

## Certificate of Need – Hospice Services

### Notes for Stakeholder Meeting – December 17, 2015

#### WAC 246-310-290

Meeting began at 9:10AM

Review and group confirmation of consensus points from prior meeting (October 29, 2015).

Introductions.

Bart: (With respect to the topic matrix) Not sure we have flushed out our policy goals. With other CoN methodologies, there is an underpinning issue or issues that need revision, or part of the existing methodology that is not working well. This drives the conversation. We end up with a list of items very similar to what we have developed here, particularly in the far left column of the matrix. For the most part, we find these topics in our existing methodology. Underlying all of this, from a policy perspective, we can look to the work that has already been completed that shows us the makeup of hospice from a Medicare perspective statewide, and here is where we stack up nationally. The fundamental question is what do we want to fix? Do not need to re-start our work, but what are we looking for as a result in changing what is happening in Washington right now? What do we need to help focus our discussions? If we want to exceed other states in Medicare utilization, what can CoN do to influence that? Not sure that is a CoN question based on our current state of care. When we are done with our work, what will we have changed? What do we need to do differently to change hospice? Don't want to derail process, but does this make sense?

Jody: Recalls discussing underlying policy at first meeting. Recently met with HCA in Spokane; concern raised regarding home health and hospice in rural areas. Very little access in rural areas. HCA might have some insight as to what it would like to see as the transformation takes place.

Bart: Did you look at maps and data?

Jody: Looked at Medicaid and Medicare expenditures.

Nancy: There is incentive for home health to retain patients appropriate for hospice. There is competition for payments. Interesting dynamic between home health and hospice.

Jody: HCA did not differentiate between home health and hospice during the meeting. Concern was expressed for shortage of access for both home health and hospice in rural areas.

Nancy: There seems to be a dynamic between home health and hospice that is exacerbating the problem. I agree with Bart. Why are we doing this and what is the bottom line in terms of policy? I think the group as a whole preferred to work from the bottom up as opposed to the top down, although my preference is from the top down. The methodology is laden with policy, and I do not believe that anything about the methodology is neutral.

Leslie: Home health is reimbursed (by Medicaid) at \$89 per visit and it costs \$180 per visit. There is an access issue with home health because of the low reimbursement rates, particularly in rural areas. There is currently a decision package in front of HCA requesting to raise the reimbursement rate to \$99 but it

still is not enough. There are bigger problems with home health. With respect to the policy issue, analogy of how do we “eat an elephant.” Bart is talking about the elephant. Issues will be sorted out as they come up. Group can talk high-level policy for the next three meetings, never really get anywhere and never reach consensus on anything. Concerned about the time of group members. Wants to make sure that we have some policy direction, but does not want that to lead the process to the point that we do not make any progress. Our goal is to improve access.

Jody: Need to know goal is to move forward. To keep moving variables without knowing what we are trying to accomplish is, from a planning or policy perspective, not the way you would do it.

Leslie: Do we want to make sure that everyone in the state has access to hospice? Maybe providers in room can help us with that.

Bart: The maps we have access to examine Medicare beneficiaries. (Reads stats from maps/Cordt’s presentation). If this data is true, there is clearly a difference by some percentage of rural populations’ access to hospice. It does not reflect that there is not access, but that there are somewhere between 30 – 39% of Medicare beneficiaries that die have access to hospice and died in hospice. In the more populated areas, the maps are saying that we have 40-49%. I can look at the most heavily populated CoN county in the state, and it falls in the 40-49% range. Therefore, it is not arguing that another CoN approved hospice agency is going to change the utilization rate, at least of this population, in King County.

Nancy: If we want to look at data, just looking at WA State seriously shortchanges the perspective of what is possible for WA. If we look at penetration for days for Medicare in other states, we can also see other patterns of availability and accessibility that we might want to look at.

Bart: Based on what I see in this data (national data), we as a state seem to be falling in the middle. The difference is less than 10% difference in the Medicare population.

Nancy: The only data we are looking at is penetration. We have not looked at other national data that correlate to states that have higher use rates. We need to borrow those ideas for WA. Saying how can we make that number go up, looking at what other states do helps us understand what they do and will help us get to a higher penetration rate.

Jody: Is higher penetration a good thing? Do we want to improve the penetration rate?

Mark: We are using multiple terms to describe utilization. We are using access, penetration and utilization. These are not necessarily correlated. For instance, if you go to the Southeast, you will find access to hospice is the highest in the country with more providers per capita. However, that does not necessarily correlate to penetration or utilization when used synonymously. So, to Bart’s question, is the policy issue “are we concerned with increasing the number of providers which may then lead to increased utilization” or are we just making sure that there is sufficient access to address whether a Medicare beneficiary, if they want hospice, can get it. CoN has nothing to do with the quality of the hospice provided; they only have to do with access. I am with Leslie, if we flesh out some of the issues then we’ll get to the policy issues.

Barb: (to Jody) Yes, we do want more access, more penetration. Families want to know about hospice services. We are 31<sup>st</sup> in the country, that is not something to aspire to. We are mediocre at best. In contrast, Oregon is 6<sup>th</sup>. Washington and Oregon are in the lowest percentage for fraud, and this is a

good thing! However, we just are not reaching the people we need to be reaching and I think we can do better.

Jody: So if I understand what you are saying, the policy would be around increasing the penetration rate to the national average and increasing length of stay.

Jody/Nancy/Barb: What are the definitions of penetration, utilization and length of stay? Barb understands penetration as it is used in marketing, meaning the number of people who are dying a natural death who are on hospice. It could be one day or it could be 180 days.

Bart: I think I am hearing a policy position that is not on the list, and it is do we want to move the needle so we are not at 44% or 32% use rate, or 31<sup>st</sup> in the country. Length of stay is another. Two important policies that will form the detail about what are our targets for length of stay usage. What do we talk about with viable organizations and average daily census? Those things will result in a decision as to whether you will add a new provider or not, and where we set those bars. If we want to have an underlying policy that says, "We want to have more utilization," it has to mean, from a CoN perspective, you want more providers available, because that is all CoN can do. We cannot change your marketing strategy as an existing organization.

Jody: I disagree. As a provider, say that if Mark is trending up, if he is growing at a rate of 8 or 9% a year, do we hold it constant? Or do we allow him to continue to trend up? That does not mean they need a new provider, it might mean that Mark is fully capable of growing.

Bart: What can CoN do about that?

Jody: Trend him. In the methodology, allow for trending instead of holding it flat.

Bart: Those are the issues that we are looking at here. Consider King County. Five hospice providers that are certified CoN providers. What can we do to make King County's use rate higher? If we do not add another provider, how do we get the utilization up? Would we put another provider in King County? Under the current methodology, no. If a county with the most density of providers is not meeting the performance expectations that we want to have, the only thing CoN can do is create a methodology that allows us to approve another one, to see if that makes the difference. That is going to be the same concept across all the counties then. Do we want to trend things? We have a good baseline, it is not meeting our expectations of utilization performance and providing appropriate access. Then, what we can do now is to make that leap in assumption that this is the result of not having enough providers.

Catherine: It may not be an issue of not enough providers, because those five or six may have enough capacity to grow. It is also about people not ready to make that decision to go into hospice, or physicians not ready to have that conversation. I would caution that we do not just jump to yes, adding a new one will affect utilization. It may or it may not. I think length of stay does not even belong in our discussion because CoN cannot do anything about length of stay.

Jody: Need the data. Example: Franciscan could be meeting need and growing. Just because the population is growing does not mean Franciscan cannot meet that need.

Bart: What is happening in King County is outside what CoN can do.

Catherine: Is Iowa a CoN state?

Nancy: Looked at states; persons per hospice average, WA 700 admits per year. In Florida, there are 2500 admits a year. CoN states have fewer admits. Washington, at the cost-report level, has 18 hospices. Reduced number of hospices are available in Washington. Very few providers, very low penetration in CoN states, reads this as CoN states “detering” growth and utilization.

Catherine: Admissions do not account for population. Admits do not mean utilization. Iowa has high utilization, and is a CoN state. I believe that utilization is a better measure than admissions or number of patients.

Bart/Nancy/Jody discussion: Nancy believes this is a policy matter and that CoN caps program size. Bart asserts that CoN is not interested in capping the size of an agency. If the general policy goal is patient centered, and people have appropriate access, not sure CoN would think that is a bad thing. Nancy believes that caps exist in heart, home health, hospice and others. Jody observes that CoN holds agencies flat, CoN does not continue to assume that the agencies will grow. Does not like the idea of several new providers in King County.

Barb: Looked at Iowa’s rules. They are 4<sup>th</sup> in utilization.

Bart: I do not think utilization is strictly a function of CoN. Think there are some places that it would probably make a difference from a policy perspective.

All: Additional discussion. Increased penetration and increased average length of stay are our goals. Penetration defined. There can be more goals added in the future, but these two will help us along.

**CONSENSUS**: Basic policy goals: Increased penetration and increased average length of stay. (Tape 1, 54:00)

### **Average Length of Stay Discussion**

Kathy: Back to matrix. Average length of stay discussion at last meeting concluded without consensus. Pick up there with review, and open floor to further discussion.

Leslie: Where is the line drawn between home health providing palliative care and when is hospice picking it up? Nancy says home health is holding on to people deliberately and not letting them go into hospice based on a financial incentive, and I do not know if that is the case. People may be getting really good palliative care and they are not ready to sign off on hospice yet. In terms of length of stay, that might impact that.

Barb: Where the line is drawn regulatory wise is when the notice of election is signed. Notice of Election means you are signing away your Medicare rights for that diagnosis for other treatment options.

Leslie. So, maybe that is why people want to stay on palliative care as long as they can, because of the treatment.

Nancy: Has three clients who say their home health clients want to go to hospice, but they do not want to let go of the relationship they have with their caregiver now. So, the decision can be based on dynamics that are invisible to us that keep people from electing hospice, but have financial underpinnings.

Leslie: But is that something CoN can address?

Nancy: We can stop saying it is cultural and people do not want to make that decision.

Leslie: So, where does that get fixed in this? (referring to current version of WAC 246-310-290)

Jan/Nancy: Group has not made the decision that we are throwing everything out in terms of the current methodology and creating a new one. As time has progressed since the group worked with Cordt, a few things have changed along the way with hospice. However, the decision has not been made to start anew. We want to use the current rule as a basis to discuss things we want to change within the methodology that exists, what is good about it, what is bad about it, and what needs to be changed within it. That was the take away from the first couple of meetings. We are looking at making changes more aligned to what we want to see for Washington as opposed to throwing the whole thing out entirely.

Leslie: So, what is the current status of length of stay in the rules as they now exist, and what are we looking at changing?

Jan: Right now, it just calculates the average length of stay.

Nancy: We do not really have a good definition. In rule it is one way but in practice it is another.

Barb: I think median length of stay is what we should talk about as opposed to average. It is accepted nationally that median is more reflective of the trend of hospice length of stay because the really long stay can skew the average.

Jan: Is there a desired length of stay that is a good one that we should be looking for? We have not had the discussion of what the number should be but we agree that the measure that we would be looking at is median.

Catherine: I agree it should be median, but we still need the average length of stay definition in there because that is how we are calculating the average daily census.

Jan: So, length of stay would be using a median, and that was a consensus? Do we want to have a discussion about the number?

Frank: Right now it is calculated on the state average.

Discussion: Median length of stay, Washington versus national.

Leslie: Explains "Honoring Choices" program: as awareness increases and doctors get paid for end of life conversations, trends will change. Hospice will increase. The big question over time will be how these trends impact hospice.

Discussion: Where do we want to be? What is a good target? Ideally, within the top 10 nationally, but that decision should be agreed upon by all end of life professionals in WA. Nationally, the average is 24 days, WA is at 23. This is from Medicare data; this is the median number of days. Mean is 59 WA, 71 nationally. Discussion of distribution of mean and median, distribution of length of stay and people. In Washington, there is an assumption that Medicare fraud is low because providers are financially healthy. Or are we just more honest? If that is true, that we are not looking to have people in hospice that should not be, why don't we use our mean? Why don't we say our average length of stay for people in hospice is 59 days, and if we want to have programs like Leslie shared, it should drive that number up,

why would we pick 25 as our average length of stay? Median is more useful when comparing across populations. There is data showing average length of stay by diagnosis in WA.

Bart: Is the consensus, then, that we want to use median?

Mark: Offers another proposal. As long as the focus is Washington, if we are trying to improve, it does not matter mean vs. median as long as we are using our own state as the reference. In some cases, if you have a stable group of providers, and Washington does, mean is appropriate. We could use either one.

Barb: Then you are just comparing to past performance.

Frank: If you just want to use median, that is not as much of a policy tool that shows differences between Washington and the US, whereas with mean, if we are at the lower tier of the states in comparison to the nation, using mean would be a more useful policy tool. Mechanically, mean would be a more useful policy tool that would get you to the stated goal of having more penetration.

Catherine: Need to be careful about setting high goals for length of stay because that is something Medicare may question.

Mark: From a policy and provider perspective, I do not think anyone would argue with increasing length of stay to get patients on sooner. Some measured target would be something everyone could agree to. When we look nationally, there are not the same factors considered. In the Northeast, use rates are high based on tax status, availability of other services, people are accessing hospice in the absence of other programs, other factors. Hard to tie our improvement to what is going on in the country. I would be more inclined to pick a length of stay target.

Jan: Another option is to look at western states. Historically, western states typically have lower utilization. Maybe could use these states as part of an improvement model.

Bart: Issue with that option. If WA is mediocre, what is the margin of mediocrity?

Mark: Difficulty is benchmarking.

All: What do these numbers do and how do we use them? How would we use our existing methodology generally, and what are the things we need to change? Let's take a look at the methodology at step 6 [WAC 246-310-290(6)], and discuss the impact.

**\*\*BREAK\*\***

Bart/Group: (Demonstrates and discusses average length of stay on overhead screen with current methodology "live" worksheet. Group walks through testing modification of a few rows of data. Did not make significant difference). If we want to change average length of stay, we need to pick a value and see what it will do. How does it change, what does it do? Statewide, need for approximately 10 additional agencies throughout the state after manipulating data. No need in any additional county. Is it interesting at all to explore what the length of stay would need to be? No. There are two ways to calculate length of stay – state rule is based on actual death. But federal calculation is different. Cost report recognizes unduplicated death and unduplicated admission. No parallel to WA. 12-15% of our patients are being counted twice in the federal data based on the way cost report is prepared. (Tape 2, 12:15) Counting patients twice changes the average length of stay. Ex: Patient is in hospice for last 30

days of 2011, first 30 days of 2012. In 2012, report would represent that the patient was in hospice for 30 days when the stay was actually 60 days.

Mark: Claims data is accurate with no start/stop. Cost report has start/stop.

Discussion: Death data versus non-death data (admissions, discharges). Length of stay could be underreported.

Mark: Penetration is not related to average length of stay. We are looking at the number of deaths on hospice vs. total deaths. Penetration number is based on deaths not admissions.

Bart: We will verify that the data we are getting from Medicare is reporting the average length of stay because either it is so unimportant that you take so many number of days, or Medicare is reporting that statistic in the same way, that the person received hospice care and died. (Tape 2, 26:02)

Mark: (to Catherine and Candice): You both have urban and rural hospice. Are discharges alive different in urban/rural?

Nancy: Would want to look at two lengths of stay: One would be from the financial perspective for workload; one would be to look at deaths.

Mark: When we look at workloads, we look at patients who were discharged and those who died. Deaths best for operational tool.

**CONCENSUS RE: AVERAGE LENGTH OF STAY:** Definition of average length of stay is a mean length for State of Washington. If we go from 59 to 71, not much of a major impact.

### **Average Daily Census Discussion**

Frank: Where did the 35 come from?

Bart: It came from Mark.

Mark: We are not sure that it is still accurate. When developed, it was a minimum standard. Anything above that is fine, anything below that will be a challenge, unless subsidized.

Bart: That's where we ran into this concept that is embedded in our rules now, that is single county, planning area-based projections. The projections for that county have to financially pencil out.

Mark: Because the discussion was that we did not want people coming into the market that could not sustain themselves.

All: Assume someone is not in the hospice business, but wants to start providing care. How do we create a standard that allows this that is not unfair for existing providers? Need to be mindful of new providers. An unintended consequence of that is a threshold. The 35 was the threshold showing where we would approve a provider. Here is a continuum, and we wanted to show where someone could be feasible. ADC is the threshold, and what is the definition? Is this a realistic number in rural areas? Should we consider two different thresholds sorted by population as opposed to county? Rural areas might not be able to meet the 35. There were some CoN approved hospice agencies that served portions of counties as opposed to an entire county.

Mark: Is there a definition in CoN or elsewhere at DOH, are their definitions for rural and urban?

Jan/Leslie: It depends on usage. Department of Commerce has many definitions. Planning area and service area are different. For counties that cannot get to 35, combine two rural counties, and then show the counties that are eligible for combination.

Catherine: If the problem is that a hospice cannot get to 35, a cleaner approach would be to adjust ADC. This would be much easier than combining counties. In other words, maybe urban then becomes 20 or whatever number we think it should be.

Nancy: What about the idea of patient choice? How do we get choice into these small counties?

Frank: This is where exceptions would come in. There would be criteria for the department to grant an exception.

Bart: Need a current with map with CoN approved hospice agencies. If we want to increase utilization, what can CoN do to increase that in today's market? How do we open counties up to other providers who can augment provision of care for existing providers? That is really all that CoN can do. The biggest impact is to do something with the ADC, if not eliminate it, for certain types of applicants that want to go in to these counties. A certain level of populated county would qualify.

Mark: ADC is going to be based on admissions. Other than population, for a county to have 35 ADC at 71 days, you would need 180 patients per year. In a rural county, there is going to be a point where it is not possible to have two providers that are both financially feasible.

Leslie: What about accountable communities of health? These already exist, and we may be able to work with other agencies.

Jody/Bart/Leslie: Areas are too big (group agrees). 8 – 9 areas currently, and areas are huge. Population density map would be useful here. Areas that have older populations might end up skewing the number. Medicaid has said that it wants to establish larger areas where there are primary providers. Theoretically, cradle to grave service providers. We could do that here, as well. We did this already in our sample spreadsheet (from 59 to 71). If the state of Washington, as one big accountable community of health, identified need for ten providers, then the first ten providers to sign up that met the quality of care standards would be approved. But, if we put three ACH in Eastern Washington, and we look at all of Eastern Washington, and want to know the total average daily census across that total planning area, we might come up with at least some number of that ten that we did statewide. But now, conceptually, that provider is signing up to provide serves across that entire geographic area. Providers cannot travel those distances. Think about rural areas and blending. (Tape 2, 1:00)

Catherine: It is already difficult to serve a rural area. By just saying you can serve a larger rural area, that does not work.

Bart: Statutes addressing rural health from 1989 identify the same issues we are dealing with in 2016. Look at the maps (population density maps).

**\*\*LUNCH\*\***

Nancy and Bart: Discussion re HMO hospice providers and access. Perception that for HMO, hospice capacity is portrayed as being available to all when it is not; dampens overall need. Makes it look like there is more capacity than really is available in four specific counties. The higher use rate creates higher demand, and makes capacity appear to be available to the entire county. Is that more than offset by the

fact that they created a higher use rate? Creating a higher use rate will create a higher demand, subtracting out a supply that is based on the current provision of care by that provider. How does that skew anything? Small effect statewide, but greater affect, large market share in King County. Capacity is not inflated. Group Health is subjected out of what is available. On the demand side, Group Health enrollees and their families are in the population. On that basis, you have an artificially high use rate if you think about it that way, but then on the other hand, we've got their supply, so in theory, they balance. We don't have any way to know that, but it is logical. The only difference is the payment mechanism; as far as CoN is concerned, there is no difference.

Kathy: No consensus on ADC. Do we want to come back to this? Does group want to think about how we want to come to consensus on this?

Nancy and Mark: Does ADC mean target penetration? We could talk about the target as the statewide census in hospice.

Frank: It seems to me that the way we are using ADC in the methodology is to measure some minimum viability, some threshold below which an agency is not viable. That could be clinically viable, or financially viable, but I never differentiated or worried about it. It was just that minimum threshold, so I think that's really what we need to concern ourselves with.

Mark: The issues we dealt with in 2003 are still there. Have to be a certain size to be viable if you are not subsidized, and now we are thinking about introducing the ability to explain how you are going to stay viable with an ADC that does not meet a numeric threshold.

Bart: ADC is one of the ways that we can establish state targeted utilization expectations. So, if we want to increase utilization, one of the things that you can measure is, what is the ADC over that population? We can tie it back to a population and say that on a normalized population of every 100,000 people, we would expect an ADC of X as the utilization target.

Group manipulates spreadsheet with minimum ADC and ALOS, then checked differences.

Nancy: More than one trigger for approvable projects?

Frank: That could go under exceptions

ADC is broader way of driving ALOS.

**CONSENSUS RE AVERAGE DAILY CENSUS:** ADC is important for group to decide, but members need more time to think through issues and develop a definition. Also, set numbers have not yet been decided and agreed upon

Nancy/Frank: Discussion of viability (cost report level). How are we going to address this issue? Has some one studied it? Should we look at work that has already been done on this?

Mark: Variables have changed, rates have changed, what is expected of hospice has changed. We could do an analysis of what it costs to have a full staff, etc. Could come up with break-even scenario (minimum point to make financially viable with full range of required scenarios). Would also be important to look at who is going out of business across the country and why. Would validate that you do have to achieve a certain size to be viable.

Frank: Will work with Mark to build some minimum volume revenue cost model to come up with a successor number to 35. Very doable.

### **In/Out Migration Discussion**

Frank: What does the methodology do now? It is both a placed based and a provider-based model, so in some respects, it is picking up migration because we are looking at provider counts, and those counts are not bounded by a county. So, it does pick it up in some regard, and I'm not sure how much more migration we could push into the model. We could be more formal about it as in other methodologies, but I am not sure if you have that information or it is even accessible to allow it to be done. So, I'm not sure you can do a lot more than you have already done. Unless you are looking at an exception.

Bart: What we're really looking at is capacity. We aggregate the data at a level that becomes statewide, so it does not overstate anything unless you were to look at what the use rate is for a specific county. We don't look at specific counties. Using the statewide use rates, it increases the expectation of what use rate is in rural areas.

Steve: If we make a distinction between rural and urban, and you have a rural adjacent to an urban and that they migrate, then it could affect use rate.

**IN/OUT MIGRATION CONSENSUS:** In/out migration ideally should not be happening. Hospice is a home-based service. Group agrees that we do not need to do much more with the analysis. What we do now is reflective of where patients receive care.

### **Population Trends Discussion**

Mark: Methodology re-aggregates.

Leslie: Is it more about the "silver tsunami" coming?

Bart: How do we fix the aging issue of the population? Should we extend the projection horizon beyond three years? There is argument about how the projection target should be in rule, and we have been using three years versus just a point in time. A projection time horizon makes more sense.

Frank: Five years give more flexibility to pick up the aging of the population.

Mark: How will "aging" the population affect hospice as far as utilization is concerned?

Frank: If it is like the acute care bed methodology, there is great difference in acute care bed use by personal services to those who are 65+. So, in counties where there is more 65+, because the methodology is discreet in forecasting for those age cohorts, it adds them together. In counties where the elderly population is growing more rapidly, that really does have an inflationary effect, rather than if that inflation did not occur. You could do the same thing with this methodology and keep the age cohorts separate because we are estimating incidence rates for the separate age cohorts, and we just keep the population separate and multiply them by the incidence rates, then add them together at the end. That would more accurately reflect aging as defined by OFM over the forecast interval. (Tape 3, 47:00)

**POPULATION TRENDS CONSENSUS:** Keep the data disaggregated and then sum it together. Best way to deal with population trends is to separate age cohorts. 65+/64 under.

Group advanced to cancer v non-cancer to follow progression of methodology.

### **Cancer versus Non-Cancer Discussion**

All: Cancer used to have a distinctly different use rate. For hospice purposes, do we want to keep that distinction or should we look at deaths in total? This was discussed in 2003 that things were starting to change, and they have. We will continue to split our age groups but remove the complexity of doing cancer versus non-cancer deaths.

**CANCER VERSUS NON-CANCER CONSENSUS:** Cancer versus non-cancer is no longer a significant measure. Remove.

### **Special Populations Discussion**

All: Do we really have some particular special population that are using or we expect should use hospice at a different rate than everyone else? Majority would rather see that in exceptions. Pediatrics could be part of that conversation.

Move “special populations” into exceptions.

Bart describes how a typical exception works for CoN. If there are special conditions or special types of things that should be considered for a certain type of service that aren’t common, is there something that the department should look at? (Tape 3, 1:00)

Group Discussion: Lady Bug House. (Tape 3, 1:03)

### **Closed Facilities Discussion**

Nancy: Issue that came up this year, one hospice closed and another “picked up” its patients. Methodology needs to be updated. When a hospice closes, capacity needs to go “back in the pot.”

Frank: Isn’t this just a timing issue, timing matter?

All: Moving forward, what do we think should happen that we can write in the rule clearly? We have two scenarios that can create a different count. Either a facility is purchased and the existing facility closes, and essentially buys, rebrands, employs all employees and moves forward; or a hospice decides they are no longer viable and they close. Another scenario to consider is when facilities are wholly owned subsidiaries. As we have changes in the healthcare system, there could be more affiliations, acquisitions and restructuring of forms that could result in having fewer named facilities, but essentially the same capacity because of the purchase or business relationship. How do we want to express this in rule? When a facility closes, their capacity leaves the “pot.” Their patient days are part of the use rate, however.

Discussion shifted to letter of intent and facility closure timing.

**CLOSED FACILITIES 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 it, and all applicants have at least the 30-day letter of intent period to make the decision to apply. If closure happens any time after that, we will not modify methodology based on that closure until the next year. Applicant cannot apply until the next year.