

Certificate of Need – Hospice Services

Notes for Stakeholder Meeting – October 29, 2015

WAC 246-310-290

Meeting opened with introductions and agenda overview.

Group reviewed topics developed for discussion during the September 17, 2015 rulemaking workshop.

Discussion involved whether to address each topic individually as listed, or group and organize topics by theme/category.

Group agreed to organize topics by theme/category as follows:

- Numeric need methodology
- Policy goals
- Other Review Criteria
- Other

A table was created with the identified themes as column headers. The group began to sort the developed topics by placing the topic under the theme header that best aligned with the subject and substance of the topic or item.

Because the list was created in a “stream of consciousness” manner, the group agreed that there were some topics that were significantly similar and to add them to the table would be unnecessarily duplicative.

Discussion involved the distinction between larger, overarching policy goals versus more specific subject matter focused policy issues. Participants discussed how policy goals identified on the chart/table should be limited to more global issues as opposed to technical policy issues.

Planning area: Discussion of whether planning areas should be a policy goal. Assertion that planning areas are about more than numeric need followed by suggestion that larger planning areas are needed. The goal would be access, and as access, “you get in with access then you get into the methodology to support the access. So, the policy goal really isn’t really the planning area, that feeds into whether...patients have access to services.”(28:59)

Nancy: 35 used to be considered a “break-even point” for hospice agencies. If they had an average daily consensus of 35, the question was could they be financially viable. Whether the same is true now and what we’re seeing in the future, hard to tell. But we need to look to the future, and move forward.

Death with dignity was discussed with respect to how the concept factored in to CoN hospice methodology. Nancy contended it was a choice and range of service issue; that “a whole bunch” of hospice agencies will not serve patients who seek end of life services, limiting access to services. Asserts there is nothing legislative about clinical scope of care, and it is well within the department’s authority to require hospice agencies to comply with the Act. Discussion related to whether the department has the authority to approve or deny CoN based on whether a hospice agency complies with the Death with Dignity Act. Others in the group asserted that the department should be neutral on this issue; to require

compliance with the Act goes beyond the authority of the department. This is a legislative issue. The issue was parked in the “Other” category for potential future discussion.

In and out migration: place based versus provider based. For example, hospice care center methodology is provider based methodology, not community based.

Closed facilities: what happens when an agency closes? How do we account for them? Issue with current methodology. In the future, how would we address those?

Meaningful distinction of *cancer vs. non-cancer* – hospice use is changing and methodology should change to reflect this. Is cancer vs. non-cancer a meaningful distinction any longer? Same with age cohorts – is the variability of hospice use rates by different age cohorts – who is using is more – 65+ or younger than that? While this may result in different use rates, is it enough to make it more complex? Length of stay data captures that. Is there still any value in looking at cancer vs. non-cancer and is this analysis more complex than it need to be? Is this analysis outdated? Been a while since this methodology was developed (2003).

Superiority criteria: cost containment, described in WAC 246-310-240. Should be in other review criteria. Question arose as to what superiority is. Jan described: If you have multiple applications, how does the department determine if it can’t approve all applications? How does it decide which applications are approved?

Exceptions: Discussion as to whether exceptions should fall under numeric need, other, policy or multiple categories. Policy example where exemption might apply was special ethnic nursing homes, but this specific topic is addressed in statute (KH note: RCW 70.38.220 – Ethnic Minorities – Nursing home beds that reflect cultural differences). Jan’s exemption example: Kidney dialysis facilities where numeric need shows no need but the existing providers or provider are/is operating well above the capacity of the facility. The provider can apply for additional stations under an exception. Another example: under WAC 246-310-220, a hospice agency has to demonstrate that after the third year of operation, their revenue is going to exceed their expenses to be approved; an exception could be that the agency will be located in a rural area, and they can demonstrate that they will be financially viable after the fourth or fifth year, an exception might be allowed to give the provider a longer period of time to meet a standard that in an urban area would be a shorter period of time.

Jan: If an agency has been in existence for 20 years, and area shows by our definition that there is additional capacity needed, and minimum volume for the current facility has not been met, do we allow them to be a barrier to a new agency coming in? If they haven’t been able to increase the use of hospice in the area for an extended period of time, are we going to do that? ESRD example: if they’ve been in a service area for five years, and they have not met the minimum standard for treatments per station, that facility is not going to be a barrier to another party coming in when need has been shown.

Service area vs. planning area: Goes under need, but also financial feasibility. Nancy: mentioned this concept; has to do with rural counties that can’t meet 35 but are grandfathered in. If one of them were to close, they could not show 35. So, if it really takes 35 to show that they are financially feasible, maybe our planning areas for CoN should be multi-county.

Jan: 35 may not be the patient standard/volume standard that we’re looking at. Application forms predate the rules. Service areas/planning area are the same for the application because your agency can

have a different service area in total, just like home health and hospice currently - can be state licensed and have multiple counties that they provide services in as licensed only, but they are only CoN approved for maybe a subset of that.

Hospice specialties: larger policy goal? Jan raised this: looking at recognizing, for instance, a pediatric hospice and how CoN treats this; are they the same as a generic hospice? Question about whether pediatric hospice are Medicare certified – they are, Medicaid and Medicare certified.

Beth: The way I read special populations was whether or not we count them in the supply.

Special populations: both need and policy goal. Clearly will affect need. Will effect need methodology, can discuss further as we get to those pieces.

Use of non-medical criteria for scope of care: Nancy: means having philosophical, religious or other opinions about what care your organization ought to offer vs. what is accepted clinical practice.

Frank: Is this something CoN has purview over? Doesn't this have more to do with licensure?

Nancy: People do all kinds of stuff in hospice like reiki and pet therapy. Brought this up because of the Death with Dignity matter. If there is only one hospice in my area and they don't support the full scope of clinical care, shouldn't I have a choice to go to one that does? I think of choice as a policy matter.

Jan: Talking about the non-hospice related organizational positions that are perceived to impact the availability of hospice services to patients. Should go under "other" at this point so we can look at the bigger question.

Sale/purchase/lease: clarification regarding expectations if an approved hospice is sold. Goes under "Other" category at this point.

Concurrent review: under "other;" group decided to add a column to table entitled "process " and move this item there. Jan explains that concurrent review is defined and identified in statute.

Source of access/utilization standards: Nancy: this is a matter of policy, whether we set our goals to meet the national average vs. a state average.

Jan: As you look at numeric methodology, you can say that Western states are underserved, but historically, Western states use services at a lesser rate than the Central and Eastern part of the country. Nancy asks if this is "good" for hospice. Jan: This could be viewed differently. Central/Eastern states are overusing while Western are using services appropriately; whether that's good or bad is irrelevant. This might be part of the discussion when we get to this topic – those are things that come up in the numeric piece.

Effectiveness of current agencies: How is this measured? Is this a policy issue? Thought of in terms of numeric methodology and other review criteria, primarily in WAC 246-310-240 (cost containment) as well as the numeric side of it. A lot of these things are going to need definitions for purposes of our rules.

Choice in every county: comes in during superiority criteria? Tag with exceptions? Tie in with other aspects of review criteria? Falls under both policy and other.

Urban vs. rural: Goes under methodology. Group may define these terms differently based on geographic location.

Performance standards for issuance: Park under “other review criteria.” Context: if we start having Medicare Compare-type information, we would have numeric criteria to use about other existing agencies or existing applicants and how they are performing in other markets. Discussion followed re volunteer hospice and licensing in a particular county.

Side bar: we might want to postpone November 24 meeting since it conflicts with other meetings.

How to count capacity for closed facilities – redundancy, strike from list.

Aging population: same as population trends.

MCO enrolled populations: Leslie: Accountable Communities of Health, separating into regions now so it has something to do in the way the services are paid for regionally, not sure how this will fit in with this, but sure it’s a parallel thing happening with the Health Care Authority and reimbursements that we need to pay attention to, or at least be mindful of. Might be a good idea to have a speaker from HCA come in and talk about the ACH and how that might impact CoN. Just to see if there any parallels. Unsure of connection, just something to keep in mind.

Jan reiterates that today’s meeting is designed to flush things out. Lists will be retained and expanded as the workgroup moves forward.

Placed *MCO and ACH* in “other review criteria.”

Tribal: not subject to CoN review. Discussion re sovereignty, exemptions. Add to special populations.

Financial viability: added to “other review criteria” as place holder for financial viability.

For profit vs. nonprofit – agreement to place under “other” with a note.

Clarify that profit vs. nonprofit is not a criteria. Include items we won’t be looking at in the table. This will paint a whole picture of what was considered during these deliberations. (1:1:39)

Competition and choice: CoN is managed competition. Part of that speaks to choice in every county, and we’ve added this to the list already. What kind of choices are available in every county? Competition should not be a policy goal.

“Red flags” in applications: other review criteria or other. Item describes things that providers can identify that the department should be aware of that if seen in an application would be something that provider would have challenges in providing service.

Application discussion; develop FAQ list or introduction to application.

Group invited to add any additional topics under categories identified.

Consideration of in-home and hospice service rules: placed under “other.”

Consideration of HCA payment models included under “other” as well; before HCA/DSHS merger, DSHS understood linkage between Medicare, Medicaid and CoN and what needed to happen in the way of payment for services. After merger, some of the institutional knowledge base was lost. Jan suggests a

contact at HCA and include them in list of listserv for hospice. Leslie mentioned Gail Krieger (in-home services) and Barb Lanz (deals with MCO for home health). Kathy knows and has worked directly with both from prior employment at HCA.

Nancy refers to additional list she has independently created: first, refers to item she views as a process matter: projection completion definition. Is that when first patient is seen or when Medicare certification is received? Nancy is in the second group; but contends department is in the first group. Asserts lack of clarity as to what is a “complete project.” Not added to table because there is a difference between when first patient is served versus when facility becomes Medicare certified.

Leslie: let’s clarify what goes in rule, what might be a guideline, what belongs in forms.

Discussion around forms, guidelines, FAQ, how long CoN monitors agencies (bricks and mortar, services, etc.). Should we start a list of guidelines? How about sheet of guidelines for new hospice agencies that come into the state? Department encourages entities to come in to speak with program about CoN in advance – establishing guidelines would be very helpful for these entities.

Nancy: referring back to items on her independently developed list: discussion of concurrent review; letters of intent; superiority criteria; how do you protect a new agency and is that a policy?

Discussion re-focused to broader issues; individual issues won’t be lost, but will be discussed in context, when rules are being developed.

****LUNCH BREAK****

Group discussed where to start with table created during the AM session – down the list, major policy issues, identifying goals? Consensus was to move down the columns, and discuss each item with the underlying goal of continuous movement forward.

First column: Numeric need methodology: discussion whether we should rank order, or groupings? Trying to order the topics would be difficult. Should we start with definitions – figure out what we need to define? We have definitions in WAC, but do we need to drill down. Definitions are good place to start – our definitions are from 2003. But, if we start with the first item in the column – planning area – the first thing we’ll start talking about is the definition of a planning area. We’ll be creating definitions every time we go to something substantive.

Planning Area:

Definition of planning area and whether it still makes sense. Do we need two separate definitions for planning area and service area? Operationally, service area is never used.

Nancy: they are very different. Kentucky or Tennessee has a population based way of generating average daily census for every county, and a way of subtracting out existing capacity. Counties can be put together (Washington can do this) and you can add up contiguous counties that add up to the “n,” and that’s your service area. Financial feasibility, your entire application is based on that geographic area, and the state publishes the numbers for each of those every year. The person who wants a new hospice asks if they can gather the “n” (or 35) across counties. A new hospice, less than 3 years, is not counted.

Demand by service area – consider a 5 county service area – there’s a demand for 35, that’s 7 for each county. There is a potential for oversaturation of those markets because others will be able get in. It will be three years before someone could come into those counties. Frank: If you have different units of analysis across different applicants, there is no consistency or way to count demand or supply. If service area is self-defined, you can’t compare it to others.

Department does not want that. Can’t have competitive applications when you have applicant defined or undefined planning areas. There is no unit of measure.

Nancy: Not sure that’s true. Example: I want to serve counties A, B, C and D. Others want to serve C,D, E and F. Applications are competitive, both cannot be approved. You chose which one to approve, then these four counties cannot be applied for for three years.

Frank: If the group decides that we want a different grouping of counties, then there needs to be well-defined, transparent, replicable criteria, for example, population based. If we agree that the population base should be 250,000 people, then we look at the counties.

For rural areas, that may not be a logical service area. For purposes of the rule currently, planning area and service area are basically the same thing. Program can approve two separate hospice agencies in two counties. This is according to CoN rule under the definition of establishment of a new healthcare facility.

Discussion of whether there is any rule prohibiting group from changing definition of planning area. Only hospice services rule is open at this time, not the section of WAC defining development of a new healthcare facility. Group reviewed WAC 246-310-020 (see specifically subsection(1)(a)(ii), “The provision of services by a home health agency or hospice to a county, on a regular and ongoing basis, that was not previously included in the home health agency or hospice service area shall be considered the development of a new home health agency or hospice.”) Multiple side conversations.

Consider economies of scale; 35 in each county vs 35 across three counties. Future need assumes that existing providers can maintain, and new providers can take up new need.

Why is there a definition of service area and what role does it play? The statute speaks to health service area, and has nothing to do with health systems agencies. These are different by types of services: tertiary health services are generally multi-county areas; kidney dialysis health service area and health planning area are the same – they are the counties; in acute care they are the same and in PCI they are the same.

Jan: Current projections are done on planning area. The issue around financial feasibility is something we can look at – the 35 patients we are currently using may or may not even be how we want to measure financial feasibility. It was a measure that worked in 2003. In our first meeting we talked about things happening in the future that we might want to consider as part of this rule making for financial feasibility. Consider this hypothetical: You have a CoN for Thurston, Mason and Lewis . But you *serve* Thurston, Mason and Lewis counties, Kitsap and Pierce because you are providing licensed only services in Pierce and Kitsap. You can do that – that’s your agencies’ *service* area. (Emphasis added).

Consensus: We don’t need a separate service area definition; don’t need the second sentence of planning area. Leave the planning area as it is.

Leslie: I would like that we can all acknowledge when we have a consensus and move on. Prior group had history of coming to consensus and then it came unwound.

General agreement with Leslie's comment; many participants speaking at once.

Data and Data Sources:

Should we say data sources are nationally recognized sources, such as published Medicare utilization data? Department understands that this is what stakeholders would like, but that may not be available. OFM is available, but not nationally recognized. Department does not want to limit data sources.

The different elements of methodology will direct what kinds of data sources we'll use. For example, for population we'll use OFM.

Some publicly reported data is a year or two away.

Consensus: Data and data sources need to be readily available to the public; as we go through the rules we will identify those sources so that people know where the sources are and whether they will be published on our web, or the source of the data that will be used for a particular measure is identified, and also available in the time frame to allow for the planning area.

Projection Horizons:

Jan: Our methodology currently has no projection horizon. We have by application of department gone out three years into the future. Association proposal indicated that there was a desire to have need projected at the time of application, there was not a future projection of need. Department recognizes that it takes nine months or so to go through a review process. If there is need projected at the time of application, then the need will likely be greater at the time of approval, and even greater if there are appeals. What department has done to address this is to project out five years depending on the type of project, for hospitals it's a seven to ten year horizon. PCI is three years.

How does hospice compare to other healthcare areas in terms of growth and all of the changes in regulations? This is an unsure time in hospice and is there another model that we can compare this to?

Frank: That suggests that the forecast horizon ought to be shorter rather than longer, but it shouldn't be so short as to not include any projection whatsoever. When you apply, will be using year-old data, then a year to get approval, so three years isn't bad.

Discussion: identify base year, then how many years to the future from the base year. Home health isn't a good model for this, even though it's not a facility-based type service. PCI might be good since it's a service.

Consensus: We want to have some future projection that it is not immediate at the point of application and that it is somewhere between the five year projection into the future after the base year. Base year plus three years after approval – what the department is currently doing.

Agreement that base year is the last full year of publicly available data. There will always be a gap/lag in data.

Length of Stay:

Do we have a definition? Why do we use average versus median?

Candace: Average can be skewed by minimal differences. Median really paints the picture of who is being served and for how long.

Discussion: (group all talking at once). Need a definition for census and length of stay, median length of stay, average length of stay. Why is average used? Median gives the true data, talking about length of stay, not used to calculate ADC. Median length of stay may be a better measure of how long patients are receiving care and that can impact the need for additional providers or services by using that rather than average that can be skewed by one or two people. When we think about the median length of stay, that tells us the turnaround – it's the "churn" – that's a huge challenge for hospices. Another thing about the churn, for the last fifteen years, the average percentage across the county and in Washington of patients on service for seven days or less is 30 – 31% no matter how much education we're doing in palliative care, it's staying constant. So what we'll see is that staying constant, and palliative care will grow.

Palliative care discussion: palliative care vs. hospice care. Ambiguous in many ways. Medicare definition of palliative care, medical community definition of palliative care. From Medicare standpoint, there isn't reimbursement for palliative care under hospice; there's reimbursement if agencies use a nurse practitioner. GH has palliative care under the home health benefit. Leaves a huge gap. Hospice isn't going anywhere – it focuses on the time of nearing dying, but it also cares, post-death, for the loved one. That's something palliative care does not do. Most systems that offer palliative care see their hospice programs grow because they get earlier referrals.

Is the gap because of the federal definitions? (Multiple discussions follow, occurring at the same time).

Cordt Kassner Presentation

Explains slides, especially maps and Medicare certified hospices. Looking at what is the amount of hospice utilization in each county to determine threshold and identify underserved counties/areas. Slides examine and test different thresholds. Looked at two things:

What was the actual hospice utilization rates and how far should we deviate? If your rate is 10% or more beneath the state average, that's too low – would open up county for CoN purposes. 10% came from an examination of national and state information. Group examined different percentages.

What if only hospice in county has bad year – should county be opened up for CoN? 10% or more below threshold for one, two or three year period? Decided on two year period.

Percent is based on current data; average utilization for each county; if average over two year period was less than threshold, this would trigger need.

Discussed too many hospices – when there is an overabundance of hospices, patients are admitted who don't need/aren't otherwise eligible for hospice services, waste/fraud/abuse issues increase. Used Oklahoma as an example. Uncontrolled growth can lead to negative consequences.

Churn level in hospice contributes to high staffing needs. Looks like WA is coming in at 26.1%; national average is 26.9%. Data from Medicare claims.

How does methodology adjust for counties that drive the average? (marked yellow in slide)
Higher utilization counties will never show need. Under this methodology, there wouldn't be any additional hospice agencies other than those that are already existing presuming they continue to expand with the market. As long as they are keeping the utilization rate high in their counties, these larger counties will drive the statewide average. "Strong" utilization is defined by these counties. This model does not discuss supply.

How do we know how many hospice providers are needed? If there is a need, how do you know that provider is appropriate to approve for CoN? County demonstrates need – it's up to DOH to determine how many are needed; up to DOH to review application. If a county demonstrates need, should we restrict the number of incoming hospices to one at a time, and if so, should we allow one, two or three years to get started before we open that county up again? Recalls conversations, but group left these layers of complexity up to the department as part of rulemaking.

Lisa: Issue with assuming that the issue for the counties who are underutilizing is because they have a lack of an agency. When you look at the map, it has a lot more to do with other issues in those communities than necessarily adding an agency, and vice versa. Methodology proposal seems too simple.

Describes circumstances and details around hospice overuse in other states; MedPac report.

**** CONCLUSION OF PRESENTATION****

Steve clarifies with Jan department's involvement in workgroup. Jan confirms involvement. Barb confirms purpose of Cordt's presentation at today's meeting – information only.

Discussion of this particular rulemaking activity regarding hospice. Workgroup presentation is something to consider as a different approach. Jan provides background and history of rules review cycle with hospice.

Medicare data was used for workgroup, but that isn't publicly available. Also used Medicaid data.

Barb lobbied to not have the next meeting so close to Thanksgiving. Group agreed.

