

Certificate of Need – Hospice Services
Notes for Stakeholder Meeting – March 17, 2016
WAC 246-310-290

Meeting commenced at 9:00AM.

Introductions, review of January 19, 2016 meeting summary, general housekeeping.

Kathy Hoffman presented on select state survey instruments and exception language.

Kathy: The department does not endorse any of the survey processes or instruments presented; rather, this information is review only and to allow workgroup members to consider the approaches of other states with respect to hospice surveys.

Group discussion during and after presentation included:

Nancy: Some states may be gathering information by way of survey for other purposes (licensing). Medicare Compare and CMS data is being collected, not published yet. Maybe 2017. Depend on this data instead of surveying entities twice. Keep in mind that the timing of this activity is a year early in terms of qualitative data we might have access to.

Jan: There's a lag in data; one to two years in Compare. Most Medicare data is delayed at least a year until it is released.

Jan, Leslie, Barb, Kathy, Nancy: Discussion of current DOH CoN website, DOH website in general, user applicability and ease, access to data. Program is limited to what can be posted on web based on bandwidth, formatting, resources, and staffing.

General questions were raised regarding whether the extensive nature of some state surveys was based on the survey being used for rate setting in addition to utilization.

Leslie/Barb: Pediatric hospice discussion – do other states have any provisions for pediatric hospice care? There aren't a lot of agencies set up for pediatric hospice care, especially for babies because specialized equipment and medication is required. What happens in Washington state when an agency has a Certificate of Need but they aren't taking care of children? Do they meet the CoN requirement? Nancy, you've raised the question whether hospice in Washington is supporting death with dignity, so we wonder if pediatric hospice is available in every county in WA? If they have a CoN, and they aren't providing pediatric hospice, are they in violation of their CoN?

Nancy: Looked at this for an application in a rural area where obviously there weren't enough kids. Looked at, other than infants, what are the ages of kids dying, and there are very few between [age] one and teenagers. We had zero, and this was for Clallam County. So I drilled down into the rules, and for this applicant, I said, "What ages are you going to serve?" and I usually just say we're not going to serve kids, but I thought, well, there's nobody serving kids because for the Seattle applications you've got Children's so I read down into the rules, and what it allows, and I kind of put this in, was that a hospice

that normally doesn't staff to kids can contract with a pediatric group or people that have nurses or other staff, on a one time or sort of as needed basis to augment their usual staffing, because it's so unusual in a small county. Now, for Spokane or the bigger cities, I'm not sure what is appropriate, but I thought that was pretty appropriate for a county of that size.

Leslie: Was that in WAC?

Nancy: I think it's in Medicare.

Barb/Leslie: We knew Medicare had those rules, but we wondered if the Washington CoN rules addressed it, if it was on a state level. When you say they can contract, for instance, when the medically intensive children's program that takes care of kids who are on vents and traches and things like that, it's a skilled nursing program in the state, would that be the type of agency a hospice could contract with? Or what type of group?

Nancy: It wasn't specific at all, it was more that within the usual staffing of the agency, they could go outside for specialty services. And it probably would be on more than just pediatrics, it might be some other special circumstances, but they can go outside and contract on an as-needed basis for additional resources. So, I felt comfortable, given that the numbers were one every two or three years, saying we could serve kids.

Leslie: And, I'm not going to say who we were just talking with, but their particular facility has 180 active patients – kids – and there have been 9 deaths this year, and none of them ended up in hospice because they're not doing hospice for kids.

Nancy: Well, I think there are a lot of folks around the state serving terminally ill people that are not hospices, at home and in other facilities.

Gina: Is this something we want to continue to talk about in terms of our exceptions language? If you are the sole provider in a county, and you aren't providing pediatric care, then perhaps another entity can get in because there's need.

Group (generally): Yes, that's a good example of an exception.

Gina: Last time we made a list of the things we wanted to come back to in terms of exceptions, and this was one of them.

Jan: I think that in my time with the CoN program, I think we've done one CoN for a pediatric-type hospice, and it might even have been home health. As much as they thought they were going to be able to get that business, there wasn't enough to help them maintain that business on just the pediatrics because their CoN was limited to just pediatrics. They applied only to pediatrics so their services were limited to pediatrics. They ultimately came back in and asked to have the condition removed, and applied to expand it to general [hospice] services as well. I'll be real honest, the issue of serving pediatrics hasn't really come up until recently.

Leslie: Well, there are a bunch of things going on. We're working with the Health Care Authority about pediatric concurrent care, which is the mandate under the Affordable Care Act. We've got some problems over at the Health Care Authority because they say these kids have to be returned to a disease-free state, which doesn't exist for these kids, so they've had a manager over there denying pediatric concurrent care to lots of kids in our state, and we've thrown the appropriate fit about that by

getting that fixed, and they are probably going to have to change their rules because they put that in their rules, and it does not matter what's under the ACA. So, you are going to see more kids that are going to be able to transition and you've got a lot of groups that are taking care of these kids – there's medically intensive, there's children's pediatric care groups, there's Stepping Stones, Carousel, Sunshine, I mean there's a bunch of these groups in the state, but are they really geared up to take care of kids? Do they have the appropriate equipment? There does not seem to be any rules or regulations in Washington state about them taking care of the kids. You go over to the medically intensive care program for children, and there's all sorts of rules and regulations about how they are taking care of kids.

Jan: And none of those required a CoN.

Leslie: So, the medically intensive do not require a CoN.

Jan: Right.

Leslie: But, if a pediatric group, and there's one trying to do it right now, and they are calling themselves a pediatric hospice, they would have to go through the regular Certificate of Need process just like everyone else, I'm assuming.

Nancy: Only if they charge.

Leslie: Only if they charge?

Barb: They could be a volunteer program.

Nancy: There's a real issue with there.

Steve: And also if they are Medicare and Medicaid certified and meet the definition of hospice.

Nancy: Well, not in this state.

Steve: For Certificate of Need.

Leslie: We do have that one volunteer hospice that was run by Rose.

Nancy: We have a volunteer hospice, at least from the CoN standpoint, it can be doing anything. You cannot be doing anything like hospice and call yourself a hospice. As long as you're not charging, you can call a horse a hospice.

Leslie: So hospice really isn't a protected term.

Nancy: Nope. If you're not charging, anyone can call themselves a hospice.

Jody: For Certificate of Need.

Jan: Under licensing, you have to look at the licensing statute, for where the volunteer hospice is. It is a protected term in the sense that they can't just call themselves a hospice. They have to identify that they are a volunteer hospice, and they do have to register with the state....

Nancy: But they don't have to be doing anything you would call a hospice.

Leslie: Don't they have to meet any kind of medical criteria to be a volunteer hospice?

Nancy: No.

Candace: The community is so confused on what hospice really is. They don't understand what it is. They think that it's perfect and they are not getting their services.

Nancy: There is a lot of misrepresentation going on.

Candace: The doctors don't refer to the Medicare because of the paperwork. It's easier to let them use their home health benefit and use their hospitals.

Leslie: And that's what's going on in the Peninsula?

Nancy: Yeah, it's shameful.

Leslie: I wonder if their legislators know that.

Nancy: I can assure you the legislators would protect this.

Leslie: Because it's beloved in the community.

Jody: So, is this a licensing issue or a Certificate of Need issue?

Jan: It's a licensing issue. It is not a Certificate of Need issue. That is the only volunteer hospice that I'm aware of in the state.

Peter: Isn't there one in Ellensburg?

Jan: Not that I'm aware of.

Jody: And there's one in the Tri-Cities.

Peter: There's one in Ellensburg and there's one in Chelan, I think.

Nancy: It needs to be addressed.

Gina: When we get to the exceptions and we talk about kids, I've certainly got more input.

Kathy: Shift focus for a minute; floor to Jan to discuss internal changes.

Jan describes changes in Bart's new roles and responsibilities as acting interim director for CHS. Bringing this up because Bart's participation in this workgroup will be limited through the summer.

Kathy: Should we start exception discussion?

Nancy: What is an exception?

Barb: Do we have a definition?

Jan: We don't really have a definition in hospice rules. We do have it in other rules, and typically, when we think of exceptions, it is a set of circumstances in which you would, and I'll use these terms, override the need methodology or there is something that's unique that the department would look at and would approve a project even though, under normal circumstances, you would either not accept applications or not approve an application.

Gina: I know there have been a couple of hospices over the years that have gotten a CoN because of an exception, and maybe just for our own, kind of, history, just knowing what those circumstances have been, do you want to share what those circumstances have been?

(General group discussion, several people speaking at once, some unintelligible, some referring to Kline Galland legislation)

Jan: There really hasn't been [many exceptions] in hospice. We've had them in other areas, and I guess the question is, are there instances where we should be able to consider. For example, let's use the Peninsula as an example, that applying the methodology it would appear that there's no need, but you have a situation where it appears that folks aren't able to access the full breadth of Medicare and Medicaid hospice services, and should that be an exception. Or, should there be an exception that you have a community where the county is so large, that it's unreasonable to expect one hospice agency to be able to cover the entire county in serving. Or, the road configurations make it nearly impossible for them to serve it.

Jody: Where it just so rural.

Frank: Or, you just have situations where the provider simply isn't providing care, and referring physicians can't get their patients into hospice. I've had situations like that.

Jan: Right, and in that case, how do you go about measuring that to be able to say that it is an exception?

Nancy: It almost sounds like, well, there's sort of these statutory things like if there's no Medicare hospice, like the only one in the county closes, and somebody can apply at any time during the year in that situation. And that's less about need, I think, it's less about the numerical need, it's more about the global need or the Kline Galland thing where someone just comes in and gets some special legislation. I think there was something like that for inpatient hospice when it first got created and some people got grandfathered. So there's sort of these things around the edges but then I'm thinking we may be going toward some kinds of need that are not just based on the numeric method.

Jan: Yes, I think that's what you look at. What are the circumstances that you would grant a Certificate of Need when the numeric need would say no? For clarification, when hospice care centers came into play, hospice care centers prior to the licensing were licensed hospitals. But, they received all sorts of waivers from the hospital licensing requirements. The licensing activity for hospice care centers when that came about, the existing licensed hospitals that were specialty hospice hospitals, had an opportunity to convert to a hospice care center without going through Certificate of Need review. I think there is only one out of the ones that were eligible that took that opportunity. All of the rest of them ended up going through Certificate of Need. They missed their window of opportunity and most of them consciously made the decision not to do that. Not sure why, but they missed that opportunity to convert. And so, then they kept that hospital license until they applied for Certificate of Need to be a hospice care center. And that was the way they handled that type of thing.

Jody: What's our responsibility here? If we think it's important to allow a community or an applicant, absent numeric need, can we just call out that an exception is allowed if they can demonstrate whatever as opposed to define what meets the criteria for an exception?

Jan: I think, from a selfish standpoint, I think it's much more challenging to just let everybody figure out and make whatever arguments that you want. I think we're trying to have an opportunity to create our rules so that people know going into it that applying the rules will be as predictable as possible for folks so that they are not spending a whole lot of money to go through CoN review, and we don't agree with whatever argument that they put forward for an exception.

Nancy: It's called planned and orderly.

Jody: What I'm concerned about is ten years from now, have we contemplated what is an extraordinary circumstance? And it's a high bar, an exception should be and is a high bar. I am not sure that we, sitting around this table today or next week or next month can anticipate what that's going to look like. And, I would prefer a more open opportunity. But, it should be a high bar.

Nancy: I'm not so sure it should be such a high bar. In my view, we need to balance this numerical need with some other kinds of needs that aren't being met.

Jan: Numeric need is only one part of need and it is how you go about defining the other criteria under need that you determine are important is and it is how you come up with, as you said, the global need. But, the numeric need is generally the place that we all start.

Nancy: And that's really what we've had, numeric need except for the absence of a Medicare provider.

Peter: Does every county in the state have a hospice provider?

Jan: That has an approved provider? Yes.

Nancy: What I'm saying is that I'm troubled by the word "exception." I would like to see some other kinds of need recognized because so much of hospice is beyond just black and white, are you dying or not, there's so much subjective about end of life and it's so value laden and preference laden and just because there's one entity that says they do hospice in a county and that fills the need given that half the counties don't have the population to generate the current 35, I'd like to move away from the term exception to other kinds of need that CoN recognizes. And if they're not being met, beyond the numbers, if they're not being met and the existing providers aren't meeting them, then the market should be open to additional providers. Now, you don't want to drive the other provider to below some number that Frank and Mark are working on, but I think that for obvious reasons, the CoN rules have been very protective of existing hospice and I think we need to recognize that over the next ten years the baby boomers are going to have a lot of opinions about what hospice ought to be, and I think we need to loosen up this idea of this purely numerical.

Gina: I think part of what we're doing here is shoring things up so that hospice organizations don't spend years in the court system. I think that the methodology that we have includes other kinds of need, it's not just numeric but we start there.

Nancy: And what are those?

Gina: You know them as well as I do.

Nancy: Well it's pretty much the numbers drive the decision right now.

Gina: They start with the numbers. But it's not that there aren't other types of need built into the methodology.

Frank: There's the more generic access, and inside the more general need there's the numeric need.

Jody: And you don't get to that.

Nancy: Nobody is arguing any of those. The numbers have driven every decision I'm aware of.

Jan: But that's why we're having this rulemaking process, to identify the criteria to be used, not only the numeric but other review criteria that we're going to be using to make those decisions. So, that's what we need to be focusing on. Yes, we need to spend some time on the numeric piece because that does have a good piece of applications, but what other review criteria do we want to have to help inform that decision and the issue of whether there is a need for exceptions was just raised. You don't have to have exceptions.

Nancy: Just using the word exception for now, I would raise one concept which the group that worked on revising the rules five years ago and then was sunset due to lack of staffing, I think we were at consensus about having choice, meaning more than one hospice available to any individual in the state. I think we'd gotten there. We never got it written down. Bart was running those and I think Jan, you were too, and I think we'd gotten to the point that we accepted the idea that people who are dying could have more than one alternative.

Jan: And that's certainly something we would consider. But that was five years ago, that was a different workgroup, we're constituting a new one, so we need to work at what we've got going now.

Nancy: And I'm just saying that would be one that I think would be easier to discuss, you know, I saw a group really get there a few years ago, and a lot of us are the same people.

Leslie: How does that work in rural areas though?

Gina: The thing is, those are the areas that lack choice and we're not going to see a lot of motion. It's really hard to make it work financially. But the other thing is, that's where the kids are the problem.

Leslie: I think the kids may be the key to the exception thing because what I want to know is how many big CoN's who might have two or three counties in major urban, metropolitan areas, are not serving the pediatric population.

Jody: We could just fix this by getting the survey to get each, specifically.

Gina: You know what I would love, is to just say, if you are going to get a CoN, you're going to serve kids.

Leslie: Yes, because if you are denying that population, and you're tying up all of the CoN and you aren't serving kids, that to me is outrageous.

Nancy: The alternative is, I can come in and say I'm going to serve kids, and get a whole new CoN just because I said that?

Barb: I would agree with you Gina, because I think if you require hospices to serve kids, and you are allowed to subcontract to do that, then it would force hospices to go ahead and get contracts so that they can serve kids.

Jody: But the most important thing is to look at the data and see if they are actually doing what's on the CoN.

(Several side conversations)

Gina: I don't know how you go back and force the existing providers to take this on.

Leslie: I'll tell you how you do it. We have the in-home services rules open right now, and when they get to hospice, if you decide in CoN that they have to serve the pediatric population, then we make sure that there's rules in the in-home services that they have to have the appropriate equipment to serve hospice or contract with a group. And then one of the things that we're going to have to firm up, too, is what do those groups look like? So could somebody like Alliance Nursing or Maxim who is serving that medically intensive children's population and has all this equipment and skilled nurses, could they contract with a group like them because they're not hospice qualified or would they have to hire somebody or train somebody to do hospice?

Barb: The hospices could subcontract under the Medicare rules, and you would have to provide some sort of orientation like you do for nursing home staff.

Jody: So we're back into licensing. That's what I'm worried about, we keep sliding back into licensing.

Barb: But I think the CoN rules should require it.

Jody: The CoN rules can require it, but the mechanism is not CoN.

Steve: The problem I'm seeing is, in the 30 years I've been doing this, how many times have I seen the CoN program go back, and pull someone's CoN or revoke a CoN because they didn't do something they said they were going to do? You are putting a huge burden on the department. How are you going to enforce this? Everybody is going to say, "I'll treat children," so they're going to have to go in on an annual basis and say, okay, you treated ten kids last year. What are you going to tell them – you should have treated twenty kids? And they're going to say, "we didn't do it because of x, y and z." You can't put that kind of burden on the CoN program. Even if you want to put it on them, and this is no trashing of you guys, it's not going to happen. They're too busy. They're not going to just go out and audit hospice providers ten years after a CoN has been issued to see if they are treating kids. Who isn't for treating kids? If you want to go to the legislature, and do it through licensing or some other way, and say, "If you want to be a hospice provider in this state, a certain percentage of your patients have to be kids" but CoN is not the way to do it.

Gina: So when we go through the hospice survey, these are the questions that need to be asked.

Nancy: But you could also ask in continuity of care or whatever that question is, about continuity of care and whatever relationship there is to the system, what are your plans for serving children? You can ask that application, especially if you have a comparative situation.

Jan: And I guess, Steve, in response to what you were saying, one of the things if we do an annual survey, and you do ask for some breakdown of some of the patients that they are serving, we are taking a more active role in contacting folks when they are not doing what they have identified in their [application] and have been awarded for. You're right, we have had very little revoking of CoNs. But we are also having greater integration with the surveyors as they are going out and they are getting copies of the CoNs to know what the folks are supposed to be doing and while they are on site, we have calls back and forth sometimes with the surveyors to say, "This is what we have found, is that consistent with

what your CoN says, is this a problem?" So, there is some more integration. And it's taken a long time to get that going on.

Leslie: I am very happy to hear that, because in home health, as well, we have areas where people have CoN and they are just not serving that area, and there's no backlash or recourse and there's no reason that they should because they don't have the state saying, "You're not meeting your requirements here."

Jan: And sometimes we have to rely on people telling us that someone isn't serving an area so we can make a requirement.

Leslie/Barb/Nancy/Jody: Discussion of complaint process under licensure, how to include or alert CoN of an issue. Home health/hospice discussion, including issues related to lack of service with home health, whether kids are in home health, whether they are getting the benefit of hospice under concurrent care. Discussion of home health agencies that are hospice in fact. This is because palliative care is being billed through the home health benefit. The problem is that kids are being taken care of through home health, and even though they are terminal, they are not able to access the concurrent care funds under the ACA, and they are not receiving the benefit of hospice. HCA was supposed to be billing for both under ACA concurrent care but was not, so kids weren't getting hospice while receiving palliative or curative care. Discussion of applicability of hospice for kids vs. home health for kids. Some of the largest CoN hospice in the Puget Sound aren't taking kids. Discussion of financial incentives for hospitals to keep kids, and inclusion of kids in overall population considered for hospice care as opposed to distinguishing between kids and adults. Counter discussion of issues hospitals face when working with kids and families facing terminal illness.

Jan: Seems that there is an issue regarding access to hospice services for children. The question becomes, how do we address that in our current rules for approving hospice agencies? One could look at our current methodology because it includes populations from zero on, that it is assumed they are going to serve the full breadth of individuals, not just those 18 and over.

Rule already contains underserved language. But, how do we measure that? When we look at charity care, we ask for charity care policy, patient acceptance rules, etc. Possibly ask who entity is contracting with for pediatrics if not staffing to that on a regular basis, ask for contract, have systems in place. Hospitals are doing a good job; have resources that smaller entities may not have. Prefer that entities hold themselves out as capable; in structure and process, will expect some policies and procedures to address pediatrics. So, when we are collecting data, we can identify that population as we are develop the survey tool.

Nancy: Comments regarding perception of department data quality gathered through surveys, timing of department reporting data in relation to due date for letters of intent. (See notes 10/29/15, 12/17/15, 1/19/16).

Jan: Refocus on purpose of rulemaking: part of the issue with current methodology and data sources is that when rules were originally created, data was supposed to be available well in advance of the letters of intent. But CoN does not control part of the data within the department and they have their own issues in terms of turnaround, so data never timely came out. This is the reason we're changing the rules.

Peter: Should we discuss compensation for pediatrics?

Discussion of reimbursement rates, etc.

Discussion of who is responsible for gathering death data for kids. General agreement that this is the responsibility of the consultant. Are we going to approve someone just because they treat kids? This is where an exception applies, if it ever applies.

Nancy: So, I'm an existing hospice that either does or does not serve kids, and another hospice is going to come in to town and easily say, well yeah, if a kid dies in the next five years we'll see them, and therefore I get a whole new hospice in town.

Frank: It's a little more egregious than that. There are some hospice agencies that simply don't serve children. And that's discoverable.

Discussion of what might create an exception. One child per year probably would not create such an exception.

Steve: There are two arguments here: one, is there going to be an exception for someone who wants to upgrade a pediatric hospice (unintelligible). That's a true exception. The other argument is that you have to make all applicants represent that they are going to serve children, so let's keep the two distinct. For instance, Florida has an exception that says, if an applicant can demonstrate a specific terminally ill population is not being served, then they can get a CoN. So, looking at it as an exception, no one is going to come in and show that they are going to operate a financially feasible pediatric hospice program, I'm guessing that, so they are going to have to say, I'm going to be a hospice, but one of our specialties is going to be pediatrics. And as Frank says, you can say look, in this county, last year there were only a dozen kids counted, and 500 kids died. You can monitor them if they get a CoN based on that representation, they can be monitored in the future. To focus on that is one thing, but to focus on requiring all hospice applicants to represent that they are going to serve children, based on my experience, it is a black hole. My advice to the group is, approach this with the legislature or approach it through licensing, that's how you're going to enforce it. Keep in mind also, because this is in the regulation and nothing is going to change this, that the definition of hospice for our purposes is Medicare and Medicaid certified, so anything that Jan says people have to include about treating children will only cover a limited universe of people who can be licensed as hospice. Just my observation – don't try to solve this problem here.

Discussion of what we can/cannot fix through CoN, but only going forward. The challenge would be a large hospice agency proposal saying that they were going to have a program for kids, and existing providers indicating they serve kids already. Documentation would have to be provided to demonstrate that existing providers served kids, and would probably be challenging for them. Hospice does not control who they serve. But do they hold themselves out as capable? How is the agency going to serve the entire county? Ask for zip codes, and those are things that would be in the survey, and identified in the application. Discussion of exceptions vs. other considerations and whether both terms should be used.

Nancy: I have an idea about how to address this, this exception idea. When the rules were initially written we said all the hospices that are in existence can just keep growing without bounds, there's no limit, capacity is a moving target. How about if you only allow hospices that are meeting certain criteria

to be those that get to keep growing and the others are set. So, if you aren't showing any Medicare, if you're not seeing patients in the last two days of life, if you're not serving kids, if you're not doing this list of things, you are not protected. You're not going to get your franchise if you aren't going to step up to the plate and serve everybody. And then it's not an exception, it's an exposure to the market, if you aren't going to serve it all, we're going to bring in some new providers that will, and then it gets built in to capacity, your capacity is not going to have some kind of protectionism on in if you can't get with it. (Tape 1, 1:32:52)

Steve: This is the same idea you were floating last time but in a different direction.

Nancy: Yeah, but it's more responsive to, if you are going to do all of these things that are more qualitative.

Steve: You are enamored of the idea of putting caps on existing providers. My question is, what are your criteria going to be and who is going to enforce it.

Discussion of who will enforce Nancy's idea. Department of Health through surveyors? Surveyors can ask lots of questions, but is there a statute or regulation that says a hospice can be de-licensed if their Medicare percentage is not a certain percentage. Not an issue of de-licensing, but rather an issue of not protecting growth.

Nancy: This is a perfect solution. If we develop these exceptions, either you are going to step up and do them or you aren't going to be protected. We can legally enforce this on existing providers because right now, capacity is a moving number and we're ten times the national average size of 75 and we're 750.

Clarifying discussion: Not capping how many a hospice can serve, you're capping how many the department will count of what they are doing, so that if you say the max is providing (hypothetically) 75,000 visits and we say that the max capacity that we will count toward any one agency is 50,000, if you can serve 75,000, you serve as many as you can serve, but for planning and projection purposes, that agency is going to be counted at a max of 50,000. That says there is additional volume that we're going to allow someone else to serve, and if they are successful at utilizing that, that brings in both the protection for the existing agency, but also allows for some market competition for the agency as well. It's just an approach. Heart surgery rules used as example; tiered approach. Didn't go that way, but something considered.

****AM BREAK****

Resume discussion.

Leslie: We need to create more incentive for private pay people to serve especially in rural areas. In those areas, some of the private pay folks actually have internal policies that say they won't take many or any Medicaid agencies. Instead of private pay, I mean for-profit agencies. Smaller non-profits are getting an overwhelming amount of Medicaid patients that are being turned away by for-profit folks. So, they may take one or two to meet their CoN, but they're not taking the lions share, and our smaller, rural area folks like Community Home Health & Hospice are getting dumped on. That creates a real problem. What happens is that those smaller home health and community hospice type people are having to cap the number of Medicaid patients that they take, because it's bankrupting them. So, there's no mechanism in place to force the for-pay people to take Medicaid clients. The non-profits have a mission statement to serve the poor, so it's not really an issue because they get some funding for

charity care. But the for-profit folks don't get that and they are reluctant to serve the Medicaid population.

Discussion as to whether this is a home health or hospice agency issue. There are agencies that don't serve Medicaid. Doctors believe that what happens in home health is the same as hospice. If they are underserving Medicaid, how would we track that, and if they are underserving children, they aren't meeting their obligations. So why protect them. We'll see this in the data over time. In terms of hospice, the per diem rate is pretty much the same.

Applicability discussion. If I'm a home health agency with half my patients terminally ill, am I a hospice? No. Sometimes palliative, home health care and hospice all blend in to one.

Return to focus of this group: Reviewing methodology that measures the need for Medicare and Medicaid certified hospice. There are lots of issues that relate to the ACA regarding whether a service is palliative, etc., but all we can do here is regulate Medicare and Medicaid certified hospice agencies. CoN only apply to Medicare/Medicaid certified hospice. Focus on need methodology. We can only do what we are authorized to do.

GENERAL AGREEMENT: Serving pediatric patients is an area of concern. They may not be getting the hospice coverage they deserve. Whether we do that as an exception or other criteria, or superiority. Should be included in our decision matrix at some point.

Jody: If there is no numeric need, can't get in. We have exceptions, not ordinarily language in other CoN rules. Do we want to provide applicants, individuals who want to be Medicare/Medicaid certified to have the ability to file an application where there is not going to be sufficient numeric need. If we answer that, then we deal with this. Right now you get stopped, and there are very few CoN rules that stop you simply because there's no numeric need. Do we want that?

Revisit Florida exception language. No one in group advocating for it, but provided as an example of what another state did. Special populations mentioned, but not defined. It would be the burden of the applicant to prove who isn't being served based on data. The other agencies would have the opportunity to respond if they were serving that population based on data. Assertion that this approach addresses shifts in landscape of population in the future. Counter assertion that there are kids that won't be going away, we know we want choice, that to leave it that vague (as in Florida), they can sue each other.

Nancy: This is not durable – to say that planned and orderly includes something as vague as special populations, and then have to guess what is going to stand up in court in eight years.

Jan: The concept of CoN is planned and orderly, but it also looks to ways to increase competition. Is there consensus that there is some sort of exception language that would allow for special populations or other needs beyond the numeric need?

Leslie: I would say yes, but I still think in addition, there needs to be clarification that when you say you are serving a population in a county that that includes children.

Nancy: Thinks the idea of an exception is the tail wagging the dog. It's okay to have a general catch all in the end. But we need to identify some durable and quantifiable things that allow an agency to have the protection that it has now, and those should be the exceptions. In other words, instead of an exception from the numeric methodology that gives a 1500 a year agency protection, let's give the exceptions to

the agency on the other side inside the methodology. Instead of the exceptions being after the fact, put the exceptions inside the methodology. Have exceptions be reverse of what they are today. We don't have a definition of capacity right now. Unlike any other CoN I think of, capacity continues to grow without CoN approval. There's no basis in policy for what we're doing right now.

Steve: Not aware of any state that artificially caps hospice capacity.

Jody: Straw vote? How many of us would rather deal with this via criteria outside of the numeric need methodology as opposed to trying to adjust the capacity within the methodology.

Nancy: I support the idea of special treatment of special categories, but I'm not sure that after the fact is where that belongs.

Steve: Reminder of last meeting: went through the regulation in last session and talked about what we wanted to adjust and take out, and you didn't raise this whole issue of wanting to establish artificial capacity limits.

Nancy: You are wrong. At the last meeting there was a proposal that capacity be defined with a trend into the future. And I wasn't very appropriate in my response because I laughed at that because I thought it was very protectionist and over the top. I beg to differ, I certainly disagree that capacity would be trended because I think capacity as it is defined now is outrageous. You remember it differently than I do, but I'm pretty confident in my position.

Frank: You were the only one that wanted to cap.

Nancy: Right, and I'm the only one that isn't working for a hospice here today.

Peter/Jody/Others: We're not representing hospices.

Gina: Not okay to think one person's opinion outweighs everyone else.

Nancy: No, not one person. I think I'm just saying that we each have our own (intelligible) and some of us are being paid to represent large organizations interests. Nobody's paying me, I'm here to protect patient rights.

Leslie: Now we've jumped the track.

Jody: Because Nancy's trying to say she thinks the exceptions should be trumped in the need methodology by capping the volume of providers who aren't performing to certain standards. And I think the rest of us are saying, let the numeric need be what it is, and deal with it by giving a path forward, if you think you have a rationale to justify a program absent numeric need. I'm really uncomfortable with making judgments about historical programs.

Vote: Instead of messing with variables within the methodology, just calculate need and if there is no numeric need, we still have standards that allow an applicant to put forth an application based on data they have to substantiate special circumstances.

Jan: I think it's too early in the discussion to do this. Looked at methodology revisions. Does these make it more restrictive? My personal bias is that seeing the run of the methodology over these years, it is very restrictive. Does not serve providers or residents of the state very well. Some counties have never shown need for another hospice agency, and some are large ones, Spokane showed this one. I think we

want to be a little bit careful here. I understand where everyone is coming from, and let's try to meld that.

Steve: We went through the methodology and dealt with all of the variables. Maybe we should go through the definitions. We are in danger of undoing a lot of work that has been done.

Nancy: Some of us are very policy oriented and disagreed with doing this bottom up approach. We agreed to go along with the group to do that, but we didn't agree with the idea.

Steve: Kathy prepared a six page document showing all the points we reached consensus on. We have to understand what consensus means. In my mind, it does not mean unanimity.

Nancy: No, consensus means talking to each other until you have an agreement.

Steve: We decided to start by going through each of the elements of the methodology and I don't want to undo all of that work.

Nancy: It was a risk we took by avoiding discussing policy until the end. There were folks that wanted to deal with the details first because they thought we'd get agreement easier but it just put off the hard stuff which is the policy matters that we are going to inevitably have.

Group: Numbers haven't been run yet. Nancy asserts that, "a number of us understand the numbers well enough to know what the policy is going to be" and that she know what some of the numbers will be, even though we haven't discussed ADC or run anything yet.

Refocus again. Just voted that the majority of group would think that something that allows for a capability for exceptions similar to the generic language of Florida was appropriate (conceptually). No definitive definition of exceptions at this time. Should we talk about definitions next? Quickly reviewed and discussed revisions in proposed in methodology. Eliminated a step. Added that two groups would get trended separately. This was Jan's main concern after glancing at revisions; helped to discuss prior work. Brought language of methodology into conformance with consensus that had been reached on various points during this rulemaking process.

Discussion between Frank and Nancy regarding how to define capacity. Nancy does not like the way capacity is defined in current methodology.

Nancy: Unless my client is served by it [capacity].

Jan: What I heard by way of vote is that exception language be considered and the concept of something like Florida but not necessarily exactly like Florida in terms of a more generic exception rather than detailed exception language – am I summarizing this correctly?

Jody: It showed up in the last notes.

Leslie: Let's make sure it includes children.

Discussion: Confirmation and reminder that application will be revised to be consistent with the new rules. Noted consensus about pediatrics being included in exception language. Data can be extracted about pediatrics by way of the survey. Discussion of how to filter data to determine whether kids are being served. Does the state have a cutoff? Maybe we should match that. Kathy will research Washington state hospice for kids. Will help group determine what our approach will be.

**** LUNCH BREAK****

Reconvene at 12:45PM.

Begin definition discussion (currently WAC 246-310-290(1). Start with ADC (currently WAC 246-310-290(1)(i) and (ii).

Nancy: One of the issues with this is that there are two versions of CMS data. One is length of service meaning the individual's number of days of care without regard to the calendar year. Another is the number of days of care given during that fiscal year by the provider. These are very different. They can be used in different ways. If looking for census on any given day, you would use the financial one, but if you are saying what is the level of service people in the community are getting, you would look at the length of service without regard to county. When we ask the questions on the survey and when we apply length of stay, we have to be really clear which it is.

Kathy: So how would you redefine ADC then?

Nancy: Depends on where we're going to use it.

Frank: When we talked about this before, we agreed to use the same ADC standard that is used in the methodology as it is now. We tested it, and found that the differences were immaterial. 59 vs. 74.

Nancy: Well, that was just an artifact of what some current numbers were. It's not necessarily the case. Because in the same situation, in the same market, they are 12 – 20% different. But we were comparing Washington to the national.

Frank: We tested the two different numbers in terms of their effect on the end result that was calculated and found out the difference was immaterial so we elected to stay at 59.

Nancy: But that was from two different markets.

Frank: No, that was in the methodology. We applied it to the methodology. We talked about this some time ago. We agreed on it.

Nancy: I remember talking about it but the thing is that this doesn't give the analyst specific instructions about which one to use.

Frank: The methodology gives the analyst specific instructions about which ADC number to use. ADC is used a couple of places in the methodology.

Nancy: I'm saying not ADC but the length of stay number hasn't been clearly defined. And that's what we need to do.

Frank: I thought we were talking about ADC.

Nancy: Well, we are and if ADC is $a \times b \times c$, and a is the length of stay, and length of stay has two definitions. So we need to be more clear so that everybody is calculating in the same way because CMS publishes two lengths of stay.

Frank: I thought we decided that. I thought we decided that the methodology we'd use is the methodology we use now by CMS (Tape 2, 5:17) We agreed on the shorter of the two.

Nancy: So how do we describe the shorter of the two?

Previously agreed on average.

Nancy: We didn't define length of stay. What are we telling an analyst three years from now to look for? Because that's what's been fuzzy for all these years.

Group: Length of service vs days of the year? For calculating future census it would be the number of days per year. This should coincide with how many deaths there are. Doesn't the methodology look at days in the year and patients served in the year? We are not calculating ADC in the methodology. We are using the report from CMS that identifies the average length of stay.

Nancy: The way they calculate average length of stay, the number they're using is average length of stay in a calendar year, so it substantially undercounts patient's experience of average length of service.

Frank: We're using admissions on a calendar basis.

Group: Discussion of CMS average length of stay table; we need to find out what the name of the table is. Discussion of duplicated or unduplicated patients. Looking at effectiveness of an agency or quality of service, we'd want to look at length of service, but we're not there yet. For the ADC definition, we're going to find what report it is that includes all patients in the calendar year and identify that report. Do we need to have the description of how to calculate average daily census since we are not actually calculating it? (Tape 2, 10:27) No, it's in the definition.

Kathy: Okay, we're good on ADC?

Group, generally: yes

Nancy: But, projected annual agency admissions is based on, is that lower? Where do we get the projection?

Frank: That's the methodology.

Nancy: Yeah, right.

Frank: That's what we use the methodology for.

Nancy: Yeah, I'm not sure if this is where you want to deal with it, but one of the reasons the numbers have stayed low for so long is we're using a statewide average to generate need at the county level, which it doesn't happen in very many services. (Tape 2, 11:24) Mostly we have regions or counties. What's been happening and why the number has stayed so low, is that when you use a mean, half of the counties are going to be serving too many people in hospice. So those counties can't show need because they are above average, even if the average is low compared to national you're using a Washington state average in your projected annual agency admissions because you're using the Washington state use rate.

Frank: So what is the point?

Nancy: We might want to consider using a different use rate and I'm not sure where to raise it because it uses projected annual admissions as part of the definition of ADC, but I'm not sure the way we project

annual admissions is optimum. Because we're using, again, half the counties can't ever have need if they're setting the upper bound.

Frank: The methodology calculates it purely on a county level basis, and then it grosses up the additional supply, the statewide average length of stay, to get estimated patient days by county.

Nancy: No, the use rates are statewide use rates. And they are applied to county level deaths. The projected annual admissions are driven by statewide average and in an urban area, that may have higher utilization because actually people are coming in from rural areas and like for example the hospice at Evergreen probably has people from a lot of counties showing up in King County. King County and the larger counties that have more hospice use have a much harder time ever having need because they're above the statewide average. So by definition, half of all counties, even though they may underserved in a national context, we're using a Washington average as our standard. And I think it may, at least we want to acknowledge that number and see if we think that is acceptable.

Frank: I think what we decided is that we would build a methodology with a set of tools and definitions and see what that methodology predicted, and then we can decide if we want to go in and subjectively make adjustments. That's the bottom up approach you were describing earlier today. So that's what we decided.

Nancy: Did we decide how the use rates would be calculated? Isn't that later here?

Frank: The use rates are embedded in the methodology...

Nancy: Well, I, I guess I don't mean the use rates, I mean the penetration rate. We're setting the Washington historical penetration rate as our standard. Which may be low.

Frank: But we won't know that until we run the methodology.

Nancy: Why would running the methodology tell us? Do we want to be just average?

Frank: There again you are imposing policy when we're still talking...

Nancy: Well no, these are our policies, we just don't acknowledge the policy. If we accept this language in the method as it's built now, our policy is that the Washington average is our standard. And I don't accept that on the face of it. Without looking at the national average to see if other states are doing better then why wouldn't we target that?

Steve: If you look at the hospice methodologies around the country, which Frank and I have been doing, there's two basic approaches. Our approach, roughly speaking, is supply and demand approach. The other approach is to use a hospice penetration rate approach, which is what Alabama and Arkansas use, and Maryland does kind of a spin on that. They use as a use rate the most recent MedPAC nationwide hospice use rate. So if you want to talk about use rates and whether we're above or below the nation, or above or below Oregon or whatever, then you want to move away from this methodology which we're trying to laboriously parse through and reach agreement on. We can maybe talk about that at another time, like let's just throw it away and let's do what Arkansas does or Kentucky does, that if a county is 80% below the statewide HPR, then they get a CoN. I think you are trying to do that kind of thing in the context of the methodology which we're basically saying, and Frank's right, we were going to make these corrections, and then run the methodology, and see what it comes up with, we still have that big

issue to deal with and that is whether we're going to deal with this ADC factor in the end, but the kind of thing you're talking about is an entirely different methodology.

Nancy: Well not really, it's just the use rate would come from a different source. (Tape 2, 17:32)

Jody: I actually agree with Nancy. Not that we can't keep going, let's run it both ways and see what the difference is with running the statewide average and the Medicare...

Gina: I don't think we ruled that out, at the end.

Steve: We have a presentation from the Association which was essentially an HPR model.

Gina: I think it's fair to readdress.

Nancy: But that was with a lot of other parts of the method not changed, so it didn't tell us...

Jody: Why don't we just get through it, run it both ways and see how sensitive the methodology is?

Gina: The one thing we talked about is if we went to a straight percentage and if you are below by this percentage, that does not tell us how many agencies may be warranted, right? So you're still going to need this (intelligible)

Steve/Frank: Right.

Nancy: Well, you still translate it into patient days and census, if you are below, I mean that would be the way you would do it. I'm just submitting because again, I don't know where else it comes up, is the idea and it's a policy question, is where is our standard, where do we think Washington ought to be? Is our own average fine? Or do we want to be thinking about what the better performers nationally are doing? We didn't resolve that.

Jody: Or what is the midpoint between ours and the national average so we don't destabilize the market and existing structures. We just have to understand the magnitude.

Nancy: We could move a percent a year toward the national, or Oregon or California. I don't know who but we didn't settle that.

Jody: So can we still get through this and say that we're going to run different methods with different penetration rates so we understand what the impact is?

Nancy: And I think we may have more than one variable that we can put into a table and run a bunch of different ways.

CONSENSUS: (Tape 2, 20:01)

Kathy: Current supply of hospice providers is next definition (currently WAC 246-310-290(b)).

Jan: Current supply includes both licensed only and Medicare and Medicaid certified hospices. I can tell you that when that was written, it included all of those.

Several side conversations. How should we re-write? Both licensed and Medicare certified. Should be licensed *and* Medicare certified not *or*.

Jan: If we only want to count Medicare certified agencies in the methodology, then you could say the current supply means Medicare certified hospice agencies. And that's the only thing that counts.

Currently, we're counting both licensed only, Medicare certified, and HMOs, because they have a certain amount of the population and we do not take that population out of the methodology, so you have that also.

Group: General discussion of HMO hospice, licensing, who is licensed and isn't, volunteer hospices.

Jan: A licensed hospice is a hospice that qualifies for licensure but is not Medicare certified and Medicaid certified. They serve private pay only.

Gina: I think we want to say Medicare certified.

Steve: It seems like given the fact that the only kind of hospice that is reviewable is Medicare certified, we should take out licensed.

Jan: That's fine, and I think the original thought around including the licensed only is that they are serving a portion of the population, the private pay population, that is also served by the Medicare certified. Just to be clear what ones we want to count. No preference on that.

Discussion: Comparison of counting hospice similar ASC. ASC volumes are included, but capacity is removed. Department does the same thing with home health. How many agencies would this impact if we took out just the licensed category? Jan indicates that currently there are not any licensed only hospices, that is an option that they have, but in home health there are many. Medicare does not certify by county, but when a hospice applies for a license, it has to identify its service areas. Medicare would certify the entity as an agency, they don't care about [what area a hospice serves], but state licensure does, and a hospice can only operate as a Medicare certified agency in the counties that it has CoN approval for. Licensed only hospice services can be provided in any county that the department concludes an entity can provide reasonable supervision and oversight. There may be some hospice agencies that are providing state licensed only services in some counties, but are Medicare certified where they have their CoN.

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."

Further group discussion of "current supply." Is this about a count of agencies per county? Is this confusing capacity? Does it need a different name? Current supply consists of the providers providing hospice services, or the inventory of providers. Could you take supply out and just say "current hospice providers"? When is this used? Is current supply used somewhere in the methodology? It is how you define the hospice providers per county that are going to be used in the methodology to determine if there is a need for another hospice agency. It's a supply and demand model. Assertion that supply and capacity are "...confusing to the new reader."

CONSENSUS: Agreement that "licensed" will be eliminated under current WAC 246-310-290(1)(b)(i). What it will say is, "Services of all providers that are Medicare certified as a provider of hospice services, or that have a valid, unexpired certificate of need, but are not yet Medicare certified."

Must be Medicare certified to be Medicaid eligible. Should we spell that out? That hospices have to be Medicare certified to Medicare eligible, just to be clear.

Jody: I think that (b)(i) should say “service area providers that are Medicare certified” because that’s what we’re trying to do.

Group: Reminder that we elected to not use service area, and instead rely on planning area. Should be “planning area providers.” What we’re doing with this is identifying how many providers are in a service area, correct? It’s just telling you how you define supply, and then you apply the supply at a county level. Maybe change definition to current supply? Final version: (b)(i) “Current supply” means providers that are Medicare certified as a provider of hospice services, or that have a valid, unexpired certificate of need, but are not yet Medicare certified.”

CONSENSUS: Agreement that current WAC 246-310-290(1)(b)(ii) is fine as is.

Group Health discussion; what are their volumes? Look into provider vs. agency. HMO has a very specific statutory definition.

CONSENSUS: Agreement that we defer conversation of capacity (c) to the end.

Kathy: Let’s move on then to (d) “Hospice Agency” or “in-home services agency licensed to provide hospice services.” (Currently WAC 246-310-290(1)(d)).

Discussion: Hospice agency and in-home services are interchangeable because you have the in-home services license that is a single license, and underneath that you have the various endorsements, almost like a driver’s license where you have a commercial endorsement for driving commercial cars and you have a motorcycle endorsement for motorcycles. Same thing with in-home services license. You have an in-home services license, and then under that you have home health, home care and hospice. Would a hospice agency ever be independent or would it just be an in-home services agency? Jan thinks it is an in-home services agency license. 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.

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)(Tape 2, 42.02)

On to current WAC 246-310-290(1)(e). Nancy says that e “...is the one that is missing the in-patient portion of hospice services that are required by Medicare.” 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.

Group: Get licensing to list agencies by county? Resource issue with licensing database.

Leslie: Suggest that under (d), after “in-home services agency licensed” add “under RCW 70.127.”

Group: Planning area and service area have already been discussed in previous meetings. Service area is no longer needed.

Group: Discussion of previous discussion and consensus on October 29, 2015 of urban vs. rural and two-tier ADC.

Kathy: Is there anything that we would like to add to our definitions that isn’t here?

Jody: Projection horizon.

Kathy reads proposed projection language. Discussion of current language in the methodology that projection is inflated by one year; needs to be cleaned up and consistent with proposed projection language.

Leslie: Wants to add Medicare certified because we use it throughout the rules.

Jody: We need to have base year defined and projection year defined.

Barb: Definition of Medicare certified hospice from CMS: "A Medicare certified hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals, meets the conditions of participation for hospices, and has a valid Medicare provider agreement." On CMS.gov.

Group: Discussion of who our audience is. Is certificate of need defined anywhere? The section we're working on is part of the CoN chapter. We can add additional definitions as the rules and methodology develop,

Group: Move back to current WAC 246-310-290(1)(c) "Current Hospice Capacity." Discussion of how ESRD rules address capacity, historically and proposed. Home health methodology discussed, as well. Jan thoroughly explains each, various approaches, strengths and weaknesses of each. (Tape 2, 1:10:00)

Jody: Under the current hospice capacity, the place we've seen the most problems is the averaging of three years of data, because sometimes we're projecting into the future less than the current (unintelligible) data. So if we're going to modify anything, it would be nice to understand why we want to use that average minimum. Or if we really think it's growing, should we be trending the data?

Discussion: Maybe use the last years data, and relying on that as current capacity? Might get a better response because people won't have to go back and see what their last three year were.

Nancy asserts that there was consensus about the need for a survey with the caveat that we would use cost report data to verify retrospectively. (Tape 2, 1:17:03)

Group: That was not consensus. That was Nancy's preference.

Steve: One of the things we discussed was giving people the opportunity to review what was submitted, and it was purely a matter of scheduling. The surveys are due on March 1st, then we have 30 or 60 days for the providers to look at them and review for discrepancies. Doing that rather than trying to true it up with whatever Medicare does involves lag time with the data because they have to have cost reports audited and stuff, and let's face it, there is a reason and Kathy's looked at other states and Frank and I have looked at other states, everybody does surveys. There has to be a reason for that, and the reason is there isn't a CHARS database that we control as a state, that we can just tap into. So we rely on surveys, and we know the staff is overloaded, and the analysts do a great job, but when they have 6 applications to review, the providers have to help too.

Discussion of attestation in survey, and whether to add.

Frank: What I find most helpful is comparing some observations in the survey to prior observations. And, that's why time series is useful...when I look at, for example, ASC surveys, or hospital surveys when they are attesting to beds or whatever, I look at variation and I look at prior responses and if something is

highly varied or different, then I'll go back and look at it more seriously and try to understand the reason for it. So, I think a survey can be a very valid instrument, and like Steve said, we've looked across all the states that have CoN and they all use them and they are used for a reason.

Jan: I think as we get into that portion of the rule writing and identifying when surveys need to be returned, that sort of process can have lead time built in for having the surveys posted so that people can look at them. We do post them, and that can all be built in.

Group: Discussion of reliance on survey, department creating compilation, consultants creating their own database for comparison to compare variance. If an agency is growing, market is changing rapidly, and methodology is projecting one year into the future, need may be understated. According to Cordt Kassner's 2014 update, overall hospice growth in Washington was 0.2% and nationally it's flattening out, it's 0.5%. What we're talking about is the organizations growth, and it does not work for or against a more restrictive or less restrictive policy. It's just a little more a cushion for a blip. Likely we won't see rapid growth that we have seen historically. If there is going to be a decline, then averaging would be better.

Nancy: What is the policy reason for using capacity to calculate need? What is actual about it? I remember at our last meeting, I think it was Susan that said, well, why not protect them if they are going a good job? And I think that's a big potential modifier. The big hospices have had about 15 years of pretty severe protection, our hospices are ten times the national average in size.

Discussion: Do we want the one year or three year lookback? Nancy wonders why we care what your recent volumes are.

Gina: This is the place where we are on two different sides of this issue, and we respectfully disagree about this. I think we could talk all day long, and I wouldn't change your way of thinking and my guess is that you wouldn't change mine. I think it is relevant to look at the historical so I think it is pertinent for us to decide whether we have consensus around that and then we can continue to grapple with the other issues.

Nancy produces a page out of an Abt report, but no other part of the report for context. Map is of visits in the last two days of life. Asserts that she has never understood the policy rationale for protecting existing volumes at their current level. Asserts that 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 (see notes from 12/17/15 and 1/19/16 meeting, same arguments, assumption that allowing more than 750 admissions per agency equals poor quality and protectionism).

Discussion of approaches. Constraint and artificially reducing supply to an undetermined number that does not reflect reality vs. allowing full capacity. Nancy asserts that a census day is "nothing more than money flowed from Medicare to the provider. It does not mean that any visits took place. It's not capacity, its funds flow...it's strictly money." (Tape 2, 1:43:22)

Jan: We need to see the whole report to put that chart in context.

Nancy agrees to share the whole report.

Group: This is best addressed by special circumstances. If an area is underserved, that's what special circumstances are for. Department is recognizing and identifying what entities are actually doing as opposed to the assertion that department is protecting existing providers to restrain growth. Group again revisits the design of this rulemaking process and reason for rulemaking.

Jan: What you are advocating for, Nancy, is that you're not going to count the actual visits by somebody beyond a certain level and in home health, the number used is nobody's current.

Discussion of hospice vs. home health visit numbers. Jan explains. Steve asks Nancy to create a methodology. Nancy 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.

Straw vote: Do we want capacity to measure what providers are actually doing or do we want to artificially cap it or approach it in some other way? Do we want capacity to reflect the actual utilization of providers?

5 yes; one abstain; one against.

Nancy believes the special circumstance would be the agency who would be fully protected; the agency that has death with dignity, and a bunch of things that assure us that it will provide superb response to the community and gets to be protected at its full volume and we're not going to let anyone come in and take that away (Tape 2, 1:58:10). Believes this is way beyond special circumstance. Asserts that 70% of the state supports death with dignity. If religious communities are taking over more and more of health care, it becomes more important today than it was yesterday.

Others asserts that this sounds like a great special circumstance. Nancy asserts this is way beyond a special circumstance.

Leslie: Legislature has a minority report; maybe Nancy's argument could be added to the final rule in this way.

Jan: That's a good way to capture the other side of this discussion.

Nancy agrees to send whole report to department.

Kathy will prepare and circulate notes and summary of meeting; will also prepare draft of definitions pursuant to discussion and agreement of workgroup today.

****CONCLUSION****

3:00pm

