architecture firm with extensive experience in health care facilities planning, to assist it in the development of a master facility plan from which the project was drawn. Screening Response page 46. The planning process spanned from May 2007 to September 2008. *Id.* CHS did not file its conversion application or certificate of need applications for the acquisition of Deaconess and Valley until January 2008. The acquisition was not approved until August 2008. CHS Opposition Letter page 6.

**b. Sacred Heart Patient Volumes Have Remained Steady Even As Rockwood Patients Are Diverted To CHS Hospitals.**

CHS argues that its purchase of Rockwood, and the resulting shift in referral patterns during the first quarter of this year, demonstrates the impact the Rockwood transaction is likely to have on Sacred Heart and its planned expansion.[5] CHS, however, only provides information in its public comment about Rockwood referral patterns. When referral patterns from other physicians in the area are considered, the shift supports, rather than diminishes Sacred Heart's need for additional beds. As Rockwood patients are redirected form Sacred Heart to Deaconess, other physicians are referring more of their patients to Sacred Heart. Sacred Heart volumes have remained steady despite the aggressive efforts of CHS to transform health care markets in Spokane.

Sacred Heart had an average daily census of 416 in 2007 and 440 in 2008 and 2009.[6] In the first quarter of 2010, Sacred Heart's average daily census was 446, higher than the 2007, 2008 and 2009 yearly numbers.[7] This information demonstrates that the Rockwood acquisition has little impact on Sacred Heart's patient volumes, even as the Rockwood physicians are being required to send their patients to CHS hospitals.

Notwithstanding CHS' directive, Sacred Heart continues to receive referrals from Rockwood physicians.[8] Sacred Heart also receives referrals from 111 other physician groups.[9] These groups have increased their referrals to Sacred Heart at a rate slightly lower than the decline in Rockwood referrals. More than half of the largest admitting physician groups increased their referrals to Sacred Heart in the first quarter of 2010.

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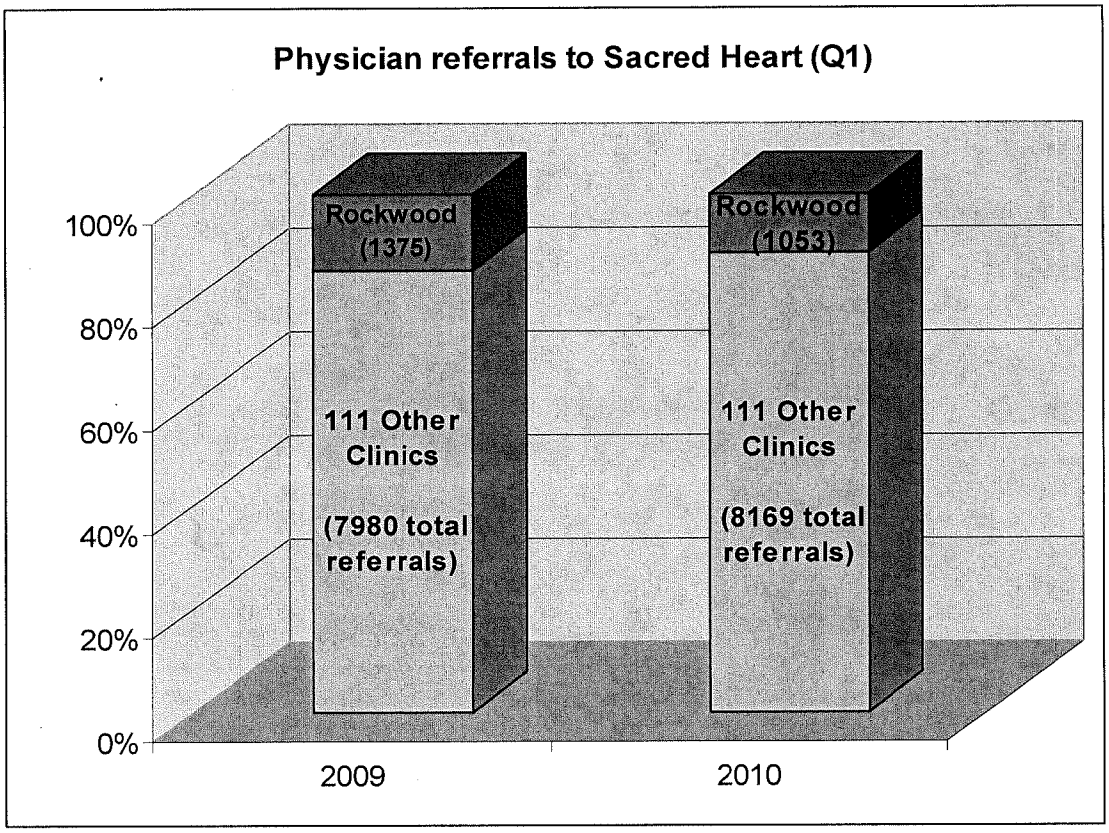
[5] In making these arguments, CHS has ignored the Department's request that its comments be limited to information already in the record. The Department has the authority to deem the record closed. *See Univ. of Wash. Med. Ctr. v. Wash. State Dep't of Health*, 164 Wn.2d 95, 99 (2008).

[6] 2007 data from Application page 11. 2008 and 2009 data from Sacred Heart. These figures are comparable to those reported to the Department.

[7] 2010 data from Sacred Heart. The first quarter 2010 average daily census was within one half of one percent of the first quarter 2008 average daily census of 448.60. (First quarter 2008 data from Sacred Heart. That figure is comparable to the figure reported to the Department.)

[8] Based on internal Sacred Heart tracking data ("Sacred Heart Medical Center & Children's Hospital, Admissions by Physician Group, Current Period: 03/28 – 4/10/10").

[9] *Id.*




Source: Internal Sacred Heart tracking data ("Sacred Heart Medical Center & Children's Hospital, Admissions by Physician Group, Current Period: 03/28 – 4/10/10"). This data is submitted in response to CHS' submission of 2009 and 2010 data. CHS Opposition Letter pages 6-7, 11, 22.

There are several explanations for this shift in patient referrals to Sacred Heart. First, Sacred Heart is a very full hospital, and patients are frequently diverted to other hospitals when a Sacred Heart unit is full. Application pages 26-33; Rebuttal pages 3, 13-15. As a bed is made available at Sacred Heart by a Rockwood patient referred to a CHS hospital, that bed has been filled immediately by pent-up demand.

Second, Sacred Heart offers services that CHS hospitals do not provide, and in some cases have recently abandoned such as Level II trauma care. *See* John Stucke, *Deaconess to drop trauma care: All critical injuries would be treated at Sacred Heart*, SPOKESMAN-REVIEW, May 27, 2009. When Sacred Heart is full, patients must sometimes be diverted outside of the region.

Finally, Sacred Heart provides the highest quality, lowest cost care in the region. CHS may buy a physician group and require its patients to be referred to a CHS hospital, but when physicians and patients have a choice of hospitals, they most often choose Sacred Heart for care. Group Health, one of the largest insurers in Spokane and recognized as a leader on health care cost containment, chose Providence Sacred Heart and Holy Family over Deaconess for the care of its HMO patients. In December 2009, Providence and Group Health Cooperative announced they reached an agreement that continues Group Health's exclusive use of hospital services at

Providence Sacred Heart and Providence Holy Family Hospital. With this agreement, Rockwood physicians who care for Group Health HMO patients will continue using Providence hospitals for in-patient and other hospital services.

### 3. The Department Properly Applied Its Judgment To Find There Is Need For Sacred Heart To Expand by 75 beds.

The State Health Plan recognizes that forecasting need involves both the interpretation of trends and the application of judgment concerning those trends. SHP C-25. It also incorporates flexibility in the methodology recognizing the unique circumstances of different communities and certain types of hospitals.

The Department properly exercised its judgment in finding there is need to support Sacred Heart's expansion by 75 acute care beds, in addition to the previously approved 21 Level II bassinets. The Department properly exercised its judgment in applying a 10 year planning horizon for the bed need forecast, considering the unique services Sacred Heart provides in the community, and the reduction in bed supply uncertainty resulting from the transfer of beds from Holy Family to Sacred Heart.

#### a. The Department's 10 Year Planning Horizon Is Consistent With The State Health Plan And Past Decisions.

The State Health Plan gives the Department flexibility to determine the planning horizon for bed need projections. Its prior certificate of need decisions reflect the Department's application of judgment to adjust the planning horizon based on the unique circumstances of the community and the size, scope and duration of specific projects. The State Health Plan provides that for most purposes, bed projections should not exceed seven years unless the project involves a major policy question, such as whether a community should have a hospital or additional hospitals. In those instances, long range forecasts should be used. SHP C-30. In applying the methodology, the Department has consistently determined that planning horizons of 10 or more years are appropriate and that the expense of building acute care bed capacity is such that the lifecycle of the bed space should be evaluated over a time period similar to the amortization of the expense and that projects should not necessarily be structured to build only enough beds to meet the immediate need. Rebuttal page 11.

CHS implies that the Department has consistently utilized a seven year planning horizon in its acute care bed decisions and attempts to confuse the issue by focusing on the first year in which the bed need turns positive as if that is the appropriate terminal year for the planning horizon. CHS Opposition Letter page 15. The planning horizon is not measured by the first year in which need appears in the projection, but it is the time period over which need for the number of beds approved in the project materializes. That time frame is reflected on Exhibit B and shows that the Department consistently uses an average planning horizon of 10 years or more. Assuming a base year of 2007, the Department's revised forecast projects need for 17 beds in 2016 (nine year planning horizon), which increases to 86 beds by 2018 (11 year planning horizon).

Even if the Department were to accept CHS' argument that the forecast should reflect need for beds by year seven to approve a project, based on the definition of base year in the State Health Plan, the Department's revised forecast projects need for beds within that time frame. The State Health Plan defines "base year" as the most recent year for which data is collected as the basis for the forecasts. SHP C-25. The Department continued to collect data for the forecasts up to the date of the hearing, which occurred in April 2009. At the hearing, CHS submitted newly revised information about its available bed count and other items such as population figures and occupancy statistics. The Department utilized that new information in the bed need forecast in its original decision, making 2009 the base year for the projection. With a 2009 base year, the Department's revised forecast shows need for 17 beds in 2016 (seven years after the base year), which increases to 86 beds by 2018 (nine years after the base year).

**b. The Department Properly Considered Sacred Heart's Unique And Important Role In Determining Bed Need.**

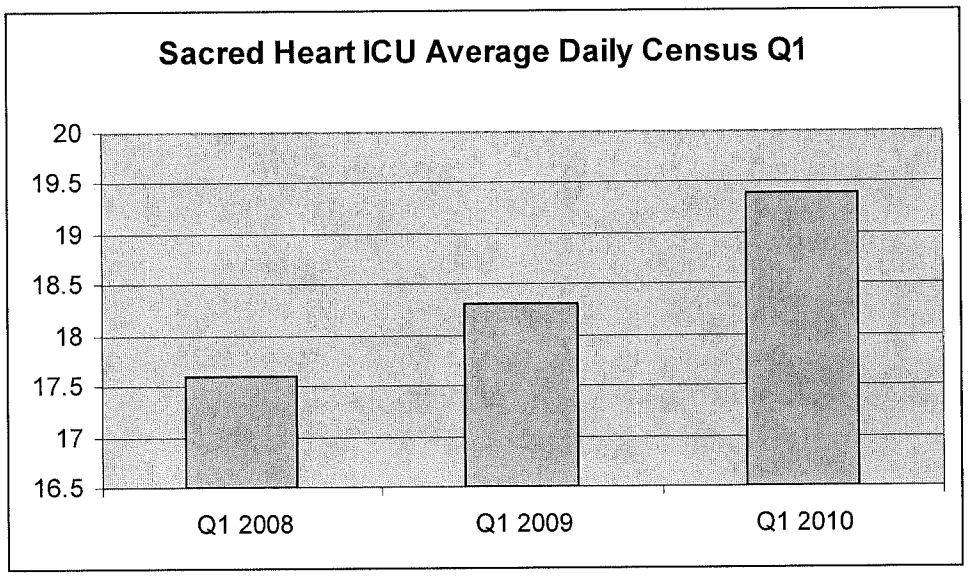
The State Health Plan indicates that separate need forecasts may be appropriate for regional tertiary hospitals drawing from a widespread patient base. SHP C-34. Additionally, under circumstances in which the total bed supply may be adequate or other hospitals in the planning area may be underutilized, it may be appropriate to allow a particular hospital to expand to improve access to services or allow expansion for a facility with specialized services or greater efficiency. SHP C-27.

Sacred Heart is the regional tertiary referral center for much of Eastern Washington and beyond. Sacred Heart receives 70 percent of the planning area's direct patient transfers from other hospitals (Rebuttal page 8) and more than 30 percent of its patient days from patients who do not reside in Spokane County (Application page 26). Sacred Heart's emergency department and critical care units are at times over capacity and without available beds, Sacred Heart may be unable to accept critically injured or sick patients from referral hospitals. A lack of additional beds will threaten Sacred Heart's ability to serve as a regional tertiary referral center.

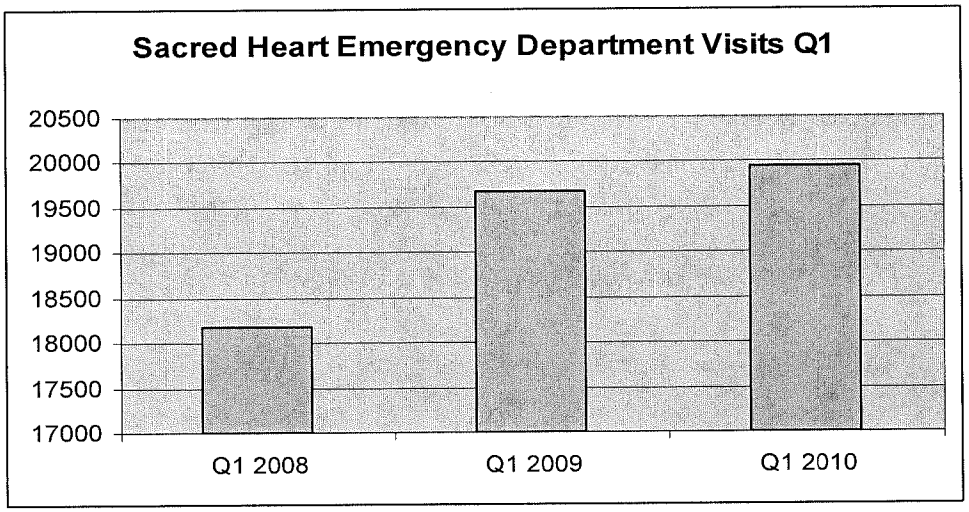
Even if one were to assume for the sake of argument that the methodology does not forecast need for beds in the Spokane Planning Area, the State Health Plan recognizes circumstances in which beds may be approved for a facility notwithstanding the existence of underutilized beds in the area. SHP C-28. Circumstances that may warrant such new beds include improved access to services for underserved groups, the expansion of a facility that has a wider range of important services, or the expansion of a facility with good cost or efficiency measures. Id.

Sacred Heart is not only a regional tertiary referral center, it is also the sole provider in Eastern Washington of many vital services such as Level II trauma, certified stroke center, pediatric services, heart and kidney transplant and inpatient psychiatric services. For a more complete list, see the Screening Response at pages 3 and 4. When Deaconess dropped its Level II trauma designation in 2009, Sacred Heart became the only resource for critically injured patients in the area. Sacred Heart estimates that Deaconess treated 637 trauma patients in 2008 and that most of that volume will flow to Sacred Heart in the future. This increase will put additional strain on Sacred Heart's intensive care unit, which had an average daily census of 19.4

for the first quarter of 2010 (97 percent occupancy) as compared to an average daily census of 17.6 and 18.3 for the first quarters of 2008 and 2009, respectively.[10]




Sacred Heart has seen a similar increase in its emergency department visits, which have grown to 19,942 in first quarter 2010 as compared to 18,186 in first quarter 2008 and 19,667 in first quarter 2009.[11]




The first beds to be added under the project are intensive care beds to relieve the pressure on these units and reduce the need to divert trauma patients to Seattle or Portland due to unavailability of beds.

[10] 2008 intensive care unit ADC derived from Table 18 in the Application (page 32). 2009 and 2010 data from Sacred Heart.

[11] Based on data from Sacred Heart. The 2008 data has been updated since the Application was filed.

In addition to providing numerous specialized services not available at other area hospitals, Sacred Heart and Providence Health & Services are charitable organizations committed to providing a comprehensive array of health services to meet the needs of its communities. Sacred Heart provides compassionate care for patients regardless of their ability to pay and serves as the safety net for the region's poor and underserved population. From 2004 to 2007, Sacred Heart provided over $68 million in charity care as well as additional unpaid or subsidized care, medical education, research and other community benefits. Application page 48. Any shortage of beds at Sacred Heart will jeopardize access to care for this vulnerable segment of the population.

### c. The Transfer Of Holy Family Beds Reduces Planning Area Uncertainty And Improves Forecasting Predictability.

The Department has the discretion to include a reduction in the number of licensed beds at Holy Family Hospital as a factor supporting the increase of beds at Sacred Heart as it permits the Department to reduce the unused bed capacity in the planning area and reduce the uncertainty of bed need forecasting in the planning area. CHS itself recognized the Department's authority to approve the transfer of beds from Holy Family to Sacred Heart in its written comments submitted at the public hearing and agreed not to challenge such a transfer:

> [The Department] could allow Providence to reallocate some of the unused bed capacity located at SHMC's sister facility, Holy Family, also located in the Spokane Planning Area. . . . Deaconess and Valley would not object to a number of beds, no larger than the 21-bed Phase I request, being transferred from Holy Family to SHMC.

CHS Public Comment page 4.

CHS appears to argue that because the Holy Family beds are not currently set up, they should not be considered. What is clear, however, is that Holy Family may set up additional beds within its license without certificate of need review and once set up, those beds could be transferred to Sacred Heart. *See* St. Clare Hospital and Harrison Medical Center CN decisions.

## 4. The Department Correctly Found That The Project Is Financially Feasible.

Sacred Heart provided financial information in the application for a project reflecting a range of possible new acute care beds, plus the 21 approved Level II bassinets. *See* Application Exhibit 10D; Screening Response Exhibit 10E; and Rebuttal Statement Exhibit M. Those financial projections permit an analysis and conclusion regarding the capital and operating costs of the proposed 75 bed project and the impact of the project cost on the cost and charges for health services.

The Department correctly states that the patient days and projected revenues are accurate in relation to the phased bed additions from 2011 through 2013. While those revenues and expenses are based on the 89 beds Sacred Heart projected to have added through the end of 2013, even in the slightly smaller scenario of 75 beds, Sacred Heart would have the capacity to serve

all of the projected patient volumes. That additional patient volume and commensurate revenue stream could reasonably be captured assuming a 75 bed project instead of the forecast 89 bed figure.[12]

The capital and operating expenses of a 75 bed project will be lower than that projected in the financials. The original estimate of the capital cost of the 152 bed project was approximately $79 million while the revised capital cost for a 75 bed project is approximately $54 million. This cost reduction will necessarily improve the project's overall financial feasibility. The original project showed Sacred Heart would be able to cover the capital costs at a higher level. With a 75 bed project, capital costs will be lower, thus making it easier for Sacred Heart to finance the capital costs for the project. With the 75 bed project, the volume and expected revenues will be comparable to the original project, but capital costs will be lower. Thus, the financial feasibility of the 75 bed project is equally as valid as the original project, if not more so.

The Department found that Providence Health & Services had the ability to finance the original, more costly 152 bed project through a combination of long term debt held by and cash reserves of Providence Health & Services. Similarly, the lower cost 75 bed project can also be appropriately financed.[13]

### 5. The Department Properly Found That The Project Will Help To Contain Health Care Costs.

Sacred Heart is one of the most cost effective tertiary care hospitals in Washington State. Sacred Heart demonstrates economies of scale as it increases the number of beds. Thus, Sacred Heart will become more cost effective by adding 75 additional adult acute care beds, in addition to the 21 level II bassinets previously approved. CHS' concerns are thus unfounded about whether a 75 bed plus 21 bassinet project will foster cost containment. CHS Opposition Letter pages 7, 12-13.

#### a. Sacred Heart Is Already A Low Cost Provider.

Sacred Heart has lower operating expenses ("costs") and lower net patient services revenues ("prices") per unit of service than its peer hospitals, including Deaconess. Rebuttal page 18. In 2007, Sacred Heart had the lowest costs per admission and prices per admission among its peer hospitals. Rebuttal pages 18-19. CHS' assertion that Sacred Heart is more

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[12] CHS itself acknowledged in its written comment submitted at the public hearing that the financial strength of Sacred Heart is such that even assuming the full project's depreciation and interest expense with no incremental volume, Sacred Heart demonstrates a positive operating margin. CHS Public Comment page 17.

[13] Sacred Heart has never stated that its project is financially feasible only if 152 beds plus 21 bassinets are approved. In fact, the financial information Sacred Heart provided in the Application for a 152 bed plus 21 bassinet project, a 122 bed plus 21 bassinet project, and a 109 bed plus 21 bassinet project shows just the opposite – that Sacred Heart's project is financially feasible with less than 152 beds plus 21 bassinets. *See* Application Exhibit 10D; Screening Response Exhibit 10E; and Rebuttal Statement Exhibit M. CHS' assertion that the financial feasibility of Sacred Heart's project is contingent on all 152 beds being approved is unfounded and incorrect. CHS Opposition Letter pages 9-10.

expensive than Deaconess is therefore incorrect. CHS Opposition Letter page 7. CHS' assertion was based on the public comment submitted by SEIU on the original application. SEIU is not opposing the Department's proposed settlement.

**b. The Proposed Settlement Will Lower Sacred Heart's Costs And Charges For Care.**

USC Health Care Policy Professor Glenn Melnick previously concluded that economies of scale at Sacred Heart would allow the hospital to lower the cost per unit of providing health care by implementing the proposed project. Rebuttal, Appendix B, Melnick Report pages 3, 9-11. In response to CHS' public comment, Professor Melnick has reviewed whether his conclusions would remain valid for a 75 bed plus 21 bassinet project. Based on his prior analysis and the financial information in the record,[14] Professor Melnick concluded that a 75 bed plus 21 bassinet project will also result in economies of scale and reduce unit costs at Sacred Heart. *See* Rebuttal Report – Glenn Melnick, Ph.D. ("Melnick Rebuttal Report") pages 2-3. Sacred Heart will be able to operate more efficiently because the increase in volume resulting from the 75 bed plus 21 bassinet project will allow Sacred Heart to operate further down its declining average cost curve. *Id.* Professor Melnick also concluded that there are likely to be additional operational efficiencies from the project. Melnick Rebuttal Report page 3. For a list of potential additional cost efficiencies, see the Screening Response pages 40 through 42. Thus, Sacred Heart will become more cost effective if the proposed settlement is approved, not less.

**c. Growing Sacred Heart Will Lower Health Care Costs In Spokane.**

Despite the evidence to the contrary in the record, CHS argues that growing Deaconess is a superior cost containment alternative to growing Sacred Heart. CHS Opposition Letter page 7. Unlike Sacred Heart, Deaconess demonstrates diseconomies of scale as volumes increase at its facility. Rebuttal, Appendix B, Melnick Report pages 3, 11-12. Thus, whereas Sacred Heart is already a low cost, high quality provider that will become more efficient as its project is implemented, Deaconess is a higher cost provider that will become less efficient as it grows. As a result, Professor Melnick concluded that Sacred Heart's proposed project was a more efficient option than growing Deaconess. Rebuttal, Appendix B, Melnick Report pages 3, 11; Melnick Rebuttal Report page 3.

**d. The Proposed Settlement Will Improve Sacred Heart's Already High Quality of Care.**

In addition to being one of the most cost effective tertiary care hospitals in the state, Sacred Heart is also one of the highest quality hospitals in the country. Rebuttal page 23. In

[14] The financial information for a 122 bed plus 21 bassinet project shows patient days are projected to grow to 208,506 in 2018. Sacred Heart Screening Response Exhibit 10E. At that level, assuming Sacred Heart is operating 719 beds (623 existing beds plus the 75 bed plus 21 bassinet project), Sacred Heart would be running at an average daily census of approximately 79 percent. Even though Sacred Heart will operate at above the 75 percent occupancy standard used by the 1987 State Health Plan for bed need forecasting, it will operate at capacity levels that are within the recent experience for several units of the hospital and several comparable hospitals in the state. Melnick Rebuttal Report page 3. Moreover, this projected occupancy rate shows that even with the addition of 75 acute care beds, Sacred Heart will be very full.

2008, the Centers for Medicare & Medicaid Services (CMS) recognized Sacred Heart as a high quality provider by awarding it the highest quality incentive payment in the country for its outstanding performance in the third year of the CMS/Premier Hospital Quality Incentive Demonstration Project. *Id.*

Professor Melnick concluded that Sacred Heart's project will lead to improvements in quality, patient outcomes and efficiency because the expansion will allow Sacred Heart to operate at higher volumes in specialized service lines. Rebuttal, Appendix B, Melnick Report page 8. The project will facilitate Sacred Heart's development as a highly specialized health care organization, which will help it to compete more effectively with other specialized regional medical centers to bring needed scarce human resources to its hospital to serve the Spokane community. Melnick Rebuttal Report page 5. Additionally, Professor Melnick concluded that the project will allow Sacred Heart to deliver more specialized care at higher levels of quality, thereby positioning Sacred Heart to capture funding from the federal government for the hospital and the Spokane Region. *Id.*

# Exhibit A

# Letters in Support of the Proposed Settlement

# City of Spokane

April 6, 2010

Ms. Janis Sigman
Health Professions and Facilities
Washington State Department of Health
P.O. Box 47852
Olympia, WA 98504-7852

Dear Ms. Sigman:

I am writing to express my support of the proposed settlement for the Providence Sacred Heart Certificate of Need application, to expand the hospital and increase its number of licensed beds.

Sacred Heart fills a vital role in serving the eastern Washington region's growing need for services, particularly as the only Level II Trauma Center east of the Cascade Mountains. It is critical for our communities to have adequate facilities and services to meet the ongoing demand for medical services, now and in the future. This proposed settlement represents an effective approach toward meeting those demands.

I applaud the Washington State Department of Health for its thorough and thoughtful analysis of the Providence Sacred Heart application. Continued access to quality and affordable health is vitally important to the residents of this community and the region as a whole.

Thank you for the opportunity to express my continued support for this important project.

Sincerely,

Mary B. Verner

Mary B. Verner
Mayor

cc: Andy Agwunobi, MD, Chief Executive
Providence Sacred Heart Medical Center





808 W. Spokane Falls Blvd., Spokane, Washington 99201-3335
Phone: (509) 625-6250 FAX: (509) 625-6563

April 3, 2010

Janis Sigman
Health Professions and Facilities
Washington State Department of Health
P.O. Box 47890
Olympia, WA 98504-78890

Dear Ms. Sigman:

I am Gary Livingston, Chancellor of the Community Colleges of Spokane. As an interested and concerned citizen, I am writing to express my personal support of the proposed settlement for the Providence Sacred Heart Certificate of Need application to expand the hospital and increase its number of licensed beds.

Sacred Heart fills a vital role serving the eastern Washington region's growing need for services, particularly as the only Level II Trauma Center east of the Cascades. It is critical, in my personal opinion, that our community has adequate facilities and services to meet the ever growing demand, now and into the future.

Thank you for your serious consideration.

Sincerely,

Gary A. Livingston

cc. Andy Agwunobi, MD Chief Executive
Providence Sacred Heart Medical Center

Heart Clinics NORTHWEST

*Fellows
American College of Cardiology

www.heartclinicsnw.com

Nuclear Cardiology
Accredited Nuclear Cardiology Laboratory

ICAEL
Accredited EchocardiographyLaboratory

**MAIN OFFICE** – Providence Heart & Vascular Institute
122 W 7th Avenue, Suite 310, Spokane, WA 99204
509-838-7711 ⁂ Fax 509-747-4664
*William R. Bennett, MD *R. Dean Hill, MD *Michael E. Ring, MD
*Andrew J. Boulet, MD *Michael D. Hostetler, MD *Stephen T. Thew, MD
Eteri S. Byazrova, MD *Kevin M. Kavanaugh, MD *L. Douglas Waggoner, Jr., MD
*Donald A. Chilson, MD *Timothy J. Lessmeier, MD *Michael P. Williams, MD
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**NORTHSIDE**
212 E Central Avenue, Suite 240, Spokane, WA 99208
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John P. Everett, MD *Keith A. Kadel, MD
Marek Janout, MD *Eric D. Stucky, MD

**WALLA WALLA** – St. Mary Medical Center
401 W Poplar, Cardiology Suite, Walla Walla, WA 99362
509-522-5731 ⁂ Fax 509-522-5747
*Suwong Wongsuwan, MD

**COEUR D'ALENE**
700 Ironwood Drive, Suite 350
Coeur d'Alene, ID 83814
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*Dennis B. Cooke, MD
*Ronald M. Fritz, DO
Carl L. Hanson, MD
*Ronald D. Jenkins, MD
*Kevin M. Kavanaugh, MD
James Pataky, MD
*Wolfgang J.T. Spyra, MD

**SANDPOINT**
606 N 3rd Avenue, Suite 203
Sandpoint, ID 83864
208-263-2505 ⁂ Fax 208-263-2908
*Joseph A. Abate, MD
*Ronald D. Jenkins, MD

April 12, 2010

Janis Sigman
Health Professions and Facilities
Washington State Department of Health
P.O. Box 47890
Olympia, WA 98504-78890

Dear Ms. Sigman:

I am writing to express my strong support of the proposed settlement for the Providence Sacred Heart Medical Center Certificate of Need application to increase the number of licensed beds at Providence Sacred Heart Medical Center. I have practiced at Providence Sacred Heart Medical Center since 1990 and have observed its evolving and increasing role in the medical care of the residents of the Spokane area as well as the entire Inland Northwest. We have been experiencing ever-increasing demand for the type of services available only at our institution. This includes not only those related with providing the only Level II Trauma Services available east of the Cascades, but also a host of sophisticated cardiovascular services best provided at an institution with the experience and resources available at our facility. In order to meet the region's current and future needs for these services, it is vital that we expand the number of hospital beds required to care for increasing population, with ever growing numbers of older residents who will require precisely the type of cardiac services discussed above.

Please do not hesitate to contact me if you have any questions regarding any aspect of this issue. I sincerely appreciate the opportunity to express my strong support for the proposed settlement.

Sincerely,

M. Ring

Michael Ring, MD, FACC, FSCAI
Incoming Governor, Washington Chapter of the American College of Cardiology

Cc: Andy Agwunobi, MD, Chief Executive

Spokane
William S. Coleman, MD
D. Vernon Holbert, MD
Jack J. Leonard, MD
Steven J. Nisco, MD
Branden R. Reynolds, MD
Leland G. Siwek, MD
Mandya Vishwanath, MD
Neil K. Worrall, MD
Coeur d'Alene
Robert J. Burnett, MD
Wenatchee
John R. Rowles, MD

Northwest Heart and Lung Surgical Associates
Cardiac, Thoracic and Vascular Surgery 1.800.366.0262 • nwhl@nwheartlung.com

April 9, 2010

Janis Sigman
Health Professions and Facilities
Washington State Department of Health
P.O. Box 47890
Olympia, WA 98504-78890

Dear Ms Sigman:

As the Chair of Providence Sacred Heart Medical Center Department of Surgery, I am writing to express my support of the proposed settlement for the Providence Sacred Heart Medical Center Certificate of Need application to expand the hospital and increase its number of licensed beds.

Sacred Heart fills a vital role in serving the eastern Washington region's growing need for services, particularly as the only Level II Trauma Center east of the Cascades. It is critical that our community have adequate facilities and services to meet the growing demand for services, now and into the future.

I applaud the Department of Health for its thorough and thoughtful analysis of the Sacred Heart Certificate of Need application. Continued access to quality and affordable health care is vitally important to the residents of our community.

Thank you for the opportunity to express my continued support of this important project.

Respectfully;

William Coleman, MD, Cardiovascular Surgeon
Chair Sacred Hearth Medical Center Department of Surgery



CC: Andy Agwunobi, MD, Chief Executive
Providence Sacred Heart Medical Center

April 7, 2010

Janis Sigman
Health Professions and Facilities
Washington State Department of Health
P. O. Box 47890
Olympia, WA 98504-78890

Dear Ms. Sigman,

I am writing to express my support for the proposed settlement for the Providence Sacred Heart Certificate of Need application to expand the hospital and increase its number of beds. The settlement represents an effective approach to meeting the current and future health care needs of the residents in our Spokane region.

I congratulate the Department of Health on its thorough analysis of the application. Access to quality and affordable health care is vital to our community residents. I appreciate this opportunity to express my support for this important project.

Sincerely,

James G. Falkner, Chairman
Providence Health Care Board of Directors

CC: Andy Agwunobi, MD, Chief Executive
Providence Sacred Heart Medical Center

INLAND NEUROSURGERY AND SPINE

Sacred Heart Doctors Building
Spokane, Washington 99204
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105 West Eighth Avenue, Suite 200
Phone: 509.624.9112
Web: www.neuroandspine.com

April 5, 2010

Janis Sigman
Health Professions and Facilities
Washington State Department of Health
P.O. Box 47890
Olympia, WA 98504-7980

Dear Ms. Sigman:

I am writing to express my support of the proposed settlement for the Providence Sacred Heart Certificate of Need application to expand the hospital and increase its number of licensed beds.

Sacred Heart fills a vital role in serving the eastern Washington region's growing need for services, particularly as the only level II Trauma Center east of the Cascades. It is critical that our community have adequate facilities and services to meet the growing demand for services, now and into the future.

Thank you for this opportunity.

Sincerely,

Dean Martz, M.D.

RDM:SG

cc: Andy Agwunobi, M.D., Chief Executive
Providence Sacred Heart Medical Center

WASHINGTON STATE UNIVERSITY
SPOKANE

Office of the Chancellor

April 6, 2010

Janis Sigman
Health Professions and Facilities
Washington State Department of Health
P.O. Box 47890
Olympia, WA 98504-78890

Dear Ms. Sigman:

I am pleased to write in support of the proposed settlement for Providence Sacred Heart Hospital's Certificate of Need application to expand and increase its number of licensed beds.

It is critical that our community have adequate facilities and services to meet growing regional demand for services, now and into the future. Spokane and Eastern Washington are giving priority to development of academic health care services – Nursing, Pharmacy, Medicine, Allied and Public Health – to support the health care and economic development needs of the region. This includes plans for a medical school. With regional population growth and health care changes, demand will increase significantly. Sacred Heart Hospital fills an important role in Eastern Washington region's growing need for services, particularly as the only Level II Trauma Center east of the Cascades. Sacred Heart Hospital will be an important partner with undergraduate and graduate medical education.

Thank you for consideration of these comments.

Sincerely,

Brian L. Pitcher, Chancellor
Washington State University Spokane

c: Andrew Agwunobi, MD, Chief Executive
Providence Sacred Heart Medical Center



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greaterspokaneincorporated.org

April 6, 2010

Janis Sigman
Health Professions and Facilities
Washington State Department of Health
P.O. Box 47890
Olympia, WA 98504-78890

Dear Ms Sigman:

I am writing to express my support of the proposed settlement for the Providence Sacred Heart Certificate of Need application to expand the hospital and increase its number of licensed beds.

Sacred Heart fills a vital role in serving the eastern Washington region's growing need for services, particularly as the only Level II Trauma Center east of the Cascades. It is critical that our community have adequate facilities and services to meet the growing demand for services, now and into the future.

Thank you for this opportunity.

Sincerely,

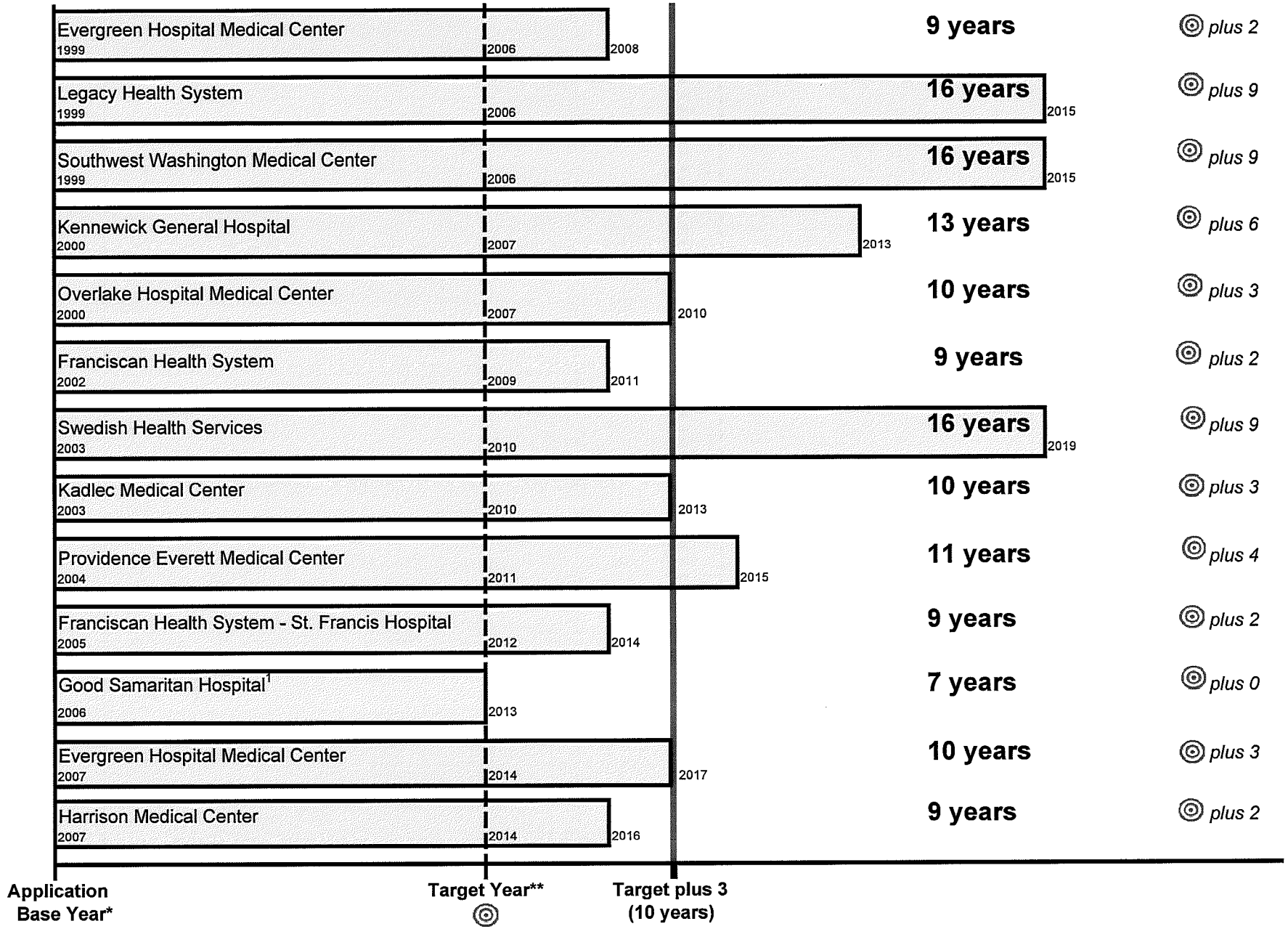
Richard G. Hadley
President and Chief Executive Officer

CC: Andy Agwunobi, MD, Chief Executive
Providence Sacred Heart Medical Center

# Exhibit B

# Planning Horizons Reflected in Department of Health Acute Care Hospital Decisions (Chart and Supporting Documentation)

# Planning Horizons Reflected in Department of Health Acute Care Hospital Decisions




*Base Year: most recent CHARS available at the time of the application, unless applicant stated otherwise.

**Target Year seven years after Base Year.

[1]Planning Horizon for Good Samaritan not beyond seven years as even with project, Target Year showed projected need.

## Planning Horizons Reflected in Department of Health Acute Care Hospital Decisions

| Applicant | App'n, hearing and decision dates | Project description and completion date | Base Yr[1] | Target Yr (as 7 yrs past Base Yr) | Net need in Target Yr (with approved beds) | Number of beds approved | Planning horizon reflected in decision | Standard(s) stated in decision |
|---|---|---|---|---|---|---|---|---|
| Evergreen Hospital Medical Center | App'n: 5/11/01<br><br>Hearing: 12/11/01<br><br>Decision 5/20/02<br><br>(p.1) | Add 78 beds to existing 166 acute care bed hospital:<br><br>20__ = 40 beds<br>2004= 38 beds<br>(p.1)<br><br>Project completion: 2004 (p.7) | 1999 | 2006 | 16 bed surplus<br><br>(App.10) | 78 beds<br><br>(p.3) | 9 years (Target plus 2)<br><br>(App.10) | The department "evaluate[s] need for a given project through at least three years following completion of the project." (p.7)<br><br>"…some surplus capacity will be created…" (p.9)<br><br>"…the lifecycle of the bed space should be evaluated over a time period similar to that of the amortization of the expense." (p.9) |
| Legacy Health System | App'n: 3/29/01<br><br>Hearing: 11/5/01<br><br>Decision: 3/15/02<br><br>(p.6) | Construct new 220-bed hospital in Vancouver, WA:<br><br>2004= 165 beds<br>2015= 55 beds<br><br>(pp.4,5,7)<br><br>Project completion: DOH conditioned approval on completion by 2015 (p.7) | 1999 | 2006 | 111 bed surplus<br><br>(App.10) | 220 beds<br><br>(p.7) | 16 years (Target plus 9)<br><br>(App.10) | "…some surplus capacity will be created…" (p.15)<br><br>" 'For major policy questions, such as whether a community should have a hospital or additional hospitals, long-range forecasts should be prepared.' 1987 SHP, page C-30." (p.16) |
| Southwest Wash. Medical Center | App'n: 4/19/01<br><br>Hearing: 11/5/01<br><br>Decision: 3/15/02<br><br>(p.33) | Add 82 beds to existing 360 acute care bed hospital (p.32)<br><br>Project completion: By 2011 (p.34) | 1999 | 2006 | 111 bed surplus<br><br>(App.10) | 82 beds<br><br>(p.34) | 16 years (Target plus 9)<br><br>(App.10) | "…some surplus capacity will be created…" (p.41)<br><br>" 'For major policy questions, such as whether a community should have a hospital or additional hospitals, long-range forecasts should be prepared.' 1987 SHP, page C-30." (p.41) |

[1] "Base Year" assumed to be the most recent full year CHARS data available when request submitted, unless applicant specified a different year.

| Applicant | App'n, hearing and decision dates | Project description and completion date | Base Yr[1] | Target Yr (as 7 yrs past Base Yr) | Net need in Target Yr (with approved beds) | Number of beds approved | Planning horizon reflected in decision | Standard(s) stated in decision |
|---|---|---|---|---|---|---|---|---|
| Kennewick General Hospital | App'n: 4/3/01<br><br>Hearing: none<br><br>Recons. decision: 8/21/02<br><br>(p.2) | Add 30 beds to existing 71 acute care bed hospital (p.1)<br><br>Project completion: 2004 (p.1) | 2000<br><br>(p.8) | 2007 | 56 bed surplus<br><br>(App.10) | 30 beds<br><br>(p.4) | 13 years (Target plus 6)<br><br>(pp.11,15) | The application "is a bed addition, not the creation of an entirely new facility, and is to be evaluated over a shorter period of time" than the 15- to 20-year time frame applied to the SWMC approval. (p.8)<br><br>"…patient utilization trends support a need for additional bed capacity at KGH, regardless of the number of beds already available in the planning area." (p.15) |
| Overlake Hospital Medical Center | App'n: 12/1/01<br><br>Hearing: None<br><br>Decision: 8/16/02<br><br>(p.2) | Add 80 beds to existing 257 acute care bed hospital (p.1)<br><br>Project completion: By 2007 (p.7) | 2000 | 2007 | 42 bed surplus<br><br>(App.10) | 80 beds<br><br>(p.3) | 10 years (Target plus 3)<br><br>(App.10) | The Department "evaluate[s] need for a given project through at least three years following completion of the project." (p.7)<br><br>"…some surplus capacity will be created…" (p.10)<br><br>"…the lifecycle of the bed space should be evaluated over a time period similar to that of the amortization of the expense." (p.10) |
| Franciscan Health System | App'n: 8/12/03<br><br>Hearing: 1/29/04<br><br>Decision: 5/14/04<br><br>(p.2) | Construct new 112-bed hospital in Gig Harbor:<br>2007 = 80 beds<br>2012= 32 beds<br><br>(pp.1-2,8)<br><br>Project completion: 2012 (pp.2,8) | 2002 | 2009 | 37 bed surplus<br><br>(App.10) | 80 beds<br><br>(p.4) | 9 years (Target plus 2)<br><br>(App.10) | The Department "evaluate[s] need for a given project through at least three years following completion of the project." (p.8)<br><br>"…some surplus capacity will be created…" (p.10)<br><br>"…the lifecycle of the bed space should be evaluated over a time period similar to that of the amortization of the expense." (p.10) |

| Applicant | App'n, hearing and decision dates | Project description and completion date | Base Yr[1] | Target Yr (as 7 yrs past Base Yr) | Net need in Target Yr (with approved beds) | Number of beds approved | Planning horizon reflected in decision | Standard(s) stated in decision |
|---|---|---|---|---|---|---|---|---|
| Swedish Health Services[2] | App'n: 7/21/04<br><br>Hearing: 3/7/05<br><br>Remand decision: 5/31/07<br><br>(p.5) | Construct new 175-bed hospital in Issaquah:<br><br>2011= 80 beds<br>2014= 40 beds<br>2018= 55 beds<br><br>(p.17)<br><br>Project completion: 2016 (p.8) | 2003 | 2010 | 4 beds<br><br>(App.10c) | 175 beds<br><br>(p.6) | 16 years (Target plus 9)<br><br>(App.10c) | The Department "evaluate[s] need for a given project through at least three years following completion of the project. In the case of construction of new acute care hospitals, it is the practice of the department to evaluate need for a much longer period of time, reflecting the high capital cost and long useful life of such projects." (p.12)<br><br>"…the lifecycle of the bed space should be evaluated over a time period similar to that of the amortization of the expense." (p.16)<br><br>"…the project would create a surplus of bed capacity…" (p.17) |
| Kadlec Medical Center | App'n: 12/30/04<br><br>Hearing: 4/22/05<br><br>Settlement decision: 9/29/06<br><br>(p.3) | Add 58 beds to existing 153 acute care bed hospital:<br><br>2005= 19 beds<br>2007= 39 beds (as stated on p.1 of 8/1/05 decision; 2009 as stated on pp.6,7 of 9/29/06 decision)<br><br>Project completion: 2009 (pp.6,7) | 2003 | 2010 | 21 bed surplus<br><br>(App.10d) | 19 beds<br><br>In 2006, parties settled and Kadlec awarded 16 add'l beds<br><br>(p.4) | 10 years (Target plus 3)<br><br>(App.10d) | "Using year 2012 as the planning year is consistent with the seven year forecast recommended in the state health plan." (p.6)<br><br>"…adding another 16 beds in year 2009 results in a surplus of one bed in year 2012, which is seven years after the addition of the 19 beds in phase one. This timeline is consistent with the recommended planning horizon in the state health plan." (p.7) |

[2] In August 2004, Overlake Hospital Medical Center applied for a CN to construct a new 120-bed hospital and a Level II nursery in Issaquah. The Department reviewed Overlake's application simultaneously with Swedish's application, and denied both projects in May 2005. Swedish ultimately prevailed on remand.

| Applicant | App'n, hearing and decision dates | Project description and completion date | Base Yr[1] | Target Yr (as 7 yrs past Base Yr) | Net need in Target Yr (with approved beds) | Number of beds approved | Planning horizon reflected in decision | Standard(s) stated in decision |
|---|---|---|---|---|---|---|---|---|
| Providence Everett Medical Center | App'n: 4/12/06<br><br>Hearing: 9/18/06<br><br>Decision: 12/18/06<br><br>(p.2) | Add 166 beds to existing 362 acute care bed hospital:<br><br>2010= 106 beds<br>2015= 30 beds<br>2017= 30 beds<br>(pp.1-2,7)<br><br>Project completion: 2017 (p.2) | 2004 | 2011 | 65 bed surplus<br><br>(App.10c) | 106 beds<br><br>(p.3) | 11 years (Target plus 4)<br><br>(App.10c) | The Department "evaluate[s] need for a given project through seven years from the last full year of available CHARS data, 2012 for purposes of this analysis. If the project is phased, another three years following completion of the project is often considered, or 2015. In review of this application, the bed need methodology was continued through 2017 to provide a complete analysis of the 106 bed addition." (p.7)<br><br>"The department practice, as outlined in the State Health Plan, is to forecast seven years." (p.10) |
| FHS-St. Francis Hospital | App'n: 9/18/06<br><br>Hearing: 3/30/07<br><br>Decision: 6/12/07<br><br>(p.3) | Add 36 beds to existing 110 acute care bed hospital:<br><br>2010= 18 beds<br>2012= 18 beds<br><br>Establish 6-bed Level II nursery<br><br>(pp.1,2)<br><br>Project completion: 2012 (pp.1-2) | 2005 | 2012 | 27 bed surplus<br><br>(App.10b) | 36 beds and Level II nursery<br><br>(p.5) | 9 years (Target plus 2)<br><br>(App.10b) | "…a seven-year horizon for forecasting…is consistent with the recommendations within the state health plan which states, '*for most purposes, bed projections should not be made for more than seven years into the future.*' Further, a seven year forecast is consistent with most projects for hospital bed additions reviewed by the CN Program." (p.6)<br><br>The Department "evaluate[s] need for a given project through at least three years following completion of the project." (p.10) |
| Good Samaritan Hospital | App'n: 3/19/07<br><br>Hearing: none<br><br>Decision: 12/21/07<br><br>(p.2) | Add 50 beds to existing 225 acute care bed hospital:<br><br>2010= 18 beds<br>2013= 32 beds<br><br>(pp.1,9)<br><br>Project completion: 2013 (pp.1,9) | 2006<br><br>(p.4) | 2013 | 10 beds<br><br>(p.11, App.10b) | 50 beds<br><br>(p.3) | 7 years (Target plus 0). The planning horizon was not extended beyond 7 yrs because even with the project, there was a projected need for add'l beds in the target year. (p.11, App.10b) | "A seven-year horizon for forecasting acute care bed projections…is consistent with the recommendations within the state health plan which states, 'For most purposes, bed projections should not be made for more than seven years into the future.' Further, a seven year forecast is consistent with most projects for hospital bed additions reviewed by the CN Program." (p.4)<br><br>The Department "evaluate[s] need for a given project through seven years from the last full year of available CHARS data, or 2006 for purposes of this analysis. Therefore, the target year for this analysis will be 2013." (p.9) |

| Applicant | App'n, hearing and decision dates | Project description and completion date | Base Yr[1] | Target Yr (as 7 yrs past Base Yr) | Net need in Target Yr (with approved beds) | Number of beds approved | Planning horizon reflected in decision | Standard(s) stated in decision |
|---|---|---|---|---|---|---|---|---|
| Evergreen Hospital Medical Center | App'n: 5/12/08<br><br>Hearing: 8/15/08<br><br>Recons. decision: 3/31/09<br><br>(p.2) | Add 80 beds to existing 227 acute care bed hospital:<br><br>2009= 48 beds<br>2013= 32 beds<br><br>(p.1)<br><br>Project completion: 2013 (p.1) | 2007<br><br>(p.8) | 2014 | 77 bed surplus<br><br>(p.14, App.10b) | 48 beds<br><br>(p.4) | 10 years (Target plus 3)<br><br>(App.10b, adjusted to account for approval of only 48, not 80, beds) | The Department "evaluate[s] need for a given project through seven years from the last full year of available CHARS data, or 2007 for purposes of this analysis. Therefore, the target year for this analysis will be 2014." (p.11)<br><br>"The re-construction of the need methodology provides the basis to consider this first phase to assure the residents of the planning area continue to have access to acute care services in the years preceding the opening of the first phase of the new hospital in Issaquah." (p.15) |
| Harrison Medical Center | App'n: 11/3/08<br><br>Hearing: None<br><br>Decision: 5/27/09<br><br>(p.2) | Add 50 beds to 44-bed Silverdale campus of existing 297 acute care bed hospital and transfer 42 beds from Bremerton campus to Silverdale campus (p.1)<br><br>Project completion: 2012 (pp.1,3) | 2007 | 2014 | 14 bed surplus<br><br>(p.11, App.10b) | 50 beds and 42 transfer beds (p.3) | 9 years (Target plus 2)<br><br>(p.11, n.5) | "…a seven-year horizon for forecasting acute care bed projections…[is] consistent with the recommendations within the state health plan which states, '*For most purposes, bed projections should not be made for more than seven years into the future.*' Further, a seven year forecast is consistent with most projects for hospital bed additions reviewed by the CN Program." (p.4)<br><br>The Department "evaluate[s] need for a given project through seven years from the last full year of available CHARS data, or 2007 for purposes of this analysis. Therefore, the target year for this analysis will be 2014." (p.8) |

Note: All citations are to the final decision issued for the particular CN application, unless otherwise stated. For example, the citations to the Kadlec decision are to the settlement decision (issued 9/29/06), not the original decision (issued 8/1/05), unless otherwise stated.

# Rebuttal Report - Glenn Melnick, Ph.D.

# Rebuttal Report – Glenn Melnick, Ph.D.

## Purpose of This Report

My name is Glenn Alan Melnick, Ph.D. I am the Blue Cross of California Professor at the University of Southern California and a health economist at the RAND Corporation. I have been asked to provide opinions and rebuttal comments with respect to the document filed by Deaconess Medical Center and Valley Hospital and Medical Center (April 16, 2010) as part of the public comment period related to the proposed settlement between the Department of Health Certificate of Need Program and Sacred Heart Medical Center & Children's Hospital (Sacred Heart). The proposed settlement relates to Sacred Heart's Certificate of Need application to expand inpatient bed capacity at its facility. Specifically, as outlined in the proposed settlement document, the Department determined that there is need for an additional 50 new acute care beds in the planning area and need for 75 total new acute care beds at Sacred Heart:

> "In its initial evaluation, the Program produced a bed need projection that resulted in the Program concluding there was not enough bed need in the Spokane planning area to support the addition of the 152 beds requested by Sacred Heart. The Program and Sacred Heart reviewed the projection methodologies prepared by the Program and now agree the data in the projections and the current application support adding 50 new beds in the planning area and moving 25 beds to Sacred Heart from Holy Family for a total increase of 75 beds to be added at Sacred Heart... The proposed settlement would approve Sacred Heart's acute care bed expansion application for 75 beds. The parties agree that 50 of the beds would be new to the planning area and 25 beds would move from Holy Family Hospital."

In a previous report, I outlined a series of opinions related to Sacred Heart's original Certificate of Need application (October 23, 2008) based on the larger scale project. For purposes of this report, I have been asked to provide opinions related to the applicability and validity of my prior opinions based on facts and information in the existing record as they relate to the revised project described in the settlement document and as rebuttal to the comments filed by Deaconess Medical Center and Valley Hospital and Medical Center (Deaconess Medical Center).

In preparing my initial report, I undertook a number of steps, including: review of Sacred Heart's Certificate of Need application and responses to screening questions, internal operating and financial data and analytical reports from Sacred Heart, statistical and financial data from a recent Deaconess Hospital Certificate of Need application, Certificate of Need regulations from Washington State and other related documents. I conducted on site interviews at Sacred Heart and Holy Family hospitals and interviewed and/or met with hospital senior management, including the CEO and COO, departmental managers and data analysts, and other staff involved with or having knowledge related to the proposed Certificate of Need project. In preparing this current report I have reviewed the Proposed Settlement between Sacred Heart and the Department of Health and the Comments by Deaconess Medical Center in response to the proposed settlement. In addition, I have reviewed my initial opinions and analyses related to the original Certificate of Need application, internal data from Sacred Heart related to patient

volume and occupancy rates and I re-interviewed Sacred Heart staff with knowledge of Sacred Heart's volume, occupancy and operating patterns to confirm my understanding of the assumptions and data used to develop various forecasts included in the record with regard to the original Certificate of Need application.

## Findings and Opinions

### Overview

Overall, I find that my key findings and opinions related to the original project are still directly relevant and applicable to the project as proposed under the settlement. The proposed increase in inpatient capacity under the settlement (75 acute care beds + 21 recently approved bassinets), while below the original requested increase, still represents a significant expansion of capacity (15%) which, importantly, will allow Sacred Heart to absorb the increase in volume projected under the original application and will result in increased economic efficiency at Sacred Heart due to its underlying cost structure, which exhibits positive economies of scale in the relevant range. This is in contrast to, for example, Deaconess Medical Center, which exhibits diseconomies of scale (per data included in Deaconess's Certificate of Need application) resulting in increased cost per patient as its volume increases.

In addition to efficiency benefits, the proposed settlement will improve access to needed emergency care in the planning area. The addition of 75 new acute care beds will allow Sacred Heart to substantially increase ED throughput by reducing inpatient capacity shortages that result in bottlenecks in the emergency department. Furthermore, with the passage of national health reform legislation, regional and national competition for health care resources will intensify. Those regions with efficient, high-quality, specialty providers such as Sacred Heart will be more successful in attracting scare health personnel and increasingly constrained government funding which will provide substantial economic and health benefits to the region. Each of these key points is discussed in more detail below.

### Detailed Findings

1. Sacred Heart's underlying cost structure demonstrates positive economies of scale. As such, the increased volume associated with the proposed 75 acute care bed expansion will increase its operating efficiency, lower its cost per unit of output and will increase the overall efficiency of health care in the region.

Sacred Heart's original Certificate of Need application and screening responses present data showing the relationship between its unit costs and volume at different volume levels. These data demonstrate positive economies of scale across a wide range of increased volume levels. The originally proposed project would have resulted in an estimated savings of approximately $54.6 million. The proposed settlement represents the addition of fewer acute care beds than the original application but would still result in a 15 percent increase in bed capacity. I re-interviewed Sacred Heart's data modeling team and reviewed the methods and data they used to arrive at their volume forecasts and occupancy calculations. In addition, I am knowledgeable of

and have reviewed the hospital operations, capacity planning, and occupancy modeling literature as it relates to Sacred Heart's proposed 75-bed expansion.

Based on the above, I conclude that the scaled down project will result in a substantial increase in volume that will contribute to positive economies of scale at Sacred Heart. The orginal Certificate of Need application included forecasted volume projected to grow to more than 208,000 inpatient days by 2018 and would have resulted in an average occupany rate in the range of the state standard (75%). Under the proposed in the settlement patient volume at Scared Heart is expcted to grow at the same rate as forecast in the original project (based on need forecasts and utilization growth trends at Sacred Heart) but, given a smaller increase in inpatient capacity and based on data in the record, the hospital's occupany rate would be expected to increase to an average occupancy of 79%. While this higher occupancy rate is above the planning standard, it is clearly a reasonable and feasible operating assumption. Historically, there are mutliple units within Sacred Heart that have operated above 75% occupany rates. Additionally, publicly available data from the DOH reporting system show mulitple hospitals operating in Washington at occupancy rates at or above 79%.

Under the revised project, volume will increase at a rate similar to that projected in the original application but incremental costs will be lower than the original project since capacity expansion and associated capital and incremental costs are less than the original project. As such, if the revised project is approved, Sacred Heart will be able to operate more efficiently since by producing at higher volumes Sacred Heart will be able to operate further down its declining average cost curve. In addition, I previously interviewed managers in departments affected by the proposed project and I conclude that the estimated savings by Sacred Heart are conservative in nature and that there are likely to be additional operational efficiencies from the project that will likely lead to additional savings beyond those quantified in the original Certificate of Need application.

I had also previously reviewed internal data and projections (operating costs and at different volume levels) submitted by Deaconess Medical Center as part of its Certificate of Need application. My analysis of Deaconess' data indicated that its underlying cost structure demonstrates diseconomies of scale -- that is, as its volume increases, its average costs or costs per unit of output will actually increase. This suggests that expanding volume at Deaconess Medical Center would result in its operations becoming less efficient and each additional patient day produced at Deaconess will be more expensive than the previous one. To my knowledge, there are no new or additional data in the record that would conflict with this conclusion. As such, the proposed settlement adding inpatient bed capacity at Sacred Heart continues to be the more efficient option since Sacred Heart is already a low cost, high quality provider and its project demonstrates positive economies of scale and increasing efficiency while Deaconess hospital demonstrates negative returns to scale and rising unit costs associated with increased volume at its facility.

2. Expansion of Inpatient Capacity Will Increase Emergency Room Throughput and Access to ED and Inpatient Care in the Planning Area

Sacred Heart's Certificate of Need application included expansion of inpatient beds to alleviate both current and expected future bed need shortages in the region. Currently demand exceeds available capacity for direct inpatient admissions and admission via the emergency department. As documented in its application (p. 27-28), Sacred Heart must close inpatient critical (and general acute units) to new admissions at a substantial rate (i.e., approximately seven percent of total available bed days during January-June 2008, p. 27, Sacred Heart Certificate of Need application) and ED closures are resulting in increased ambulance diversions over time and reached more than 150 hours per quarter by 2Q, 2008. Often, ED closures are the result of ED patients being held in ED beds while they wait for fully occupied inpatient beds to become available. With the decision by Deaconess Medical Center to drop its trauma designation, Sacred Heart is now the sole trauma ED in the area which will further increase demand for critical care and acute beds at Sacred Heart.

Demand for care at Sacred Heart will also grow as a result of its continuing role as the key referral hospital in the region, serving as "The hospital to other hospitals" and the leading referral hospital in the region. For example, Sacred Heart has been receiving an increasing share of all patients referred from other hospitals and in 2008 Sacred Heart received more than 70 percent of "hospital to hospital" referrals in the region. This is due in part to Sacred Heart's mix of specialty services, many of which are not available at other hospitals in the region[1] and its ability to handle complex and difficult cases that cannot be treated in other hospitals. Expansion of inpatient capacity will allow Sacred Heart to handle the projected growth in this area. Deaconess hospital is the only other hospital in the region to receive a double digit share of referrals. As such, Sacred Heart is the best positioned hospital in the region to efficiently expand to meet the growing needs for acute inpatient and emergency care in Spokane.

3. Approval of Sacred Heart's proposal to expand its inpatient capacity will improve quality of care and patient outcomes which will enhance its position as a regional referral center and facilitate its ability to compete more effectively on a national basis in the future for specialized medical personnel and federal funding under the Medicare Program and National Institutes, all of which will generate substantial benefits for the development of Spokane's health care system and development of the local and regional economy.

While health care is expected to continue to grow as a share of national GDP, there will be growing competition at the regional and national level for funding and specialized medical personnel. Those regions with a well-developed infrastructure that includes high quality providers with a critical mass of highly specialized services and personnel will be best positioned

[1] The following services are available only at Sacred Heart Medical Center: Pediatric diagnostic/invasive, Pediatric interventional cardiac, Pediatric intensive care services, Electron beam computed tomography, Full-field digital mammography (FFDM), Multi-slice spiral computed tomography (MSCT) (<64 + slice CT), Multi-slice spiral computed tomography (64 + slice CT), Positron Emission Tomography (PET), Single Photon Emission Computerized Tomography (SPECT), Image-guided radiation therapy (IGRT), Robotic surgery, Heart transplant, Kidney transplant, Liver transplant, Lung transplant, Tissue transplant (Source: American Hospital Association Guide Issue, 2009).

for this competitive market for specialized medical personnel, particularly those in short supply, such as physician specialists and critical care nurses.

This trend will accelerate in the next decade and many areas will experience shortages. Studies show that specialized medical personnel prefer to work and interact with other highly trained specialty personnel working in high quality, highly specialized environments. As part of my review of the original Certificate of Need, I interviewed senior staff at Sacred Heart with responsibility for recruiting specialized health personnel to Sacred Heart. These interviews confirmed that this region is already having to compete nationally for many different types of medical personnel and that expansion of Sacred Heart's capacity, even at a smaller level, will facilitate its development as a highly specialized health care organization which will help it to compete more effectively with other specialized regional medical centers to bring needed scarce human resources to its hospital in order to serve the Spokane community.

In addition, Medicare, especially as a result of changes related to recently enacted health reform, will increasingly limit expansion of specialized services to only those hospitals that can demonstrate superior levels of quality, efficiency and outcomes. Sacred Heart's proposal to expand its inpatient capacity will allow it to deliver more specialized care at higher levels of quality and as such, will position Sacred Heart to capture funding from the federal government for the hospital and the Spokane Region.

If this strategy is successful, Spokane, as a result of Sacred Heart's continued development as a high quality specialty hospital, will reap tremendous economic benefits for the community as health care is increasingly seen as the economic anchor and engine in those communities that are fortunate to have local health care organizations that successfully compete for federal health care dollars.