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 March 17, 2016. The meeting was held at the Department of Health, 111 Israel Road SE, in Town Center 2, Conference Room 145, Tumwater, WA 98501.

PRESENT:
Steven Pentz, Providence
Frank Fox, Providence
Barb Hansen, WSHPCO
Leslie Emerick, WSHPCO
Gina Drummond, Hospice of Spokane
Peter Norman, Bellevue Healthcare
Jody Carona, HFPD
Nancy Field, Field Associates
Candace Chaney, Assured/LHC Group

STAFF PRESENT:
Jan Sigman, Program Manager
Kathy Hoffman, Policy Analyst
Beth Harlow, Analyst

9:00am – Open Meeting, welcome and introductions

Overview

Kathy Hoffman – goals for current workshop, review of January 19, 2016 workshop accomplishment and areas of consensus. Group also reviewed Hospice Work Group Issue/Topic and Consensus Tracking document. There were no comments.

Presentation

Kathy Hoffman presented on select state survey instruments and exception language. The purpose of the presentation was to review and explore the way

other states survey hospice service providers and examine if/how other states address exceptions. The department does not endorse any of the survey processes or instruments presented, nor does it endorse any other state's exception language.

Group Discussion - Presentation

- Brief discussion various purposes for surveys. Some surveys gather information for purposes in addition to hospice, such as licensing.
- Brief discussion of data collection, timing of data collection, lag in data reporting for CMS and Medicare Compare.
- Questions were raised regarding whether the extensive nature of some state's surveys is based on the survey being used for rate setting in addition to utilization.

Group Discussion – Pediatric Hospice

- Group explored and discussed the status of pediatric hospice care in Washington. Currently, specific provision of pediatric hospice care in not a requirement in CoN rule.
- Discussion regarding statewide hospice pediatric population, and options for hospice agencies to contract on an as-needed basis for additional resources, such as pediatric hospice.
- Program recalls one CoN limited to pediatric hospice that later was amended to expand scope of services because limiting service to pediatric hospice population did not support hospice.
- General group agreement that pediatric hospice is a good example of an exception.

Group Discussion – Multiple Topics

- Discussion of volunteer hospice vs. Medicare/Medicaid certified hospice, hospice licensing rules and requirements, definition of hospice.
- Discussion of volunteer hospice in Washington – definition of volunteer hospice, licensing requirements, relationship to certificate of need.
- Discussion of distinguishing hospice licensing issues vs. hospice certificate of need issues.

Group Discussion – Exceptions

- Currently, "exception" is not defined in certificate of need hospice rules.
- Exception is described in other certificate of need rules, generally, as a set of circumstances that would override need methodology or there is something unique about the project that the department would approve, even though, under normal circumstances, applications either would not be accepted or approved.

- Program indicated that generally, there have not been many exceptions in hospice.
- Group discussed instances that could potentially trigger an exception. Examples: areas where numeric methodology indicates no need, but residents are not able to fully access Medicare or Medicaid hospice services; counties that are so large that it is unreasonable to expect one agency to serve entire county.
- Discussion of ways the program would measure the above hypotheticals to determine whether or not to grant an exception, absent a demonstration of numeric need.
- Group explored broad and narrow approaches to exceptions. Some indicated that exceptions should be “a high bar,” others asserted that there should be a balance between numeric need and other types of unmet need.
- Group further explored pediatric hospice service provision as an exception vs. as a requirement for CoN approval. CoN annual hospice survey will indicate how much pediatric hospice is actually occurring since this activity will be reported annually.
- Discussion of whether it is possible to require all hospice service providers to now serve pediatric hospice population, even if services must be contracted out. Who would enforce this, how would it be enforced, what would be the penalty, and where is the authority in law to do this? Better to seek this type of change through legislation or amendment to current hospice licensing rules. Program describes more active, integrative role in contacting providers that may not be engaging in activities described in CoN application.
- Since current methodology includes populations from zero on, can it be assumed full breadth of individuals is served, not just those 18 and over? Current rule contains underserved language, but how should this be measured? General preference that entities hold themselves out as capable; in structure and process, will expect some policies and procedures to address pediatrics. When data is collected, population can be identified as survey tool is developed.
- Two distinct arguments emerge: should there be an exception for an entity desiring to add pediatric hospice, and requiring all applicants to represent that they will provide pediatric hospice.
- Proposal to address exception concept by capping existing provider growth if not meeting particular criteria. Group discusses how to enforce this idea. Cap is not how many patients a hospice can serve; cap is how many the department will count for planning and projection purposes. If an agency is serving above a max capacity, the department will count the max and the additional volume will allow for some market competition – department will not restrain existing provider from serving the additional volume.
- Discussion of exception language used by Florida, *as an example,* that identifies “special populations.” Here, that might include pediatrics. Burden

would be on the applicant to prove who isn't being served based on data. Existing agencies would have the opportunity to respond based on the same data. Assertion that this approach addresses shifts in landscape of future population; counter assertion that pediatric population will remain and reliance on language similar to Florida's would result in increased litigation.

- ***CONSENSUS:*** Serving pediatric patients is an area of concern. Children may not be getting the hospice coverage they deserve. Whether that is accomplished with an exception or other criteria, or superiority, it should be included in decision matrix at some point. Children should be included in exception language.

  - Group vote:

    Proposal 1: "put exceptions inside the methodology." Exceptions should be trumped in need methodology by capping the volume of providers who are not performing to certain standards (**1 vote**)

    Proposal 2: leave numeric need alone and allow for justification of agencies absent numeric need (**5 votes**)

    (**Abstaining: 1 group participant; 3 department representatives)**

Group Vote Outcome: Majority of group thinks that something that allows for a capability for exceptions is appropriate, similar to the generic language of Florida with a more generic exception (conceptually). No definitive definition of exceptions at this time.

Discussion – Definitions (Current WAC 246-310-290(1))

*(The group discussion and outcomes are presented in table form to reduce confusion as to current language, **proposed** language, associated discussion, and consensus points).*

Current Language	Discussion	***Proposed*** Language	Consensus Points (if applicable)
WAC 246-310-290(1)(a): "ADC" means average daily census and is calculated by: (i) Multiplying projected annual agency admissions by the most recent average length of stay in Washington (based on Centers for Medicare and Medicaid Services (CMS) data) to derive the total annual days of care; and (ii) Dividing this total by three hundred sixty-five (days per year) to determine the ADC.	Discussion of previous meetings and consensus on this topic. Furthered discussion re CMS average length of stay table; discussed duplicated and unduplicated patients; will identify appropriate CMS report that includes all patients in the calendar year.	*WAC 246-310-390(1)(a) "ADC" means average daily census as calculated by: (i) Multiplying projected annual agency admissions by the most recent average length of stay in Washington, based on the most recent edition of the Centers for Medicare and Medicaid Services (CMS) Medicare & Medicaid Statistical Supplement, Chapter 8: Medicare Hospices, to derive the total annual days of care; and*	N/A

		(ii) Dividing this total by three hundred sixty-five (days per year) to determine the ADC.	
WAC 246-310-290(1)(b) "Current supply of hospice providers" means: (i) Services of all providers that are licensed and medicare certified as a provider of hospice services or that have a valid (unexpired) certificate of need but have not yet obtained a license;	Discussion of what is currently counted - licensed only, Medicare certified and HMOs. Current supply is how to define hospice providers per county that will be used in the methodology to determine if there is need for another hospice agency. It is a supply and demand model. Assertion that supply and capacity are,"…confusing to the new reader."	*WAC 246-310-290(1)(b) "Current supply means:* *(i) Services of all providers that are medicare certified as a provider of hospice services or that have a valid, unexpired certificate of need <u>but are not yet medicare certified."</u>*	***CONCENSUS*:** The current supply is limited to Medicare certified agencies as a provider of hospice or that have a valid CoN. The entity has been issued a CoN, but has not yet executed it. Last sentence should read, "…but have not yet received Medicare certification." ***CONSENSUS***: Agreement that "licensed" will be eliminated from WAC 246-310-290(1)(b)(i). Will now say "Services of all providers that are Medicare certified as a provider of hospice services of that have a valid, unexpired certificate of need, but are not yet Medicare certified."
WAC 246-310-290(1)(b)(ii) Hospice services provided directly by health maintenance organizations who are exempt from the certificate of need program. Health maintenance organization services provided by an existing provider will be counted under (b)(i) of this subsection.	N/A	N/A	***CONSENSUS***: Agreement that current WAC 246-310-290(1)(b)(ii) is fine in current form.
WAC 246-310-290(1)(c): "Current hospice capacity" means: (i) For hospice agencies that have operated (or been approved to operate) in the planning area for three years or more, the average number of admissions for the last three years of operation; and (ii) For hospice agencies that have operated (or been approved to operate) in the planning area for less than three years, an ADC of thirty-five and the most recent Washington average length of stay data will be used to calculate assumed annual admissions for the agency as a whole for the first three years.	*See below*	*See below*	*See below*
WAC 246-310-290(1)(d): "Hospice agency" or "in-home services agency licensed to provide hospice services" means a person administering or providing hospice services directly or through a contract arrangement to individuals in places of temporary or permanent residence under the direction of an interdisciplinary team composed of at least a	Program describes interchangeability of terms contained in subsection (1)(d). The reason that both were in the definition is because many just call it a hospice agency; they aren't familiar with the distinction or the technical nuance that it's an in-home services licensed facility with the hospice piece.	*WAC 246-310-290(1)(d): "Hospice agency" or in-home services agency licensed <u>under RCW 70.127</u> to provide hospice services" means <u>an agency that is or is to be medicare or medicaid certificated as a provider of hospice services</u> for the purposes of certificate of need or is or has declared an intent to become medicaid eligible or certified as a provider*	***CONSENSUS****:* Final version of WAC 246-310-290(d): a hospice agency is an agency that is or is to be Medicare or Medicaid certified as a provider of hospice services. Strike everything up to "and" (for the purposes of CoN)

nurse, social worker, physician, spiritual counselor, and a volunteer and, for the purposes of certificate of need, is or has declared an intent to become medicaid eligible or certified as a provider of services in the medicare program.	Workgroup member request to add RCW 70.127 after "licensed under" for clarity.	*of services in the medicare program.*	
WAC 246-310-290(1)(e): "Hospice Services" means symptom and pain management provided to a terminally ill individual, and emotional, spiritual and bereavement support for the individual and family in a place of temporary or permanent residence and may include the provision of home health and home care services for the terminally ill individual.	Discussion: add interdisciplinary team, and volunteer. Take from (d), starting with "under the direction" and end with "volunteer" and move that behind "residence" in (e). Strike everything from "and may include…" on from (e). As opposed to expanding definitions, let's make sure that we clarify.	*WAC 246-310-290(1)(e) "Hospice Services" means symptom and pain management provided to a terminally ill individual, and emotional, spiritual and bereavement support to the individual and family in a place of temporary or permanent residence <u>under the direction of an interdisciplinary team composed of at least a nurse, social worker, physician, spiritual counselor, and a volunteer.</u>*	N/A

- Service area and planning area (WAC 246-310-290(1)(f) and (g) respectively, have been addressed in prior workgroup meetings.
- Group discussed whether additional definitions were needed. Definitions proposed were:

    - Medicare Certified (use CMS definition)
    - Projection Horizon (previously defined on 1/19/16)
    - Base year

<u>Discussion – Definition of "Capacity" (Currently defined in WAC 246-310-290(1)(c)</u>

- Group considered how the proposed ESRD rules address capacity. Program describes each, along with various approaches, and the strengths and weaknesses of each.
- An observed weakness of current capacity calculation is averaging three years of data. Question as to why we would continue to use that average minimum, or if growth is anticipated, whether trending should be considered.
- Group revisited prior discussion of surveys, lag time with Medicare data, reasons to rely on surveys, and whether an attestation should be added to current survey. Also discussed were the usefulness of surveys. Looking across all states that have certificate of need or similar programs, all use survey instruments.
- Discussion of department's role and consultant's role in survey process. Department may create a compilation of reports; consultant can create own database to compare variances across years.
- Member produces one page (a map) from an Abt Associates report regarding visits in the last two days of life; asserts not understanding CoN "policy rationale" for protecting existing volumes at current levels. Asserts the result of current methodology has been a tremendous barrier to entry "that we're all familiar with."

Asserts that Washington has the second largest agencies in the country and "they don't need to be this big."

- Request to member to provide entire report.
- Discussion of hospice vs. home health visit numbers. Program explains. Member wants to know what the policy basis is for protecting growing capacity. Group does not know if access problem has anything to do with size of the agency.

- Group vote:

  Do we want capacity to measure what providers are actually doing? Do we want capacity to reflect the actual utilization of providers?

  - **5 yes**
  - **1 no**

  (Abstaining: 1 group participant, 3 department representatives)

***Group Vote Outcome*:** Majority of group prefers capacity to measure what providers are actually doing and to reflect the actual utilization of providers.

<u>Conclusion</u>

Nancy will provide entire Abt Associates report to Kathy.

Kathy will report to group on pediatric hospice in Washington state (and nationally).