



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 January 19, 2016. 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
Gina Drummond, Hospice of Spokane
Colleen Connors, Hospice of Spokane
Lisa Grundl, HFPD
Catherine Koziar, Providence
Nancy Field, Field Associates
Candace Chaney, Assured/LHC Group
Mark Rake-Marona, Franciscan
Leslie Emerick, WSHPCO

STAFF PRESENT: Kathy Hoffman, Policy Analyst
Beth Harlow, Analyst

9:10am – Open Meeting, welcome and introductions

Overview

Kathy Hoffman – goals for current workshop, review of prior December 17, 2015 workshop accomplishment and areas of consensus.

Group Discussion

- Brief discussion of Mark and Frank's ADC work so far.
- Brief discussion of whether group wished to discuss ADC any further at this point or move on to next topic in matrix (exceptions). Agreement to move forward in matrix.

1. Exceptions

Discussion included:

- Definition of “exception” and whether it belonged in a discussion of numeric need methodology.
- Discussion of whether there are other triggers of need that are not exceptions that are as legitimate as numeric need, such as choice.
- Exception appears twice on workgroup topic matrix, under “need methodology” and “other review criteria.”
- Group agreed to curtail discussion as to exceptions under numeric need methodology and discuss at a later date under policy goals or other review criteria.

- **CONSENSUS: Non-numeric need is important, but not in this context (discussion of numeric need). Group agreed to strike “exceptions” from “numeric need” column in matrix; retain in “other review criteria” column for further discussion.**

2. Hospice Specialties

Discussion included:

- Whether discussion of hospice specialties should be part of the exceptions discussion.
- Original intent of adding this topic to the matrix was to explore the notion of adding a separate need methodology for certain specialty hospice services (such as pediatric hospice).

- **CONSENSUS: Group agreed to strike hospice specialties from “numeric need” column in matrix to “other review criteria” column for further discussion.**

3. Source of Access/Utilization Standards:

Discussion included:

- Group addressed data and data source components related to these topics in previous workshop (October 2015). Source of access is a broader topic and should be discussed once concept of methodology is determined. Then, group can consider state and local standards.
- Brief discussion of mean/median length of stay; group revisited prior discussion and consensus related to this topic.
- Discussion of whether this topic is premature in the sense that it may be difficult to determine the source of access/utilization standards when group has not decided what data elements will be in methodology.

- Agreement that elements of methodology are interrelated, and may be hard to move forward without knowing what data elements are.
- Some participants asserted that current survey was unpredictable and unreliable. However, group is limited to data that is readily available, and survey falls into that category.

➤ **CONSENSUS: Table discussion of sources of access/utilization standards until group decides on data points used in methodology.**

4. Effectiveness of Current agencies

Discussion included:

- Whether measuring effectiveness can be built into the methodology or should be moved for later discussion under “other review criteria.”
- Topic produced many questions, including: Is here a numeric way to determining effectiveness? Will the CMS Hospice Quality Reporting measures address this and be available to incorporate into this rule revision effort?
- An attendee asserted that CoN provides protection to franchises that are not performing to certain levels. Discussion followed.
- Discussion of considering exceptions for effectiveness of current agencies, and purpose of need methodology – either restrictive of open. Effectiveness is subjective, may be hard to define in rule.

➤ **CONSENSUS: Effectiveness of current agencies may be a valid exception, but it does not fit under numeric need methodology column. Moved to “other review criteria” for further discussion.**

5. Urban vs. Rural:

Discussion included:

- Considering a two-tiered ADC. For example, under current methodology the statewide minimum threshold is 35. For rural counties, where it is harder to serve and remain viable, perhaps the threshold might fall to 20.
- Discussion of ADC purpose: protects viability of existing providers and establishes a threshold.
- Discussion of provision of care challenges in low census communities: potential sliding scale for applications in rural communities; hard to find staff to provide care in isolated areas.

➤ **CONSENSUS: Group will consider a two-tiered system, maybe a population based approach to differentiating the minimum thresholds for hospice agencies.**

6. Capacity/Volume Threshold

Discussion included:

- Discussion of whether group is prepared to discuss these topics yet when minimum volume threshold is still be being developed. Currently being used as a measure of capacity and feasibility while being driven by argument that below a certain ADC, viability is not possible.
- Existing capacity as part of the current calculation. An attendee asserted that the national average person per hospice is 340, and in Washington, the average is 750. Suggestion was to discuss an upper-bound on agency capacity in an effort to create opportunities for growth and develop more choice, particularly in areas with one hospice.
- Discussion of potential outcome, including detrimental effects of a single agency serving a large population as the only provider of hospice care. Even though there may be no numeric need, suggestion was to “carve up” existing agencies to create need. In general, group opposed this concept.
- Discussion of whether to establish standards to measure choice.

No consensus on this topic.

7. Definitions

- **CONSENSUS:** Group agreed to save this for later in the process. Moved to “other” on topic matrix.

8. General Discussion

Discussion included:

- Since group has addressed each topic in the first column of the matrix (either through discussion or movement to another column), group opted to begin discussion of the methodology.
- Two options considered: revising and updating current methodology or starting “from scratch.”
- Since a petition to revise existing methodology opened this rulemaking process, suggestion was to start there. Could be large or minor scale, significant or modest, but group should start with looking at “what we have.”
- Discussion included survey data (current) and CMS data (a few years old). Department was able to achieve 100% response on last hospice survey and correct any errors in reporting along with figures that are incorrect.
- An attendee did not want to depend on agency data; felt it was continually unreliable. Suggested the department rely on cost report data.

- Group discussed current survey tool and how to better it.
 - Agreement to table discussion for a later date.
- **Generally, group agreed to use survey data, and agreed that survey needs to be modified. One dissented and did not agree to use the survey, unless it's reconciled "real-time" with cost reports. Cites too many year of errors.**

9. Begin work on 246-310-290(7)(a)(i), (ii), (iii) – Need projections. .

Discussion included:

- Step 1: Removing cancer references; remove word "predicted" and use "average;" discussion of whether to use three years of admissions or deaths. Group agreed to use deaths.
 - Step 2: No change
 - Step 3: No change; leave as is since it's an estimate.
 - Step 4: Remove; not needed.
 - Step 5: Discussion of the two-parts of this step (projection horizon). Original purpose of step was to recognize some projected growth so "we weren't keeping everybody the same."
- **CONSENSUS: 3 years of data (lookback) – base year (same as application year) – then 3 years past it. Example: 2012, 2013, 2014 (data years); 2015 base year/application year; then 2016, 2017, 2018, with 2018 as the projection year.**
- Step 6: Discussion of whether to trend capacity. An attendee suggested projecting capacity reflects existing provider's interests only.

Conclusion:

- Kathy will research and present on other state's hospice surveys and exception language at next scheduled meeting.
- Kathy will prepare an issue sheet containing issue and consensus columns to guide upcoming meetings and serve as a reference of consensus points.