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PCI Need Model Alternatives Analysis

September 27, 2024

	PCI Type	DOH Model	Proposed Alternative #1 - Effectively Elective only	Proposed Alternative #2 - Acute Care Style	Proposed Alternative #3 - Constrained Supply Style	Proposed Alternative #4 - Benchmark Supply Model	Proposed Alternative #5 - Statewide Use Rate
Demand (Forecast Year)	**Emergent**	Planning area residents only, all WA facilities	Resident + non-resident cases in Base Year, all facilities within PA	Resident + non-resident cases, all facilities within PA	Planning area residents only, all WA facilities	Planning area residents only, all WA facilities	Planning area resident population w/ statewide use rate
	Elective	Planning area residents only, all WA facilities	Planning area residents only, all WA facilities	Resident + non-resident cases, CN-Approved facilities within PA	Planning area residents only, all WA facilities	Planning area residents only, all WA facilities	Planning area resident population w/ statewide use rate
Supply (Base Year)	**Emergent**	Resident + non-resident cases, CN-Approved facilities within PA	Resident + non-resident cases, all facilities within PA	Resident + non-resident cases, CN-Approved facilities within PA	Resident cases, CN-Approved facilities within PA	Benchmark level of 300 emergent + elective PCIs	Resident + non-resident cases, CN-Approved facilities within PA
	Elective	Resident + non-resident cases, CN-Approved facilities within PA	Resident cases, CN-Approved facilities within PA	Resident + non-resident cases, CN-Approved facilities within PA	Resident cases, CN-Approved facilities within PA	Benchmark level of 300 emergent + elective PCIs	Resident + non-resident cases, CN-Approved facilities within PA
Pros		Status-quo so not disruptive. Reflective of actual practice of CN-Approved facilities in a planning area. Relatively easy to model and understand.	Adjusts for in-migration for emergent cases; Effectively "cancels" out the impact of emergent cases, since the same emergent PCI figures are in both supply and demand estimates. Thus, reflects capacity and demand for elective cases for residents only. Model is a mix between "Acute Care Style" and "Capacity Constrained" style. Overall need estimates closer to DOH model, but smoothed across planning areas where patients migrate.	Adjusts for migration which matches current patterns.	Demand reflects planning area resident demand; Corrects mismatch between supply and demand; Model revision is straightforward.	Solves mismatch of supply and demand by replacing supply with some to-be-agreed upon benchmark. Model is straightforward and can be "calibrated" to reduce disruptive impacts on need estimates.	A minor change to the current model with very marginal impacts to need estimates. Mitigates the bias in planning areas along the Washington border where we do not observe use of PCIs in neighboring states.
Cons		Mismatch between supply and demand; Does not adjust for migration on demand-side	Does account for resident PCI out-migration, but assumes all residents prefer planning area providers for elective PCIs. "Locks in" demand migration patterns for both elective and emergent PCI cases over the forecast period. Undercounts actual capacity of CN-approved PCI providers. Complex calculations, but possible to simplify by making the model elective only.	Locks in current migration patterns over forecast for both elective & emergent; Zeros out need for programs because PCI methodology different from Acute Care method in important ways, especially the planning horizon; Relatively complex to model	Jettisons in-migration; Creates odd dependencies between planning areas which may not be realistic; Results in large increase in need estimates, so potentially disruptive relative to DOH model.	Benchmark is inherently arbitrary and without a benchmark >300, there will be a disruptive impact on need model. Impact on need estimates is disproportionately large for urban areas with large programs. Will tend towards geographic dispersal of need even more so than present.	Use rates for the state overall would be biased downwards and affect all planning areas, rather than only the planning areas on the border. Eliminates and ignores planning area specific factors such as the population age structure which may affect use rates.

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Estimates of Net Need (# of New Programs) by Proposed Model

Note: All cells reflect rounding consistent with current methodology

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		DOH Model	ALT #1 - Effectively Elective only	ALT #2 - Acute Care Style	ALT #3 - Constrained Supply Style	ALT #4 - Benchmark Supply Model	ALT #5 - Statewide Use Rate
PCI PA #1	Adams, Ferry, Grant, Lincoln, Pend Oreille, Spokane, Stevens, Whitman, Asotin	0	0	0	1	4	0
PCI PA #2	Benton, Columbia, Franklin, Garfield, Walla Walla	0	0	0	1	1	0
PCI PA #3	Chelan, Douglas, Okanogan	0	0	0	0	0	0
PCI PA #4	Kittitas, Yakima, Klickitat East	0	0	0	0	1	0
PCI PA #5	Clark, Cowlitz, Skamania, Wahkiakum, Klickitat West	0	0	0	0	0	1
PCI PA #6	Grays Harbor, Lewis, Mason, Pacific, Thurston	1	1	0	2	2	0
PCI PA #7	Pierce East	2	1	0	2	2	2
PCI PA #8	Pierce West	0	0	0	0	1	0
PCI PA #9	King East	0	1	0	3	1	2
PCI PA #10	King West	0	1	0	2	1	0
PCI PA #11	Snohomish	2	1	0	3	4	2
PCI PA #12	Skagit, San Juan, Island	2	1	0	2	1	1
PCI PA #13	Kitsap, Jefferson, Clallam	1	1	0	1	5	0
PCI PA #14	Whatcom	0	0	0	0	2	0
Sum across planning areas		**8**	**7**	**0**	**17**	**25**	**8**