

Certificate of Need – Hospice Services

Notes for Stakeholder Meeting – January 19, 2016

WAC 246-310-290

Meeting commenced at 9:10AM.

Introductions, review of December 17, 2015 meeting summary, general housekeeping.

Group discussed whether to begin with a discussion of ADC and begin trying to define ADC, or move directly to exceptions. Mark indicated that he and Frank are working on ADC from a minimum threshold standpoint, and have not finished their work yet. Data is being compiled, and it is broader than just their two organizations. They are looking at Medicare cost report data. ADC isn't as simple as it was fifteen years ago.

Nancy, Mark: Brief discussion of Mark/Frank ADC work for hospice rulemaking so far. Nancy asked if there was a Medpac analysis of margin by size of organization. Mark indicated that the approach being taken is to break the revenue and expenses down into component parts that would include a margin assumption at some point, but before that, need to determine if there is a useable cost for drugs per day, for supplies per day, etc. In 2000, there was a range in cost of drugs per day, but it was a narrow range. Currently, some will say drugs are \$5 per day, others \$15 per day. As to staffing, in 2000 very few programs used LPNs, and now that is common. This drastically affects labor costs. So, going to some larger database to see what is "out there" and comparing it to experiences might be helpful. Do NHPCO norms per line item help? Mark indicates he hasn't seen this broken down by line item. Nancy has relied on NHPCO in the past. Mark and Frank took this under advisement.

Exceptions:

Nancy: Broad term. Aware of its use only in the context of concurrent review. Not sure what exception means.

Beth: My understanding is that it is any grounds for approval in absence of numeric need.

Mark: Confused about the difference between exceptions and hospice specialties. Historically, exceptions have come up for serving certain ethnic populations, and situations where there is no numeric need, although to me that is almost a different issue – whether or not there is choice – and I don't know that we've got that up anywhere to discuss. Exceptions are an instance where there is some identified unmet need that a provider brings forward to the state, and submits an application on that basis.

Nancy: Does not like the term "exception" but agrees with Mark's concept. Sees it as, yes, there is numeric need but there are other triggers of need that aren't exceptions and are just as legitimate as numeric need. Would not term these exceptions but as other criteria for need, some of which are numeric. For example, choice. In the prior workgroup had "pretty much gotten to consensus" on the concept that every county should at least have two hospices so that people have a choice for something like end of life. Would not call that an exception. Suggests that Bart preferred to call this an exception.

Lisa/Nancy: I think the reason to say that is because there is numeric need, not to say that it is less important, but these are the only times that we would ever approve an application if need wasn't

deemed present. If need has been met, then choice just becomes a part of the application. What if we call it non-numeric need? What needs to be clarified is whether choice is an issue even if need has not been deemed met.

Steve: Exceptions appears twice on the matrix, under need methodology and other review criteria. I think we're talking about a distinction there. Not sure if it was a mistake to put it under numeric need. But to talk about exceptions in the context of the numeric need methodology at this point is kind of a futile task because we don't know what our numeric need is yet, so we'd be talking in a vacuum. I suggest we take it out of numeric need and leave it in other review criteria. As to choice, it's a policy goal under policy goals, and to talk about it now will get us into a policy discussion when we're still in the nuts and bolts stage of the numeric need methodology. Propose to leave exceptions in "other review criteria," don't discuss choice today as an exception – discuss it later under policy goals or other review criteria in the future.

Lisa: The decision will need to be made as to whether there are exceptions to the need methodology, and I think that was why it was there.

Frank: The way the department has used exceptions has always been almost always in relation to need. And it's used very rarely. Typically what you'll see is that there is no need, but there may be a rationale for approving an application anyway. I agree with Steve that until we know what our need methodology is, it may be premature to talk about exceptions.

CONCENSUS: Non-numeric need is important, but not in this context (discussion of numeric need).

Group agreed to strike numeric need from "exceptions" column in matrix; retain in "other review criteria" column.

Moving down matrix, group has already reached consensus on planning area/service area.

Hospice Specialties:

Steve: Again, we're talking about the nuts and bolts of numeric need methodology. This to me almost goes under exceptions category and is best discussed under "other review criteria."

Lisa: The only thing I remember coming up about this is that someone thought we might need a separate need methodology for children's hospice, and even then, it could come after the general need methodology.

CONCENSUS: Group agreed to strike hospice specialties from "numeric need" column in matrix to "other review criteria" column.

Source of Access/Utilization Standards:

Nancy: It has been a continuing issue with data and its quality, the timing of it. I don't know if "sources" is what years, but I'm assuming sources is what entity.

General Discussion: We addressed data and data sources previously. We identified criteria that our data sources needed to meet, but we didn't identify the sources yet because we aren't sure what the methodology is yet. This was a broader concept that we were going to look at – state or national standards. Are utilization standards related to the ADC? Length of stay was considered a measure of access. Both would be related to ADC. The methodology proposed by the previous group focused on

state data, so there was a question about whether we wanted to stay with that. Brief discussion on median/mean length of stay; confirmed group consensus from last meeting re mean length of stay. Mean is a better descriptor. Group decided to review notes from prior meetings to confirm previous discussions and consensus. (Tape 1, 25:00) Recalled that based on some sensitivity tests performed at last meeting that it didn't matter if we used 59 or 71 that we would still have penetration and higher length of stay as targets, but we would use the mean length of stay as we are using it now (59). Rehash same discussion on this topic from last meeting; Nancy points to and discusses errors in current methodology. Moving forward, we want to make sure that data sources are clearly identified in methodology.

Nancy: Discharge before death. Don't want to undercount capacity and then wonder why they are spending so much money or vice versa. Maybe we need to add it to the list.

Frank: How are we undercounting?

Gina: If we're looking just within the state or compare ourselves nationally, the main thing is to be consistent.

Continued length of stay/ADC discussion, including calculations. LOS affects capacity.

Steve: We're getting ahead of ourselves. Look at the matrix. I look at this two ways. We have a current methodology where the factors are length of stay and ADC and that's basically it. That is today's methodology and we don't know if that's the methodology we'll ultimately have. How can you determine the source of access/utilization standard when we haven't determined what we're going to use? For example, using today's methodology, how do we get these numbers? We get them from surveys from hospice providers. We may or may not be using that same methodology once we get down to the methodology, so I don't want to start doing calculations presuming that we'll be using the existing methodology. Not trying to punt, but I don't think we can talk about sources of data until we know what data points we'll be using in the methodology. It's a theoretical discussion. All we're doing now is talking about what's wrong with the data now to apply this methodology. If we decide we're going to stick with this methodology, that's an appropriate discussion. But, I think right now it's not one we need to have.

Lisa: The hard part is that all of these seem connected. Hard to move forward if we don't know what the data elements are. Surveys are unpredictable. Don't know if data sources can be separated from methodology discussion.

Nancy: Opinion as to data source: if we use surveys, ask for cost report data. But don't give us a total. Current survey can't be used because it is not reliable enough.

Mark: Original consensus on the data issue was kind of a punt. We're going to be limited to what is readily available.

CONCENSUS: Table discussion of access/utilization standards until group decides on data points used in methodology.

Effectiveness of current agencies:

Group Discussion: Is this something we can put into a methodology or is this something we need to look at in other review criteria? Do you address that issue in numeric need or as a policy goal or in other review criteria? Is there a numeric way of determining effectiveness? CMS Hospice Quality Reporting is

in the works, collecting qualitative data from agencies. More measures of the effectiveness of agencies will be available. Would there be numeric need based on performance? Is there a way to put effectiveness into a numeric need methodology? Does not happen [measuring performance and effectiveness] in any of the other methodologies. Usually it is used to look at someone new coming into the market. To apply it to existing agencies, it could be rolled into exceptions. Are there ever going to be exceptions to numeric need? How do we put effectiveness of a provider into a generic need methodology? Department is doing this with kidney dialysis rules right now.

Nancy: If your franchise isn't performing at a certain level, you are protected, and that is what Certificate of Need is about. If you can't perform to some standard, then should your franchise be protected?

Discussion of exception for effectiveness of current agencies. We don't really know what this is. It isn't something that should be in the need methodology. Need methodologies are not a panacea. They are restrictive or open. Effectiveness is a very subjective word and might be hard to define.

CONCENSUS: Effectiveness of current agencies may be a valid exception, but it does not fit under numeric need methodology. Move to other review criteria.

We may be using the word "exception" here liberally, but we may be able to reclassify later. How do we back up exceptions with data?

Exception discussion. Steve: "Bear in mind: there is need criteria that includes a need methodology." Read the regulations as to how you determine need. The need methodology is only a starting point. Also considered are financial feasibility, and importantly, in conjunction with these issues are structure and process of care, quality of care including fragmentation of care. A lot of these are evaluated by the department. Cost containment is discussed in superior alternatives, so it's perfectly acceptable to discuss these issues. The charge of this group is to do that. There are a number of ways to do this. (Tape 1, 1:01:00)

Urban vs. Rural:

Frank: For example, under the current methodology it's a straight minimum threshold of 35 for an ADC, and you might say, in rural counties, where it's harder to serve the counties and be viable, that threshold might fall to 20.

Nancy: I know one thing that I think relates to this, is that the rule as it is stated now permits the application to cover more than one county. But the department has not permitted that. Because in the language of the rule it says you have to provide the numbers for your service area which was more than one county. So there is a mismatch between the rule and the way it's being implemented. By having said that planning area and service area are one and the same, can an applicant accumulate, say it's 35 or 20, by combing two service areas or planning areas in one application? I ran the method as if there were no hospices in the state. And there were counties that wouldn't have any hospices. You are forced to come into the county and say I'm going to take 35, and that is hurting the existing hospice by forcing you to go to 35, if you could take 15 and 20 from two small counties, number 1 you wouldn't be forced to be so competitive to the existing hospices, and number 2, you could cobble together the 35 or the 20 or whatever its going to be. Did we prohibit this solution in the conversation we had about service area vs. planning area?

Catherine: I think what we were thinking, and it's not urban vs. rural, but maybe its population based, so there is an opportunity for another hospice to serve in a smaller county that just by the numbers could just support one, but maybe that would allow two hospices. Look at population as a density measure.

We agreed to take service area out of the rule by consensus. See Page 6, October 29, 2015 meeting notes.

Lisa: In the need methodology, and if we keep a minimum threshold, could it be different for rural? If so, when you have two applications then you have to have two stand-alone financial [statements], and you have to show that they can stand-alone. Maybe a lower ADC would deal with the financial issue too. We haven't decided on the 35 but I think what Nancy is saying is that maybe there should be a different standard for rural because the issue is, can they be financially viable?

Steve: But keep in mind that the 35 serves two purposes: it protects existing providers, too. So it's not simply a matter of saying, "Can I get in"... it's meant to protect the viability of existing providers.

Lisa: True. So maybe the need methodology could be the same, but what you project could be different for a rural? If there is an existing agency in a community you wouldn't want to say you are only protecting them at 15, because that really hurts the rural community, but you could say if you are going to provide services to a rural community you could project a lower ADC if you could show financial viability.

Frank: In kidney dialysis they had rules like this, but there they do differentiate larger counties from smaller counties in terms of population, and for smaller counties, there are about 15 of them, they have a minimum threshold of performance that's about 2/3 of what the threshold is for larger counties, so it's doable. That may be a tool for us to get to greater access.

Steve: Is it an exception?

Frank: No, it's part of the need methodology.

Discussion of providing care to patients in counties with low census. How do we find nurses to provide the care?

Mark: If we do what we do for kidney dialysis, we still need to meet the same elements of the rule. Maybe we should consider a two-tier system. Model in kidney dialysis is population based, we're looking at deaths, so we'd have to work through that.

Gina: Sliding scale for applications for providers in rural counties?

Barb: Recent report from Cordt Kasner – supports lower use rates in lower [use rate] counties. Will check and see if can be shared with group.

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

Capacity/Volume Threshold

Mark: This is my understanding of our task: We are looking at viability, aside from ADC, from a minimum viability standard which is a whole different issue than the overall need methodology. It's more of a financial feasibility criteria than it is anything else.

Lisa: But it would be applied and used in the need methodology? Are we ready to look at volume thresholds? You are developing a minimum volume threshold.

Frank: That's how it's used right now. It's used as both a measure of capacity and feasibility but it's also really being driven by some argument that below some ADC, you can't be viable, clinically or financially, which you can be.

Mark: So there's a capacity/volume threshold, and we're looking at minimum volume.

Barb: Capacity has to include waitlists. Has heard about waitlists, no one can admit them.

Nancy: Suggestion - pulled some national numbers and it's clear that CoN states have done a really good job of protecting their existing agencies. Florida has an average person per hospice of almost 2700. National average is 340. Washington is 750. I think this is at the cost report level because these numbers are pretty big. Those familiar with the current methodology know that the existing capacity is a big piece of the calculation. We take the projected need three years out depending on who you talk to, and subtract existing capacity which is a three year average. And right now we're protecting agencies up at 1000. And given the consolidation, for example, in King County, we've lost two big hospices, and I think that may continue, I suggest that we talk about the idea of an upper-bound on an agency's capacity so that we can generate a little more choice in our communities. I don't think the agencies need to be protected at 1000, I think we need to leave room for more entrants to the market and I think CoN is overdoing it's job at protecting agencies at 1000 and I would say a good number would be the national average which is 350. It would create opportunities. (Tape 1, 1:23:00)

Barb: What about when agencies at 1000 are doing a fine job and there's no numeric need?

Nancy: There's no numeric need because you are protecting them at 1000. Does not mean there isn't need, it just means that they are being allowed to fill it all.

Frank: Unless you found some performance measures that showed suboptimal performance by larger versus smaller sized agencies, I would think it would be pretty much a random basis for simply carving agencies up. That wouldn't make a lot of sense.

Nancy: But what's the purpose of CoN? Is it to protect you no matter how big you get?

Catherine: Aren't there other agencies serving that population in cases where you've got someone that large? They're not the only agency there, are they?

Nancy: Well, in some cases yes, there are large geographic areas with only one really big hospice.

Catherine: There is a single county with a hospice of 1000 and that's the only hospice there?

Nancy: Well, no, there is a very large county with only one hospice, they are very large and there is no competition, a very small part of that county is covered by a public hospital district. But the rest of the county is served by one entity. And I don't think that really gives people a choice. I think we say what is the purpose of CoN? It's about quality and cost control. I don't think it's about keeping an exclusive provider in business in one county to the detriment of choice and a little competition never hurt anybody. So what is CoN for?

Steve: I think Department of Health is a central planning agency. They don't do economic planning.

Nancy: They are supposed to be doing it but they are not.

Lisa: I think to determine if there is a need. I don't think you are protecting existing provider as much as you are seeing if there is a need. If existing providers are meeting that need by however that is calculated, then there's not a need. Otherwise what are you doing? You are saying we are going to carve up a way to show need. To say that you are going to go from 1000 to 300 seems like an extreme because you are saying that there are 700 patients that aren't being served?

Nancy: Yes, there is need and it is being served by one entity and there is no choice in that county unless you are in that public hospital district.

Candace: As a consumer, I would want choice, at least one other hospice.

Discussion of providers deciding which areas to serve: Example provided of an Issaquah provider serving just the Issaquah area as opposed to serving Issaquah and the downtown Seattle area, as well. That provider should not be penalized by adding another agency in King County because they aren't serving the whole of King County or Issaquah. If this is a matter of providers not doing what they are supposed to, this is a different issue.

Nancy: So you are saying that one religious hospice in a county is enough? Limits its scope of services. What about choice? What if you are in a county of a million people and your choices are being reduced every year by fewer and fewer hospices, we know many of them serve parts of counties rather than the whole county, we know that, then what is the excuse for protecting hospices that are twice the national average in size?

Barb: There's nothing in the Certificate of Need website that discusses protecting existing programs. It says it is intended to help ensure that facilities and new services proposed by healthcare providers are needed for quality patient care within a particular region or community. So it's not about protecting an existing program but if the existing program is doing a fine job regardless of size, that's not really addressed. They went through the CoN process to get approved, they shouldn't be subject to being carved up.

Discussion side tracks to hospital districts, choice.

Nancy: Discusses a hospital district appellate court decision, asserting that it is the same issue as hospice. "I need someone to explain to me why a county of 700,000 should only be served by one hospice under CoN. It is being protected by the rule."

Steve: With all due respect, you've got a political viewpoint on something which I think was best addressed at the very outset. The purpose of CoN law is expressed very well in the first paragraph of the statute which I suggest you read. People apply for stuff, and if they are successful at operating a business, then they should be rewarded for that. If you have a political problem....

Nancy: Well why do we review beds then? How can a hospital just keep adding beds? It can just keep adding capacity because it's doing well, why are we reviewing beds?

Lisa: Building beds is different...

Nancy: You've got a good hospital, it's the only one in the county, why can't it just get as big as it wants to?

Steve: I think maybe you have a political view....

Nancy: I do have a political view.

Steve: Maybe you want to get rid of certificate of need law or maybe you want to have certificate of need law...

Nancy: I do have a question about its value for hospice

Kathy: We can have that conversation at another time, right now we're in the rulemaking process...

Nancy: Yeah, right. Can someone explain why it's so vague?

Group: No, we're going to move forward.

Lisa: This is a committee to develop the methodology for certificate of need. We're not here to decide whether we need certificate of need or not for hospice.

Nancy: I'm not talking about whether it should exist; I'm saying if we're going to have CoN that's rational, on behalf of the public we're giving out franchises, what interest of the public is served by a large number of people only having one hospice in a major urban area? What is served by that?

Frank: There needs to be some criteria to evaluate that. You can't just say choice matters without having some standard to measure choice.

Nancy: Well why not?

Steve: Describes regulation adoption process. No one has to give an explanation of why somebody is big and why somebody is small, it's just the way the CoN system works. It doesn't set out to protect anybody...

Nancy: It's not a matter of viability obviously because the national average is 340. Make it 750 which is the state average. I know you all are paid to represent your organizations and the one reason I'm coming without a client is because I want to represent other than those organizations because I've lived with the way the rule has prevented competition and prevented new entrance for twelve years, and I think the simplest approach is to arrive at a reasonable size that's a big agency. On your drive home think about the other side of this.

Definitions:

Consensus: Group agreed to save this for later in the process. Move to "other" on matrix.

General Discussion after Completing First Column of Topic Matrix:

Mark: We've talked about two ways to approach this. Revising and updating what we have or a blank slate. Deciding between those two is the work we need to get to at some point. Are we really just going to revise what we've got or are we going to open ourselves to proposals for new methodology? What opened this was a petition to revise existing methodology, differentiated by forecasting versus lookback and what the threshold was. So I suggest we use that as a starting point.

Nancy: We talked about a blend with the hospital method because we saw a better way of doing the population.

Frank: I think Mark is right. Do we want to modify what we have, either large scale or minor scale, or do we want to throw it out and start with something completely different. And it seems like the Hospice Association's methodology was completely different, but it seemed to me also, when we talked about it, there were enough what I perceive to be flaws in it that we didn't elect to go down that road. So, I think we're left with really two choices: modify what we have, significantly or modestly depending on people's preferences, or come up with something completely different. I would recommend that we take a hard look at what we have because it's easier to modify what you have in large part or minor part rather than to come up with something completely new where you don't where the twists and turns are.

Group discussion of how to go forward with Frank's suggestion, including additional projection horizon discussion. Group wasn't sure what we decided as to projection horizon. Determined there was limited discussion in prior workgroup. Discussed data sources. Survey data is current; CMS is a couple of years old.

Beth: Able to get 100% on survey data. It took five weeks, but got all of it.

Nancy: 2 out of 2 counties had major errors in what was reported in the survey. Does that suggest all the others were correct? Both of those errors were discovered after the method was posted. We were told we could not apply using the accurate numbers because they had already been published. A system like that is subject to a lot of problems and we should not perpetuate it.

Beth: If we post the methodology before the LOI, we absolutely correct it. Referred to consensus from prior meeting where this was discussed and decided.

Nancy: Wants to use CMS data. Does not want to use agency data.

Frank: The major flaw with CMS is that its' old. I wouldn't throw out the survey. It's flawed because there is no accountability. We're doing this with ASF. There is no better place to pick up what we need. In hospice we have the Medicare cost reports, but they are very old.

Discussion of cost report data. Suggestion to send cost reports to agency to confirm data. Acknowledgement of possible human error in survey. Won't that always be a problem? What about trending? The difficulty with trending is that with hospitals you can have ten years of data and form trend lines that are reasonably more predictable. Unless we get that much claims information from CMS for the hospices, one or two years really isn't going to be very useful for trending forward. Or department could go in and reconcile cost reports. Cost reports are broken down by county, kind of like a consistent survey, then reconcile backwards for discrepancy between what was reported and what was actually claimed. Should we rely on anecdotal experiences to throw out the whole survey process?

Nancy: There has never been a year when the data has been correct, ever. There are five or six ways of checking and finding the errors. That's been going on for twelve years.

Catherine: Could the difference between the survey data and the CMS data be that the CMS data does not have non-Medicare patients?

Mark: If the lag time for claims data is too long, then we have to use the survey data. Once we take the cancer/non-cancer out it will be easier.

Beth: Moving forward, we do make the effort to check figures that don't look right.

Frank: I like the survey. But we need to discuss the survey tool and how to fix it.

Additional discussion: deadlines, ways to administer the survey, impacts to concurrent review cycle. Look at data elements and make sure that our survey will comport with that. Nancy suggests that agencies be required to attach cost report to survey and an attestation to survey. What purpose will an attestation serve? We agree that there should be a concerted effort to increase accuracy on survey reporting. Maybe training for providers? Mark fills out survey – instructions are okay, but not sure what duplicate and unduplicated is. Are there legal issues with attaching the cost report to the survey that will become part of a public record? Additional discussion of survey particulars – define survey items along with method. Want to do a generally better job on survey. Can we look at what other states do for surveys?

Generally, group agrees to use survey data, and agrees that survey needs to be modified. Nancy dissented and does not agree to use the survey, unless it's reconciled real-time with cost reports. Cites too many years of too many errors.

****LUNCH BREAK****

Copies of a table of hospice methodologies for other states Kathy prepared previously was shared with group. Kathy also offered to research and present on other states' use of surveys, and present on findings at a later workshop. Group agreed.

Kathy: Since we didn't reach consensus on use of the survey, I think we'll table that for this meeting. We can move forward with parsing out the existing methodology as Mark suggested at the conclusion of the morning session. We'll start at WAC 246-310-290(7) if we all agree.

Group begins work at 246-310-290(7)(a)(i), (ii), (iii). Step 1. Propose to remove references to cancer since we're removed cancer from the methodology. Also, inconsistency as to "past three years" and other uses current deaths.

Nancy: Are we talking about trending? Is our goal to trend? If we are going to trend where are we going to do it?

Mark: I think right now we're only in the part of the process where the calculation is just looking at just the hospice part of it. Later on we can figure out how we're going to trend it forward.

Discussion of the word "predicted" in current rule. It isn't really predicted, it's an average. Group agrees to take predicted out of sentence, and leave in percentage. Right now, the section refers to admissions. Should decide if admissions are duplicated or unduplicated. How material is that? Should be unduplicated – average number of unduplicated admissions. Main thing is to be consistent whatever is decided.

What's the difference in look back years? More observations are always preferred to fewer unless there is profound change. Nancy asserts that there is profound change based on baby boom hitting 65 and there is a huge number changing. Barb shares from verified data that utilization in Washington between 2013 – 2014 went up .2%, from 43.2% to 43.4% (this is deaths, Medicare only).

Group agrees to use three years of admissions. If we use admission, that is the most reflective of true hospice use rates. Deaths may impact length of stay, but admissions means that people in that county had access to hospice. Current deaths = average 3 years. If we use admission, we're depending on

survey data. Nancy wants to use federal data, but others want to rely on survey. Group asks why? If we use hospice admissions, and you are looking at three years period, there are going to be some people in year one who are still alive, those are the outliers. Right now, percentage is calculated by dividing the average of the hospice admissions over the last three years, for age 65 and over, by the number of past three year statewide total deaths 65 and over. For that first piece of data it has to be deaths, not admissions. You have to use admissions both places, or deaths both places. Use survey data for admission and OFM data for deaths, it will show a higher use rate. If you use only deaths then you are undercounting the live discharges. Discussion of what Alabama does – divides hospice deaths by county, by hospice deaths in the state. Is that where we want to get to? Alabama calls this the penetration rate. Mark provides a visual of the calculation on the white board available:

$$\frac{\text{Hospice deaths (source: survey)}}{\text{Total deaths (source: vital statistics)}} = \text{Use/penetration}$$

Step 2: Okay as is. These are pure numbers, pure data. Easy to follow.

Step 3: Also okay. Here we are applying use rates from Step 1. What you are doing is multiplying the average number of deaths by the use rate of the people that used hospice in Step 1. The use rate is Step 1 isn't county specific, so that is something we might want to consider. Do we want a state average or do we want to be county specific?

Discussion of penetration rates, use rates, out-migrating. National standards vs. state standard discussion. There is a .2% difference. A variation we talked about years ago is whether there is a best practice cohort within the state. WA was ahead at that time. Middle of the pack for us now might not be a bad thing. We are comparing ourselves to a lot of hospices that might not be doing very well. We can pick the states we want to model ourselves after. Need to be careful about who we model ourselves after. Assertion to use our own numbers; if we're getting a result that we don't need hospice, we can revise on the back end. We are just describing the market with this section. It's just a penetration rate we're looking at.

Gina: I think we're talking about taking what we have and tweaking it. If we have a 44.3% penetration rate in WA and we have the ability to look at every individual county and determine their penetration rate, wouldn't it be easier to just say we agree on a percentage, a number. If you are below by 5%, you're in the yellow zone. Or if you are below by 7% or 10%, that's not good.

Frank: If you load too much in the front end, it gets far away from simple, but you can take care of it in the back end. Let's get through the math first.

Group agreement as to Step 3: Leave as is. It's an estimate. Number of projected should be a 2014 estimate. Use estimated instead of projected.

Nancy: Wants to put survey results in the front of this section because the results are never the same, and the state's calculations are the only ones that matter. Wants to add to rule that survey data is "in there." Wants a "live" worksheet referenced in rule where it's a required part of the methodology. (Tape 2, 50: 00)

Group agreement as to Step 4: Superfluous; not needed.

Step 5: Discussion of OFM data, and the two pieces of this step. There are fractional increases in the population, and different experiences as far as death rates. The original purpose of this step was to recognize some projected growth so we weren't keeping everybody the same. If there was one county that was really hitting the state target then we would give them at least a little bit of room. There was no point in being over or under because we put them back together again. (Tape 2, 00:53)

(Multiple side conversations)

Need to find out what data is available from OFM and then run the method both ways. (Tape 2, 01:00)
Group reviews OFM website to confirm available data, but decided to come back to this at a later time. At this time, default will be population. Step 5 will be new Step 4, may add additional language.

Discussion of forecast period: lookback, base year and projection. If you look across the array of data elements, the variables don't change very much. There are exceptions, but by and large, picking three years or five years is not going to have any effect. That's the only value of picking a five year projection period post base year as opposed to three, to be able to show the applicant's ability to show financial viability.

There are two subsections to this part of the rule – one is determining need and one is to independently capture need. Why do we have these two subsections if there wasn't an intention for them? Hospice has two years to become operational. They won't all start exactly five years from now, and also, this took into account the concurrent review cycle and at the time, we thought this was going to speed things up. Three years is a common projection horizon.

Frank: The difficulty with keeping these two completely separate - the applicant submits an application then we've got two completely separate methodologies and unless one is tied to the other, then the department has no basis to evaluate the second methodology that has now become untied from the need methodology.

Gina: Okay with confusing them, but does not think it is fair to apply OFM inflation data five years going forward unless we're going to say that's the projection horizon, because we either project out three and call that our projection horizon, or we project out five.

Lisa: The department will say, "You have to show us that within three years you'll be financially feasible" and that might be three years from an application, or four or five depending on when you start because you have two years before you have to start seeing patients. So, it's not going to match up exactly. So you determine need, and the department will say, "Applicant, by the third year of operation you have to show ADC" so I think it's not an even match.

Nancy does not think that it's reasonable to have two separate projection methods.

Lisa: There aren't two separate methods.

Frank: The question is, does the applicant piggy back on the need methodology or do they prepare their own separate methodology for their three years of financial viability demonstration.

(Several side conversations).

Gina: If we're going to call it a three year projection horizon, then there's three years to apply inflation data. We apply OFM data to those three years. That does not mean that the applicant doesn't have a

grace period of three years, it's just that we're only going to apply OFM data to three years going forward.

Frank: Is your reticence to go beyond the three year forecast period due to what? The uncertainty of the population forecast?

Gina: I look at hospice being different from a hospital.

Frank: So you are more comfortable with three years from the base year?

Gina: The savvy applicant looks out far enough and says I can't start until here, because they need that much time to establish need and they back into it. And it could come down to two applications coming in at the same time, one being the savvy applicant saying I can't get my business going until 2018, and the other one saying, we're going to get it going in 2016. The one who says they can't get it going until 2018 gets a CoN.

Lisa: The operational stuff is so different from establishing need.

Gina: The rule has to be black and white.

CONCENSUS: 3 years of data (lookback) – base year (same as application year) – then 3 years past it. Example: 2012, 2013, 2014 (data years/lookback); 2015 base year/application year; then 2016, 2017, 2018, with 2018 as the projection year.

Step 6: Should we trend capacity? Do we want existing providers to continue to grow as the population warrants or do we want to stop providers from being able to grow and bring new people in? Should new providers come in as population or practice patterns or Medicare rules allow, or if existing providers aren't doing well, or ? There is a very different look depending on the policy you have on that. Nancy wants to know where there is another CoN rule that allows for trending of capacity. Steve asserts that hospice and home health are unique in this regard. Most CoN reviews are related to facility measures, like beds or operating rooms, or dialysis machines. This step may need to be moved if we trend age cohorts, and may consist of two parts.

Nancy: "I don't have the words." Believes that projecting capacity is reflecting existing provider's interests only. Others believe it reflects actual practice. Nancy contends that WA agency size is twice the national average, and to her, 750 seems big enough. If 750 is the average agency size, "there ought to be some room for some new entrance."

Mark: Seems big enough to whom?

Nancy: Big enough to assure quality and cost efficiency.

Barb: How do you know that there isn't quality and cost efficiency in those agencies? I would beg to argue that. That's your personal opinion.

Nancy: Yeah it is and I'm the only non-provider here.

Barb: I'm not a provider.

Catherine: I don't know of any business that would want to plan flat every year.

Nancy: Well, that's okay. You can plan for growth but the state isn't obligated to grant you growth.

Catherine: But how do we plan for growth if there's a cap there?

Nancy: Are you kidding me? You are going to use CoN to protect your future growth?

Catherine: But you are talking about a cap.

Nancy: I didn't say anything about a cap. I just think, you guys, this is the height of the industry protecting itself, you know, that's what we've got going on here. But you really have to realize that it's beyond reasonable public policy.

Group discusses testing trending.

Lisa: There is a CoN program to determine need. And if you have existing providers that until 2018 continue to meet that need, I mean this is a policy and it isn't laughable issue, it's a real policy...

Nancy: I think it's laughable. I've been doing this for forty years.

Lisa: We represent people going into the market, too. Its business planning and you have to look at who is going into the market, are they really good, high quality providers? There's lots to look at rather than just....

Nancy: I think if they have 750 patients which is the average size in WA and they can keep doing a good job they shouldn't be afraid of a little competition.

Gina: How will we use the next 17 minutes?

Group discusses upcoming meetings. At next workshop, we will pick up where we dropped off at this meeting.

Kathy will research and present surveys from other states at next meeting; Frank and Mark will be ready to present in March.

Last thoughts?

Lisa: Looking through notes – can we link discussions and consensus to discussion?

Steve: Quick recap of prior meeting was offered at the beginning, also look at Kathy's summaries. Read the notes before you arrive.

Kathy: I'll do an issue sheet with a consensus row and issue row and circulate to group.

****END****