

Certificate of Need – Hospice Services

Notes for Stakeholder Meeting – April 26, 2016

WAC 246-310-290

Meeting commenced at 9:00AM.

Introductions, review of March 17, 2016 meeting summary, consensus tracking document, general housekeeping.

Nancy shared that she might have made an error in the last meeting regarding ALOS, specifically whether it should be annual or unduplicated length of stay. Should be unduplicated, believes she may have indicated the opposite. The math won't work that way.

Nancy also shared another correction with respect to notes from January 17, 2016 (captured also in the consensus tracking document) concerning national average hospice size. Should be 75, not 340. Kathy will review meeting tape and update accordingly.

ADC presentation by Mark and Frank: Accessed 2014 CMS data out of cost report. Looked at 2,400+ freestanding hospice agencies, and looked at volume and financial performance statistics. "The table that we've got has two sets of columns: one is all of the agencies, and the one [column] to the right is all of the agencies, excluding outliers, because there is a lot of variation through the data. Looking first at the "All Agencies" column, the columns are described as "number of agencies" and that is the number of agencies that were counted within this group; "cumulative number of agencies" and that's sort of self-explanatory; "average margin" just is what it is, and that is average operating margin; and "maximum ADC" is the group of the agencies with an ADC anywhere from 0 to 10, so maximum ADC for that first row where we say 10 is everything from zero to 10, or agencies from zero to 10. And then, the next row, there are 169 agencies in that group, cumulative total of 464, average margin -29%, and the maximum ADC was anywhere from zero to 15. And so, that's how you read these tables. It became very clear that because of variation, we had to take outliers out and what we decided to do, was that we couldn't use the standard statistical definition, plus or minus two standard deviations. Instead, what we did was just look at the really good margins. And so we've got all of the agencies with plus or minus 50% margins, and so we've trimmed the outliers out.

And so, the second set of columns are the more representative ones. What you can see is that as you go down the average margin column, break even performance based on ADC includes all of the agencies from zero to 25. So, to sort of cut to the chase, our analysis told us that, whereas, in our current rules we have 35, it would be reasonable, based on break even performance if that were the criterion to reset that minimum threshold to 25. That's what this analysis told us. (Tape 1, 6:42).

Nancy: Is the 50%, in other words, my margin was -50% or 150% or...

Frank: Zero was the axis. So, anything that was 50% above zero, a margin of 50% or a margin of -50% in percentage of dollars.

Nancy: So it wasn't a statistic it was just a flat...

Frank: Correct. And we took those out because we initially had done a scatter plot and they were all over the place. We were quite surprised.

Frank and Mark used freestanding hospice agencies for this review because they were the most available. Capturing provider based data may have been even more challenging.

Jan: Did you have a chance to plug this number into the methodology and see what sort of impact it had?

Frank: Yes, we did and it had virtually no effect. If you drop the ADC from 35 down to 25, I think it shows need for maybe one more agency. If you drop the ADC down to 15, for example, then there would be, I think, another half dozen agencies that would show need, but there isn't much difference between 35 and 25.

Nancy: I think this is very helpful. MedPAC does not provide this. (Discusses MedPAC report). If we can find out where this data comes from we could compare. Using freestanding hospice was the best approach. Straightforward analysis. Lots more work than it looks like.

Some thought the ADC would be higher because infrastructure costs have gone up, but there are many ways of managing costs that didn't exist 15 – 20 years ago, like specialty vendors, different staffing models (like mixing LPNs and RNs). Some counties still won't get to 25. Frank and Mark were surprised by the large number of small sized agencies with an ADC of 35 or less; this was approximately half of all of the agencies that were queried. Discussion followed regarding serving multiple counties and how that may compare, geographically, to Washington (for instance Kentucky has 100 counties compared to Washington's 30ish).

Discussion re 25 vs. 35 ADC. Makes sense to most in the group. Two-fold test: use ADC of 25 rather than 35 in the methodology so theoretically it's possible that it could open up some planning areas to some additional providers. Would lowering the ADC to 25 address the urban vs rural issue? How would you staff for an ADC below 25? If you have 15, how do you staff for that? A lot of expense may be added by working in one county, but having your people go out into other counties. Lowering the number reflects what is best for operations. If our intention is access, then lowering the number for rural might be a good idea. The greatest limiting factor with rural is staffing. Have to be creative with staffing models, like setting up technology, remote access, set up whatever can be set up for that area. It would be great to open up access to rural areas, but what about the economics? There will always be the staffing issue. The cost is high for rural service.

Capping issue: For rural counties, maybe include something other than just numbers. For instance, if the existing provider is not serving children or has a history of capping admissions, this could open up the opportunity for another provider. So, lower the number with the intention that this is related to the survivability of an agency. How do you know if an existing provider is capping admissions?

Gina: They tell us. They say we're capping admissions, we're stretched too thin.

Barb: I've gotten calls in the last couple of months from families and they are not all in the Seattle area who say, everybody I've called says they admitting more patients.

Will this show up in Hospice Compare? If they ever get on service it will show.

Jan: I don't want it to be self-reporting. I haven't heard about a waiting list. Survey does not show that this has been going on. When we identify other measures beside need methodology, that's something we want to look at. The other thing we need to be careful of is setting up criteria that only existing

providers could really meet and somebody that wants to be new to the service area could not. That would be a situation where I would see a legal challenge coming forth by giving preferential treatment to existing providers over new providers, so folks can't equally have the potential for going into an area. (Tape 1, 23:00)

Resurrection of discussion regarding allowing multi- county service areas in rural counties so that a new entity coming into WA could have enough patients to make it financially in more than one county at a time. Conceptually, if you don't have enough business in a county to make it financially at least partially, and then you add another county, and there is an obligation to serve both, how will combining them make a difference? You'd get further and further away from black ink. We may be able to craft rural area criteria, but it needs to be applied uniformly. We want to support the idea of choice, but hard to do that in rural counties. In the old state plan, if a planning area only had one hospice, you could approve two absent numeric need to allow for patient choice. That is something that is possible to do, but demonstrating financial feasibility is going to be more challenging.

What are options that providers have in terms of insuring that patients more remotely located are getting services? Can they contract with other entities? The Medicare rules require certain core services to be provided by employees and you can only contract for specialty or rare services, and that could be for pediatric patients. If you only get one or two a year, or some sort of IV skills. Otherwise, core services have to be employees. You can't contract for vacationing nurses.

Do certain rural counties have populations that suggest that the number of eligible hospice patients is really low compared to other counties? Yes, some of the rural counties where you have 10 – 20 thousand people, those won't support a hospice in terms of the numeric need methodology. We can adjust the methodology by changing the ADC for example, and dropping it below 25, but that really does not affect an organization's ability to perform nor does it affect its potential viability. We ought to develop the most robust methodology we can, and then deal with this on an exceptions basis, where if the provider is capping, an exceptions basis would be the way to go as opposed to trying to tweak the methodology. Even with kidney dialysis, where we have two different thresholds, this virtually never occurs because the issue with kidney dialysis is that we see you have to be an exceptional provider to take on a very rural area where might have one or two patients per station, and that's because there is just a low number of patients in that area.

Demonstration: application of 25 ADC to current methodology. Need shows up in only a few additional counties. Discussion followed regarding levels of patient levels of care.

Mark: So seeing the unmet need in a variety of small counties in primarily single digits, I am on the exception bandwagon because the numbers just aren't going to do it. The other thing we haven't completely resolved is whether we're going to group counties, but what I've heard from those of you that do it, is that really there is not an economy that you're going to get that is going to change financial ability to provide a service.

Continued discussion of issues related to multiple-county CoN. Jan discusses many challenges, including issues with public hearings based on one application that applies to multiple counties. There are some things that can be done in the way of exceptions if people aren't being served. The numeric methodology is one thing, and if there is no need based on the numeric methodology, what things might

we consider in the counties that are considered rural? If we do that, Jan suggests defining those counties. Provides example of ESRD and 4.8/3.2 difference.

Discussion: Exemptions might address the rural agency issue. We can identify volume of services provided in each county.

Aggregate cap discussion: cap amounts paid by Medicare for total population of patients. Can't be paid more than a certain amount per patient, and if you did, you have to pay it back. Cap was originally set up to be what it would cost to have a patient on home care for six months so if you have someone on for eight months, they still count at one patient. That's one part; the other part is that no more than 20% of your patient days can be general, either in patient or respite.

CONSENSUS: Agreement to reduce ADC from 35 to 25. (Tape 1, 1:10)

CONSENSUS: We will look at exceptions for counties that have a single or no provider, and what exception criteria would look like when numeric methodology would suggest there is no need for additional service. (TAPE 1, 1:10)

Discussion of difference between exception and exemption.

Barb shared the number of live discharges for Washington state for 2014 (from Cordt Kassner's materials) and it's 11.2%

****BREAK****

Jan: Should we make an adjustment to projected numbers so that capacity would be accounted for? In other words, do a front end adjustment to account for the number of people who receive hospice but are discharged alive? Sort of a self-adjusting figure, where you would identify a source or report, and then make that adjustment.

Catherine: It's worth considering an adjustment but not sure if 11.2% is the right percent because we have a fair number of live discharges that come back on to service. Maybe they've gone on vacation and we didn't do a traveler contract and they come back on, or there are actually quite a few that come on service, decide they aren't ready, and then a week later, decide they want to come back on, and so I think that 11.2% is high. They are discharged, yes, but they come back on.

Jan: CoN can make certain types of adjustments related to things that are impacting the utilization of a facility or an industry that do not show up if, for instance, we're using deaths as a starting point for a projection methodology. But, you know that hospices are serving more patients than those deaths would suggest because they are discharged alive, so you can build in an adjustment to account for that. For example, the primary data source in our PCI methodology is CHARS data identifying the number of procedures that are done in the hospital, but we know that there are an increasing number being done on an outpatient basis that is still going on in the hospital, but they are going in and staying less than 24 hours, and then being discharged. We do a survey to do an adjustment for that, that's all accounted for as part of the volume because we know that that is a volume of service that's being provided for. (Tape 1: 1:22:54) We also did this in kidney dialysis (explains home training station issue).

Frank: We can look at the calculations at the front end because it seems to me like our use rates are driven by admissions and death rates, and so this 11% we're talking about would be picked up with hospice admissions instead of being picked up with the death, and so actually, what we're doing now by

ignoring that 11% is I think we've got a higher use rate than what we otherwise would have. It makes our use rate look higher. So applying the adjustment that everyone is talking about would actually decrease the estimated demand.

Mark: This is something we talked about at one of the first meetings – talking about deaths vs. admissions and I think the consensus was, we're getting to a use rate and it doesn't really matter because we're not comparing to the national, we're comparing to ourselves.

Nancy: But we haven't decided what we're going to use as our standard yet.

Patty: Is there a reason why you aren't comparing to the national? (Tape 1, 1:25:16)

Group: We talked about this several months ago. The difference is a couple of percentage points between state and national length of stay. We tested the state's length of stay and the national length of stay, and the difference was not material.

Nancy: But that was with the wrong length of stay though.

Group: We tested 59 vs 71 and there was no major impact.

Nancy: Those are both the wrong measures. You can't relate them to deaths.

Group: We're not talking about deaths. The question at that point was state or national. And we decided that state vs. national didn't make a material difference. (Tape 1, 1:26:27) The group reached consensus in both October and December in 2015 that the average length of stay is the mean length for the state of Washington and that if it is increased from 59 to 71, there is no major impact. . Contention that the average length of stay number is still incorrect because the national number is 80. (Tape 1, 1:27:45).

Nancy: The LOS we are using now is the LOS per year vs. per patient vs. per admission. You can die in our system twice, but you can only be a patient once; so our length of stay that is used and that was tested is too short. The numbers that being used don't work with deaths. We are using deaths to drive but then we are using the LOS per patient not per admission. (Tape 1, 1:28:07)

Mark: We'll look at the data sources; 71 is what we've seen in the data that we got from Cordt, and it's tied to the death. It is unduplicated. Most of our software gathers data by death. Need to sync up what we're going to use.

Frank: We want to be careful how we use that LOS variable in the calculations. If it's used as a proxy for resource consumption maybe we want patient admissions versus unduplicated deaths. What we want is a number that best approximates resource consumption because that is how the methodology is using it. It's grossing up admits by length of stay to get days which we then divide by 365 to get the ADC.

Nancy: That measures Medicare paying you not resource consumption. All that's counting is the days you get paid for and that's all that the method is counting is days on service. I think the issue is that there are two objectives: one, if we're going to use an average daily census and a capacity concept - that's one measure. But if we want to say why is the Washington length of stay in the bottom 10% of the country, that's access and service. So there are two different policy objectives here. One is to measure capacity and whether capacity is sufficient to meet need, but the other is to say, why is Washington serving patients with so many fewer days than most other states? (Tape 1, 1:33:20)

Group: That depends on your perspective. MedPAC isn't analyzing length of stay.

Jan: But I think Nancy, and we've had this talk before and you made that drawing for us on the board, you only have that issue really in the first year of operation because you have that loop of going up and down and people crossing over each year.....

Nancy: No, no, no that's not how it works. That is not the math, it isn't, I'm sorry. If I can die only once, what length of stay do you want to attribute to me? All the days I stayed or only the days I stayed in any given calendar year?

Frank: One would expect, and this is certainly in CHARS, that patient days get truncated at calendar year ends and so that's a measure of resource consumption for that period of time. And that's reasonable.

Nancy: But you never do a patient count. We're doing a patient count here. You don't do a patient count in hospitals or any other environment. We're doing a patient count here. Asserts that this is where hospice and hospital patient LOS should be distinguished.

Gina: If our penetration rate is within 1 or 2 percentage points of the national average...I'm not sure that length of stay is a reflection of access.

Nancy: Of course it is.

Group: Most don't agree. The opinion is not shared by everyone. We've tested this and there is very little impact on the number of needed agencies. We have made consensus and we don't want to backslide. Where we haven't reached consensus in the past is volume thresholds, and it looks like we just reached consensus on 25 rather than 35. We've revised the methodology – we have two age brackets, taken out cancer/non-cancer and we're using total deaths. We've already decided that. We will go back to 10/29/15 and 12/17/15 notes and recording and listen to what we have regarding ALOS. There was consensus reached, and we chose the mean LOS. Beth demonstrates a test of the methodology using the new numbers. Made very little difference at time of consensus, and still makes little difference.

Washington typically has lower use rates than eastern states. Lower consumption of health care services does not mean a lower access to service; other states may have higher use of healthcare services generally. So forcing a national average use rate on Washington may not make sense. Does not appear that group wants to make an adjustment for discharge live in the methodology at this point. Review of consensus points and discussion of reasons for consensus. Discussion of health care practice pattern variations across the country.

Leslie: Re Honoring Choices Pacific NW Program – do you think that's going to move the dial in terms of usage in Washington state?

Mark: It's based on a model that was initiated in Wisconsin. It's probably the largest scale institutional effort with WSHA and WSMA backing that we've ever seen.

Discussion of changing landscape of service bundles. What about an increase in the use of hospice? It will self-adjust; if use rates go up, admission will go up.

Discussion of Abt report: Nancy shares her observations and opinions related to the report. Group reviews. Leslie points out that Abt data is possibly skewed – only addresses a nursing visit as opposed to

other members of the hospice team. So conclusion does not mean that hospice team members were not there, but maybe a skilled nurse was not there. Data used for report is from 2012 and service intensity was added as a result of this report. This data will be of use for us next year. Nancy asserts that volume is protected in Washington and that “protected” is a business term as opposed to value statement. Others assert that based on objective CMS data regarding performance, we should consider it. This would fit nicely with the mosaic of exceptions where an organization could say, based on objective CMS data, here are some performance statistics and you could use that as a basis as their request (for an exception). No one would object to that, but to attach conditions, caps or other restraints might not be preferable. Timing of rulemaking precedes rich source of data.

Gina: Maybe we should put this off. We’re having to revisit every decision we’ve made. (Tape 1: 2:09:33)

Proposal: (Jan confirms) What Gina is proposing is to postpone any further work on modifying the methodology and the rules until this CMS data is available and we have that wealth of information to be making changes. Would new data coming out make any difference with the methodology? If not, then why postpone the rulemaking process? We also agreed that we were not going to backslide and go back and revisit items that we’d reached consensus on, we have to stop that in its tracks and keep moving.

Bart: What is concerning me is that I’m not certain that we’re identifying things that CoN can do to move the needle with regard to access to care. The solution might not be as simple as adding more providers. Lots of discussion about earlier education for hospice patients and becoming more aware of hospice and that is not a CoN thing. If we see a difference made by those things, then we can address it. If providers are able to absorb that demand by creating more programs, that might make a difference that we can work on. I thought we had a clear consensus on caps. If we have consensus, we need to move off it. Report is interesting, and there is some merit to it. I think everyone would agree, let’s quit revisiting things.

Gina: I don’t think our state’s penetration rate is anything to be ashamed of.

Bart: We fall in the middle in WA. Washington (referring to Cordt Kassner’s presentation reviewed by the group and Cordt at the second meeting) - that’s penetration – and the comparison from the national average is eight tenths of one percent and to move the needle to be in the top ten is going to seven percent and all of a sudden you are the top ten in the nation. I don’t think it’s adding anything. What is says to me is that Washington is doing pretty well.

Discussion: Should we put it off? Would quality data change CoN? Quality measures that are reported to CMS may not necessarily be valid for the first few years. It would take five years before you really felt comfortable that the quality was reflective of [what is really happening]. If we could decide on a percentage between a state or national average, if and when we are three percentage points or five percentage points different, we would look at our methodology and at this point, if we don’t have a reason to change it...or we could codify whatever we have up to this point. We can review rules in five years, and if we need to update, we can. There has been good dialogue and discussion, and it’s a lot of work to make changes to codify these types of rules. If we aren’t going to make a change that makes a difference, then maybe wait.

Nancy: We’ve made all the fixes it needs. The method is vastly improved. Once we put in the trending of the over 65 population, it’s going to make a big difference and there’s still a number of policy issues we haven’t talked about yet.

Bart: There hasn't been any consensus to do trending.

Nancy: Oh yeah, we made that.

Frank: What she's referring to is breaking up the age cohorts further on in the methodology. Right now, our methodology differentiates the cohorts at the front end, but it comingles them right after that, so there's no difference in the growth rates of the 65+.

Nancy: We would start aging the use rate, or the population. The demand would trend upward based on the aging of the population and we haven't been doing that. (Tape1: 2:23:02)

Frank: We didn't agree to trend anything on the trend factors or use rates, but we have broken out age cohort growth factors and given the differences in the use rates and put them into age cohort groups. That may have an effect but we don't know how big.

****LUNCH BREAK**** (Tape 1, 2:25:23)

Confirmation: Draft methodology and rule set will be ready for meeting in June. In general, group wants to move forward in the rule making process. Nancy does not. Leslie proposes ten minutes to for Nancy to present her position.

Nancy: I feel there is a policy matter that is pretty important and that is the integration of the Washington Death with Dignity law with respect to hospice care. Sent Kathy a copy of study regarding Death with Dignity law. Described study. Every county and every patient in the state should have access to at least one hospice in their county that would educate, inform and support their decision to seek the support of the death with dignity law. Fits with other items listed in matrix developed early on. Feels that this group should honor this choice, codify it, and make this a part of what is expected of the hospices in Washington. Should be codified.

Leslie: This is policy issue addressed by legislation. Unless there is something currently in Washington state law that requires CoN to address the Death with Dignity Act, it is not appropriate to address it as part of the rulemaking process.

Nancy: I think that's wrong and that may be your interpretation of it, but there's nothing about the Death with Dignity law that requires it be spelled out by setting. Bart is comfortable with the number of providers we have today, notwithstanding the fact that our hospices are ten times the national average, we could have some more hospices without hurting the existing hospices and to continue to support growth, it falls to us not to perpetuate that situation. Full range of care should be considered.

Bart: Are you suggesting that there be criteria in the CoN application that part of a superiority analysis when we have competing applications, we should look at if the agency has an active education program that includes informing our patients about Death with Dignity? Like a superior alternative?

Discussion: (Bart/Nancy) Not a matter of when two proposals come in; if a provider is restricting services based on other than medical criteria, we need another hospice in that county. Breadth and depth of scope discussed. This is the same idea as group discussion regarding pediatric hospice. How do we document whether hospices are supporting Death with Dignity? Do we have any documentation that our hospices disallow Death with Dignity? Leslie describes how information regarding Death with Dignity is discussed in hospice setting. Catherine describes how her organization handles Death with Dignity, that they are there to support the patient and the family, regardless of what the physician thinks about

the law. The patient has access to care, but the physician may not be present while that person is carrying out the act. This is an individual choice, so saying that a hospice would disallow you from making your own choice is inaccurate. We can't tell somebody they can't do something. There isn't documentation that there is a systematic barrier to Death with Dignity or that Death with Dignity is being denied by hospice providers. This is going to be one of those tough situations where the question of how do you prove that someone is being denied access to something when they can have it in a lot of other places? We would have a hard time defining this, and how do we prove it? This can be added as part of the application process as a superior alternative. But it does not rise to the level of an exception. Does not need to be a change to the rule; might be part of something the department looks at with competing applications.

MAJORITY CONSENSUS: Death with dignity will be considered as part of the evaluation process but does not require a change in the rule.

Discussion of exceptions: didn't define it, but discussed how it applied. (Tape 1: 2:59:26). Discussion included gaps in pediatric hospice, how a potential exception would be identified and reviewed. We also agreed that if there was only one other hospice provider in a county, that would be the basis for an exception.

Bart: Does everyone agree that that Death with Dignity falls into the same nature of services as pediatric or single provider? Don't have to demonstrate need, but still go forward on the premise that no one provides supportive services for Death with Dignity? (Tape 1: 3:03:37)

That's pretty vague. How would we prove that? Single provider is black and white; pediatrics is a little harder to show because how many do they need to accept to say that they do provide pediatric care; but physician aid in dying law, how would we prove or not prove that? How would we ever gauge that? Everybody gets a notification regarding policy of Death with Dignity.

Took a group vote: No, we don't want to add Death with Dignity as an exception. We've got pediatrics as an exception

Jan clarifies that Death with Dignity could be included in an examination of depth and breadth of services.

Nancy resurrects concerns with current survey and data collection practices.

Group moves to defining age of pediatrics. Pick an OFM consistent age range? Discussion of how to determine threshold. Should it be that pediatrics is defined as 0 – 17, up to 18? How much of a lookback will you do? Reality is that very few kids are served, all paid by third party payor. Providers in group share examples, group discusses moving age group to 0 – 14. What about lookback?

CONSENSUS: Regarding exception for pediatrics: age is 0-14 with a three year lookback, relying on OFM as data source.

Minimum census: in county with single providers, and need methodology shows less than 25, exception would be to let them show their financial wherewithal by their other activities outside their hospice in that county. Unless they are stand alone.

Urban v rural discussion follow-up. Frank explains how financial viability is determined, discussed ESRD rules. Difference is no dialysis facilities in some counties. Leave room for s choice in every county.

Confirmation that drafts of survey and application will be provided. Jan mentions that department is sending out survey, and making transition to an electronic format. Notice is coming out soon.

Group agreed to skip May meeting; will reconvene on June 22. Kathy will send out some preliminary rule drafts before that time