



STATE OF WASHINGTON
DEPARTMENT OF HEALTH

WASHINGTON STATE
CERTIFICATE OF NEED PROGRAM
Meeting Summary – Hospice Services
WAC 246-310-290

A meeting regarding the Certificate of Need (CoN) hospice services rules convened on December 17, 2015. The meeting was held at the Department of Health, 111 Israel Road SE, in Town Center 2, Conference Room 158, Tumwater, WA 98501.

PRESENT: Steven Pentz, Providence
Frank Fox, Providence
Barb Hansen, WSHPCO
Leslie Emerick, WSHPCO
Jody Carona, HFPD
Catherine Koziar, Providence
Nancy Field, Field Associates
Candace Chaney, Assured/LHC Group
Mark Rake-Marona, Franciscan

STAFF PRESENT: Bart Eggen, Executive Director
Janis Sigman, Program Manager
Beth Harlow, Analyst
Katherine Hoffman, Policy Analyst

9:10am – Open Meeting, welcome and introductions

Overview

Kathy Hoffman – goals for workshop, review of prior workshop accomplishment and areas of consensus.

Group Discussion

1. Policy and Policy Goals

Group revisited topic of underlying policy and policy goals. Discussion included:

- Identifying what element or elements of the existing rule set need to be modified.
- Identifying specifically what CoN rules can and conversely, cannot, achieve.
- Determining whether the group preferred to move forward with the topic matrix, working from the “bottom up,” and addressing policy issues as they arose; or shift to high-level policy discussions and then address variables (“top down”).
- Use of the terms “access” and “penetration” to generally describe utilization.
- Definition of the terms “penetration,” “utilization,” and “length of stay.” Generally, penetration is defined as the number of people dying a natural death who are receiving hospice services.
- Discussion of whether group was interested in increasing hospice use rate and length of stay as foundational goals, with the understanding that additional goals can be added in the future.
- Agreement to set basic policy goals to provide direction for current work, and return to working on topic matrix, or the “bottom up” option.

➤ **CONSENSUS: Basic policy goals**

- Increased penetration
- Increased average length of stay

2. Average Length of Stay

Group turned to the topic matrix created during the October 29, 2015 meeting. Discussion included:

- The separation, or “line drawn” between the provision of palliative care and when hospice comes in, and whether this is something CoN can address.
- Robust discussion regarding strengths and weaknesses of mean versus median and state versus national length of stay factors as a policy tool.
- Consideration of using Western states only as part of an improvement model.
- Group tested and reviewed results of average length of stay variables (59 versus 71 days) on current “live” hospice methodology worksheet. Result was insignificant.
- Death data versus non-death data was addressed with respect to underreporting length of stay.

➤ **CONSENSUS: Definition of average length of stay is a mean length for the state of Washington. If length of stay is increased from 59 to 71, there is no major impact.**

3. Average Daily Census

Discussion included:

- Origin of the average daily census of thirty-five currently found in WAC 246-310-290(6), and whether this remains accurate.
- Definition of average daily census, and whether average daily census should be different for urban and rural areas since rural areas may not be able to meet the current threshold.
- Whether combining counties to reach threshold would be an option. Suggestion that a better approach would be to adjust ADC. For a rural county to meet the threshold ADC at 71 patients, the county would need to have 180 hospice patients per year. This is not realistic.
- Accountable communities of health were considered, although the group generally agreed that the areas were too large for purposes of determining ADC.
- Current usage of ADC in methodology is to measure minimum viability and the threshold below which an agency is not viable. Group is considering introducing the ability to explain how an agency plans to stay viable with an ADC that does not meet a numeric threshold.
- Frank and Mark will create a minimum volume revenue cost model to calculate a successor number to thirty-five.

- **CONSENSUS: Average daily census is important to the group, but members need more time to think through the issues and develop a definition. The numeric threshold has not been determined yet.**

4. In/Out Migration

Discussion included:

- Current methodology, which is both a place and provider-based model that picks up migration because it looks at provider counts that are not bounded by county.
- Data is aggregated at a level that becomes statewide so it is not overstated.

- **CONSENSUS: In/out migration ideally should not be occurring. In this context, hospice is a home-based service. Group agrees that little, if any, additional analysis should occur. Current practice is reflective of where patients receive care.**

5. Population Trends

Discussion included:

- How “aging” the population will affect hospice with respect to utilization.
- Whether to retain the current structure of age cohorts (65+/64 under).
- Description of current acute care bed methodology, and how it demonstrates use of services by persons aged 65+. Discussion of how

the acute care bed methodology may more accurately reflect aging as defined by OFM over the forecast interval.

- **CONSENSUS: Keep data disaggregated and then sum it together. The best way to deal with population trends is to separate age cohorts – 65+/64 under.**

Group advanced to cancer versus non-cancer, departing briefly from the topic matrix organization to follow the progression of the methodology.

6. Cancer versus Non-Cancer

Discussion included:

- Cancer formerly had a distinctive use rate. Group discussed whether to retain that for hospice purposes or to look at deaths in total. Age groups will remain split, but all agreed to remove complexity of cancer versus non-cancer deaths.
- **CONSENSUS: Cancer versus non-cancer is no longer a significant measure and should be removed.**

7. Special Populations

Group agreed to move “special populations” to the “exceptions” discussion. Special populations include pediatrics, or any other entity where the department would expect to see hospice used at a different rate than other entities.

8. Closed Facilities

Discussion included:

- Scenarios that create different capacity counts: purchase of a facility, closure of a facility, and facilities that are wholly owned subsidiaries. As healthcare systems change, we can anticipate more affiliations, acquisitions and restructuring that may result in fewer facilities, but the same capacity.
 - Letter of intent and facility closure timing.
- **CONSENSUS: If the department becomes aware of facility closure up to 15 days prior to the letter of intent, the department will modify the posted methodology to account for that closure, re-post the methodology, and all applicants will have at least the 30-day letter of intent period to make the decision to apply. If closure occurs any time after the 30-day period, the department will not modify methodology based on that closure until the next year. The applicant cannot apply until the next year.**

Conclusion:

- Frank and Mark will build a minimum volume revenue cost model to calculate a successor to the current ADC number of thirty-five.