

Certificate of Need – Hospice Services

Notes for Stakeholder Meeting – June 22, 2016

WAC 246-310-290

Meeting commenced at 9:10AM

Introductions, goals for this meeting (review of draft rules); confirmation that workgroup members had an opportunity to review draft rules and consensus tracking document. Kathy provides describes updates to consensus doc. Reminder that once consensus has been reached, issue is off the table.

Nancy: Didn't really review documents, but didn't see exceptions with respect to special circumstances.

Kathy: Will go back to tape and update document if appropriate.

Nancy/Gina/Steve: Discussion of special circumstances. Nancy gives example of when she believes a special circumstance would apply.

Kathy: Plan is to go through proposed rule set, leave methodology for last since it may be a little more involved and want to allow sufficient time for questions and answers.

Group begins to go through rule set. All provided with a redline copy of rule, "clean" copy of rule and copy of issue/consensus sheet. Suggestion to go through set, page by page:

Page 1 – Definitions (WAC 246-310-290 (1))

Nancy: ADC definition. Question about wording with respect to "the most recent data reports."

Kathy/Jan: Program has been advised to use general language when referring to reports in rule and be more specific in applications as to which reports to provide. This gives the rule longevity as opposed to having to go through the process of amendment each time the name and/or source of data or a report changes.

Nancy: Agrees this is important, generally. Lengthy description of reasoning, agrees generality is good point. But argues that definition is vague, does not provide staff with enough direction as to what to rely on for data sources, and will "allow the current issues to continue" (Tape 1, 00:11:50). Report being used now does not match what is needed.

Beth: For ADC, we use that at the very end when we're establishing the 25. We don't calculate an ADC for agencies. What we get from Medicare gives us the ALOS and originally we got that from the statistical supplement which they are no longer producing. I was in touch with data management at CMS and in the future, they are going to have these statistics available on a data portal, but it isn't live yet. When I emailed them and asked them for the data, even though it isn't live, they provided it in a couple of days.

Nancy: Is that per admission or per patient?

Beth: The original report was average days of covered care per patient, and that was where we got the 59. When I asked them for the current number, it was 57.74.

Nancy: That was per patient. And we don't have a number of patients so we can't use that number.

Beth: Well, that's the way it's been reported...

Nancy: I know, and it's wrong.

Jan: Well Nancy, that's, I mean, we know and we have heard multiple times your position that that's an incorrect way of measuring that and we are working through those definitions and I believe that we had talked earlier about that ALOS meaning, and I think the (b) is the one that we've identified as the definition as being in consensus (Tape 1, 00:14:09) and Beth, correct me if I'm wrong, you were trying to get that, the ALOS consistent with what we had for our definition.

Beth: Yes, and I actually just sent an email on Friday asking for a couple of different versions of it, and I have not heard back quite yet...

Nancy: And (b) is correct. I'm trying to get (a) and (b) to match up, and I'm a little worried. Up to agency to figure out what ALOS they were using because it wasn't defined, but in the formula it's obvious that it's admissions plus all we have is patient admissions, we've never asked for patients and we don't ask for patients now. We have to use one that works for admissions. You've got it right here in (b) but I'm concerned that five years out or ten years out somebody will go back to that report that CMS publishes annual that's by patient, and that's substantially low.

Beth: Well, they don't produce it any more. It's going to be on a data portal and that's not live yet.

Nancy: I think it's important for this to say, "Average length of stay per admission" and that would be a simple fix so that it matches.

Jan: What does group feel about that?

Jody: I'm trying to understand what the difference is in (b) now because it says it would have to be someone who was admitted because it says "...used hospice services from the date of admission" so it's everybody who is admitted. So what are we missing?

Catherine: Actually that's right because the day of admission until the day of discharge, you don't want to count patients that haven't discharged yet into the ALOS.

Nancy: Well no, no, no, I sent a diagram that explains this and it's on your [inference department] laptops or computers if you want to bring it up...

Beth: We haven't had a chance to review it.

Kathy: Is that the thing you sent this morning?

Nancy: It was a revision of what I sent last week.

April: This definition is in line with what the national definition of ALOS is.

Nancy: Well there's two definitions that are legitimate. (Tape 1, 00:17:23)

Jody: So what happens to patients, because the last time you folks informed me about how many patients actually come off service, where are those days?

Nancy: I have a diagram that shows it if we can make that available. What's happening is that if you take all the patient days of the year of which you have ADC, if you divide those days by all of your patients,

you are dividing by not just your admissions for the year because they're all patients, but you are also adding all of the people who were patients on day one, so when you divide those days by that larger number, the length of stay is per patient not per admission and at a 60-day length of stay, that's an 8% error. And at a 90-day length of stay, that's a 17% error to the low side. So it's been an ongoing issue ever since we've started using the Medicare report per patient, because per patient doesn't work. We don't have numbers of patients anywhere. (Tape 1, 00:19:00)

April: That's two different things. You are comparing apples and oranges.

Nancy: No, I'm not, this is.

April: But what you're saying is that, because that's more of an average number of days per a time period. This is average length of stay, which is different.

Nancy: Right, and that's what we should use. But I'm just making sure that up here in (a) we're consistent with (b) because (b) is correct. Its days per admission, from the time you go in to the time you die theoretically, or leave, where (a) is subject to interpretation and I just want to make sure it's clear that it supports (b) which is per admission. We ask for admissions, we need to use admissions. We can't use patients as the basis for calculating length of stay. It creates a substantial error in the methodology. What's the issue?

April: I just don't see the issue.

(Others in group trying to enter in conversation – Kathy gives floor to Steve).

Steve: It says multiplying projected annual need is by admissions, so isn't it dealing with admissions (unintelligible) so recent average length of stay (Tape 1, 00:20:23), adding average length of stay by admissions just seems duplicative. As far as the source, I agree with Jan. We've learned from experience that if you name a specific report, it's inevitably going to go away and you're even well advised to say, CMS or a successor agency...

Kathy/Jan: We've been advised not to use the term "successor agency."

Nancy: I agree with Steve. I think your point of making it flexible about the sources....

Jan: But, but one does talk about admissions, it says that Nancy.

Nancy: Well, no, but let me just make clear: for the last five years....

Jan: But we're not talking about five years ago now, we're now talking about...

Nancy: No, I'm talking about interpretation of this language by staff five or ten years from now, looking at this like they've been doing for the last five years, and being, accepting per patient, which is creating error. I want to make sure the language is per admission. There's nothing wrong with that. Length of stay by admission versus by patient because we've been using per patient for a number of years, and we need to make sure have that....

Jan: Is there consensus that we add on the average length of stay per admission to that? Is there consensus? (Tape 1, 00:21:56)

Steve: I really can't agree with it because...

Nancy: Can I be permitted to make my presentation with this so somebody can understand what I'm talking about?

Jan: Well, I think that we've had, Nancy, we've talked about, you've raised this at almost every meeting that we've had, if I'm not incorrect, and I think that we are....

Nancy: It's a math, it's not a policy matter, it's strictly math, there's nothing...

Jan: As you've said, there is two ways of looking at the information, and I've...

Nancy: That's why we need to be clear, because there's two ways and we've been doing it wrong; we need to make sure staff has adequate direction.

Jan: And I was asking whether the group was in consensus with adding your clarification of average length of stay per admission, and I'm not seeing that there is. Is there, am I....

Jody: I understand what Nancy's saying. To me, I think the issue, and what I think Nancy is saying is that our average length of stay definition is not what we're doing. Right now we're taking total patients and we're dividing it by total days and I'm actually okay with that but that's not what this says. So, if we want to do that, can we just say average length of stay means, it's a snapshot, we're taking a census, we're assuming a snapshot... (Tape 1, 00:23:35)

Jan: Well, right now this definition isn't even in and so...

Jody: Right, so do we want to say that average length of stay means for an agency, the total number of patients divided by the total number of days? Because that's what that is. That's what we're doing.

Nancy: But we need to change the rest of the rule and use, see, a death and admission are one and one. If you use patients, then you have two patients per...

Jan: Well, no, Nancy I would disagree that an admission and a death are one and one because you can have live discharges.

Nancy: I understand, but it's a formula. We're using deaths as our use rate. And admissions are our one to one in our formula. But then we go to an outside source for our length of stay and so if it's per patient, and we have no idea how many patients there are, we never ask so we have to change all of the...if we go with patient, we need to re-engineer the entire methodology because we don't have any idea how many patients there are previously, we've never asked, we don't know now and this doesn't reflect patients, it's admissions which is in the formula related to deaths. That's why the length of stay has to be based on admissions. We do not have a patient number to use.

Catherine: But isn't CoN based on, it's all about access so we care about admissions not patients per (unintelligible) service? We care about the patients.

Nancy: I can show it to you if you'll let me. It's very simple.

April: I think if you add that in like you say it muddies the formula. The formula for average length of stay if very cut and dried.

Nancy: What is it?

April: You take the number of patient days for all deaths and discharges divided by the number of deaths and discharges...

Nancy: We don't have deaths or discharges, we have admissions

April: No, it says the day of admission until the day of death so it's all of their days, from the day of admission to the day of death or discharge, so that's the aggregate number of patient days and then you divide that by the total number of deaths or discharges. And that gives you the average length of stay, much like an HPCO does it, much like other NHTs do it...

Nancy: Where are you going to get the patient days number, from admissions.

April/Beth: We submit that, we're not calculating that, we're just getting that directly from CMS.

Nancy: Right, and that's the difficulty is the way it's being reported is different from what you are reporting.

April: But we submit patient days in our CoN...

Nancy: Per year. But it has to be divided by admissions and not by patients and that's all I'm saying.

April: The only thing in this formula that are CoN data is missing is the number of deaths (Tape 1, 00:26:42)

Nancy: We're wasting a lot of time that I could just simply address.

Steve: I think what we've got to do is this: we're going to be talking about this rule at least one more time, you said you sent an email out last week with all of this information but I didn't get it, I think everybody should have the opportunity to review your argument rather than do it now, because that's going to be another 15 – 30 minutes, and we understand your point, I think...

Unidentified voice (Nancy?): I don't think so.

Steve: Okay, well then send us your stuff.

Nancy: Okay

Jody: I'd like some time to think about it

Jan: Is that the consensus of the group? So Nancy, you said you sent an updated something?

Nancy: Yeah, because the time was so short, we only got the draft last Wednesday, so I quick put this together and it wasn't very pretty I sent it to staff Wednesday or Thursday (tape 1, 00:27:45) (NOTE: EMAIL WAS RECEIVED Friday, June 17 at 12:06PM) and then I made it a little more readable on the version I have today and sent it to them last night so it's on their computers.

Jan: So we will distribute that out to the group as part of today's summary and that so you can have an opportunity to look at it. Do you want to write something up to go along with what you did?

Nancy: It's a little hard to write up. If we put it on the screen I could just show it to people and answer questions.

Steve: So what are you going to send us?

Nancy: (Tape 1, 00:28:23) I'm going to send you, there are two examples of what happens, it's a hospice that admits one patient a month, and it's average length of stay in case one is 60 days, and it's average length of stay in case two is 90 days, and it shows the percent error you get if you divide the total patient days by patients versus admissions.

Steve: Well, I'm a complete idiot so I'm not going to understand those.

Nancy: Right, that's why I need to...

Jan: Nancy, I think it's fair that you write up a description of what you are sending out that the chart is supposed to depict so that people understand your argument. (Tape 1, 00:29:10)

Nancy: I had an email that I sent to staff and I'll revise that (Tape 1, 00:29:14)

Steve: And I also suggest that you draft some proposed language that effects what you want to do.

Nancy: But I have, it's just per admission.

Steve: That's your only change. Ok.

Jan: So you'll get that to staff and we will include that along with your chart to go out so that folks have an opportunity to look at and review that so that we will have that discussion at our next meeting. (Tape 1, 00:29:54). Okay?

Jody: One more question: the definition of "the most recent." Is it the most recent as of January 1, or how are we doing that? It's the most recent before the applications were submitted or before the letters of intent, I just want to make sure and clarify.

Jan: And we can make a note of that when we determine the actual timeline for the concurrent review so that we can get the methodology going.

Steve: Well, we've been down this road in other meetings before – do we want to say "the most recent available data"?

Jody: But as of what time? As of July 1 or August 1?

Jan: Right, because we want it before the letter of intent period so that people have an opportunity because we are, our intent is to publish the methodology prior to the letter intent period so that folks have that for making a decision.

Nancy: Does this leave open whether this is financial data or patient data? There are different kinds of data reported to CMS.

Jody: I just want to know the date.

Jan: It will be based on the review schedule.

Data discussion. Full year data. Not requesting cost report data. Difference between fiscal and calendar years. Talking about survey data, but not cost report data. ALOS directly from CMS. That's the data that Jody is asking that we put in (first working day of xxxx). (Tape 1, 00:33:48) Dialysis rules data discussion. Does CMS collect numbers of admissions and patients? Yes.

Second to last line – add "services" after "hospice" in (1)(c) – page 1.

Page Two - Definitions (continued)

Jan: Question for group re current capacity: We have a couple three agencies that they report that they are CoN approved for certain counties but they have not reported any days or any services in those counties for three years. And so...

Gina: Are they sole providers in those counties?

Jan: (Tape 1, 00:38:33) I don't believe so. So, you know, it's generally the position of the program is, if you are not continuously providing services, you don't get to claim a service area and a three year history of not providing services in there indicates to me that you are not really providing services in that planning area. Is, I mean, and so, we would not count them as existing capacity in that planning area.

General response: makes sense.

Nancy: One idea I have because this deals with the agencies that quit, you know, disappear, if you said, for hospice agencies that have operated and are still operating in a planning area, well, that's in the wrong place, but if you said, and are still operating...

Jan: Well, I was wondering if you wanted to use like a (iii) and just indicate that for agencies that have not reported any services in a planning area for three or more years and are not new, that they are an existing agency that has been in operation for greater than three years because that was kind of, we had that lead in for that operation of the folks for three years when they are newly approved if they have not provided services in a county for at least three years that they will not be counted as capacity for that county, for that planning area. (Tape 1, 00:40:00)

Nancy: I take back what I said because I think the question of people selling or getting out of the business is going to confuse this.

Add language regarding agency closing in this section.

Brief discussion of volunteer hospice and where these entities fall within CoN.

Brief discussion of counting volume of agencies that cease to operate. Assertion that "we don't count the capacity anymore." (Tape 1, 00:42:38) Group checks whether we've discussed this before – we have; on matrix as consensus point. Debate over what capacity means. Where else does the term "current hospice capacity" appear in the regulation? Why are we defining a term that does not appear anywhere else in the regulation? Because it appears in the method. Discussion of how to count waitlisted patients. Return to "current hospice capacity."

Page 3 – Definitions (continued)

No comments. Steve brought up a scrivener's error on page 12.

Nancy resurrects county discussion. (Tape 1: 00:54:00)

Page 4 – WAC 246-310-290 (2) and (3)

No comments.

Page 5 – WAC 246-310-290(3) (continued)

No comments.

Page 6 – WAC 246-310-290(3)(continued), (4), (5) and (6)

General positive response to table presentation. Complaint about schedule. Jan explains department position on concurrent review. (Tape 1, 00:58:35). Nancy/Jan discussion.

Nancy: Other states have to have data posted by a certain month in rule.

Beth: We never know for certain when we'll have complete survey results.

Nancy: What controls that?

Beth/Kathy: When people respond.

Nancy: I'm saying put it in rule that when your staff gets cut and people forget this meeting, that there is a day it is supposed to be posted. (Tape 1, 01:06:02).

Jan: Nancy, if the staff gets cut and that date is in the rule, it's not going to happen anyway.

Nancy: At least we'll have some recourse.

Kathy: I don't know that they will allow us, from the secretary's perspective, to put a date certain in rule like that because, gaining experience from our last rule set that we put through with the end stage renal disease stuff, it's hard to put hard fast dates for us to provide deliverables like that in rule.

Nancy: I'm sure that's protecting the department, but I'm thinking of the client. (Tape 1, 01:07:22)

Beth: Gives example of a provider wanting Medicare certification timely but survey occurs whenever staff can accomplish that – Medicare has no control over when it happens, nor does department. Same with web posting intra-agency. Information appears on web when media/communication staff can reasonably post, not on a program's timeline.

Nancy: And that's exactly to my point.

Jody: (Moves to discussing public comment timing in table). 30 days is a tight timeline for public comment. We can do it; would just be tight.

****BREAK****

Jan: When we took a break, we were talking about a breakdown of the review period and there was concern that the public comment period was not long enough, and so what I would be proposing is to increase that 15 days to 45, 30 and 75. That is the maximum allowed by statute for concurrent review and then that allows for ample opportunity because those are calendar days those are not in a regular review (Tape 1, 01:12:39) the 15 days is a working day time period which we had agreed to many, many years ago to interpret that as working days rather than calendar days, so is there consensus that we change that to a 45 day public comment period?

CONSENSUS: Change public comment period to 45 days (Tape 1, 01:13:10) Rebuttal and ex parte period stay the same.

Page 7 – WAC 246-310-290(7)(Reserving discussion of (8) for PM session, pages 7, 8, 9 and part of 10)

Kathy: Saving methodology for PM session (subsection 8). Just reviewing 7(a) and (b)

Jody: Under 7(b), I believe that there are still some CoN out there that limit a provider to a portion of a county, so what do we do with (b)? Should it be counties or portions of counties?

Jan: Well, but this is if they commit, this is where we're talking about...

Jody: But there might be a contiguous county, a portion of a contiguous county, that has a provider but another portion of the county...

Jan: But this is where if they are projecting to have, if the applicant is projecting an ADC under 25 patients that the department may approve if it commits to serve the Medicare/Medicaid population and to serve one or more contiguous counties and can demonstrate overall financial viability. Some older CoN have only a portion of a county. I believe down in Klickitat there was that and we determined that there was not a hospice approved for the county and so we permitted an application. (Tape 1, 01:15:55)

Discussion of these older partial county CoN. If someone files an application and they aren't going to have an ADC of 25 by the third year of operation, and they want to make use of this provision, do they call out the planning area as being more than one county in an application? Otherwise, how could you evaluate need? Is this some sort of hold-over we need to get rid of? Group checked at consensus document, page 14. Maybe rule contemplates that even though there are CoN approved providers in every county, that there may be a time in the future where they may not be a CoN approved provider in every county. New methodology may show some counties that suggest, based on lack of reported data for three years, providers in essence have relinquished CoN.

Nancy: I think we had consensus that choice was a value and a policy we agreed on but I'm not seeing that in here. (Tape 1, 01:25:35)

Group: We did not have consensus on choice. Gina refers to language transcribed from last meeting and inserted into consensus document (on page 14) regarding exceptions for counties that have single or no providers.

Nancy: We have to have a position on choice. It was on our agenda from day one. (Tape 1, 01:27:32)

Discussion of purpose of subsection 7. Allows an existing agency to extend into another agency to create ADC. This section is about an applicant, not a county. Deals with narrow issue of applicant who has identified a county they want to serve, but for whatever reason cannot meet ADC. Maybe confusion is with language, instead of referring to entities as hospice agencies, refer to "applicant." And adding the word "contiguous" is equally confusing. (Tape 1, 01:34:00) Program will go back and listen to the tape about "contiguous" – Jan believes this was discussed. Steve asserts adding "contiguous to it" (e.g. 7(b): "Commits to serve one or more contiguous counties to it that do not..."). What was the original purpose of this section?

Jan: (Tape 1, 01:38:32) This was originally developed for planning areas that didn't reflect ADC of 35. This was the exception in the rule. This section might need a little more work for clarity on the fact that we're looking at having this being more toward the financial feasibility piece that they, you know, in terms of when an agency doing their projections of what they expect the average daily census for their agency would be in an area I mean and we can look at that whether we have two of those for this one to

focus on the financial feasibility of the agency and then one where the planning area does not support an ADC of 25 to show numeric need and I'm thinking of the rural areas, you know some of the rural counties that may not. (Tape 1, 01:39:41). I thought that there was if not consensus pretty close to consensus on that if there was a single provider in a planning area that we would allow for at least applications if somebody wanted to apply for an area where there is only a single provider. I thought that was part of our discussion last time that we were going to do that and we'll go back and double check again. But I thought that that was the case and you'll see later on this afternoon that reflected in what we talk about.

Jan/Nancy: discussion of exceptions and financial viability.

Steve: Subsection 7 might be better in the exception section. Should be reviewed under whether the group is going to go forward with exceptions and special circumstances.

Consensus: Section 7 is best revisited in our discussion of exceptional circumstances (Tape 1, 01:47:22). Except, keep the first sentence as section 7. Then the second sentence and everything else would be moved to exceptions (Tape 1, 01:49:36). Also, add "by the end of the third full year of operation"

Page 10 – 11- WAC 246-310-290(9), (10) and (11)

Subsection 9 discussion: Jan describes purpose. This was a consensus item, taken directly from the consensus document. Strike "a closure occurs" after "If" in second sentence of (9). (Tape 1, 01:54:10)

Replace "hospice agencies" with "applicant" throughout the document.

Subsection 11: sub (a) might need to be tweaked for consistency. Brought into alignment with exceptions.

Page 12 – WAC 246-310-290(12)

"Applicant" – define this in the rule? Is already defined in other parts of CoN rule. Do we want to use applicant or project throughout the rule. General goal is to be consistent with approach. (Tape 1, 02:01:00)

Nancy: believes (12) does not reflect what group agreed to.

Kathy: So Nancy, what would you propose to add or strike to this section to what exists?

Nancy: I'll draft something for you. (Tape 1, 02:05:08)

Jan: I have to share with you that exceptions can't be all encompassing so that anyone can make any argument that they want.

Nancy: Resurrects death with dignity argument. Asserts there was consensus. Does not want to use population in exception language.

Additional discussion of proposed exception language. (Tape 1, 02:08:28), purpose of exception language. Applies to any applicant; not just a single applicant. Nancy believes exception is a "catch all" and proposed language narrows what qualifies as an exception too much (Tape 1, 02:12:26). Steve indicates that his client believes the proposed language is too broad.

Nancy: And that's why we need it. Your client is one of the main reasons we need it. (Tape 1, 02:15:44)

Jan: Jody and Nancy, propose some language for this section.

Extended group discussion regarding exception language. Members presented various positions and arguments for those positions.

Nancy resurrects death with dignity argument and desires that it be added specifically to exception language. Asserts that the department propose language. Jan declines. (Tape 1, 02:27:19)

Gina: This is changing the subject, but if we're going to revisit things and we're planning another meeting, can we revisit the threshold of 35 versus 25? (Tape 1, 02:27:59)

Nancy: We're not revisiting anything we got consensus on.

Gina: Nancy, I just think it's fair for me to say what I think.

Jody: Do you think 25 is too low Gina?

Gina: I don't know what the problem with 35 was.

Jan: I hope that we would not revisit that consensus because that was done, you know, Frank and folks went through and did a lot of work with that and I really...

Gina: But there's two people in the room that concur. And I feel like we are rehashing some things and I don't think it's fair to say we're going to rehash these things but not these things.

Jan: So what things do you think we're rehashing that we're changing consensus on?

Gina: I mean, I don't mean to argue with anyone.

Jan: No I'm just asking the question Gina. What items do you think that we've changed consensus on?

Gina: Well, I thought today was going to be our last meeting and so we were going to kind of try to get through this thing but it sounds to me like there are some things that we're coming back to.

Jan: Well, I think the things that we have identified, that Steve through reviewing, the taking what our consensus have been and putting them into the draft language that we've identified some clarification in the language that we have to do. And that to me is not changing consensus or moving something from one section to another. The exception language, you know, I believe that there are, and again, I'm going to suggest that we go back and listen to the tape on precisely what we did identify, but part of the consensus that I remember is that we were going to consider some exception language when there is not a numeric need, and we have identified like the pediatric population and we did talk about when an applicant could not project an average daily census of 25... (Tape 1, 02:30:37)

Gina: Janis, I'm okay, we don't have to go through all of this...if the answer is no it's no.

Jan: No, but those are things that I don't think we are changing the consensus on, we're trying to ferret out what the exceptions are going to be, but the major consensuses, we were going to be revisiting those major consensus that we've developed.

Jody: For those of you who haven't been through rulemaking, I think we're going to identify issues that we're not going to reach consensus on so the department is going to have to make a decision here, so I

think getting a position paper or getting your thoughts down – we’re not going to convince each other at this point, who we have to convince is the department ultimately.

Gina: I would have to just say that there have been days I just needed something to keep moving and 35/25....I get worn down. And that’s one I don’t necessarily feel good about, so I’m just putting it out there. And if I’m not the only person, then I think it’s fair to just ask the question.

AFTERNOON SESSION

Pages 7, 8, 9 and part of 10 – WAC 246-310-290(8)

Jan: What we asked Beth to do was to go through, and here’s where we had the consensus and everything, to apply it to the methodology, so that we could see on that. To go through and show the results of what the consensus has done for us. (Tape 2, 00:01:17).

Beth walks group through methodology, step by step. Provides hard copies for each step. Discusses data sources: admissions is still coming from survey; continued to get death data from vital statistics sheet A9. Nothing is hand-typed, everything is linked. For ALOS, used CMS figure (from recent email from CMS).

Discussion of statewide use rate, and problems with rural areas/need.

Nancy: Does not like term “use rate;” proposes something different. Propose to reverse steps. Wants to use projected volume. (Discussion Tape 2, 01:01:22) Add “current” back into methodology language.

Nancy wants to round up ADC (e.g. 24.55 people should be rounded up to 25). Gina disagrees.

Jan: I will share with you that in the home health methodology that is not in rule but is in the state health plan specifically states that you round down.

Nancy: That’s agencies. This is people. This is patients. (Tape 2, 01:08:20)

Beth: Well, it’s the average census.

Nancy: This is people going without care. There is nothing else like that in any CoN rule.

Beth: When you have a 24.5, that will compound backwards; so that .5 is an ADC of .5 patients that we are now granting to that agency, and that .5 patients per day, times the 365 divided by the ALOS could actually come to quite a few patients.

Nancy: I know, that are not getting care.

Beth: No, if we’re rounding up we’re assuming a certain number of patients that do not go into that default that we had already established in a minimum volume standard. So, that’s why I would not argue for rounding up.

Gina: But when you say home health, though, that’s patients.

Jan: You are projecting the number of patients...

Nancy: No...

Jan: Nancy, you are. You are projecting the number of patients and visits, but you are doing it by the number of patients...

Nancy: No we don't use the number of patients anymore... it's the population times the use rate.

Discussion home health calculation.

Jan: Is there consensus that we round up on the average daily census to determine the numeric need? (Tape 2, 01:11:31)

Steve, others: No, I agree with what you initially said, that sometimes you just have to pick mathematical conventions and go with them.

Jan: So the consensus is that we're not going to round the average daily census in the projected unmet need and that will be used to determine the number of agencies. (Tape 2, 01:11:50)

Beth: Want to reiterate that nothing has been rounded in the methodology.

Nancy: Not consensus; majority.

Discussion of financial feasibility, when 25 can be reached – 2 years, 3 years. Need criteria is going to be based on the projection year that is published. Could be second or third year. Might not do anything until third year of operation. Could come on line in third year. Show ADC by third full year of operation. Confirmation of what needs to be "shown" in terms of ADC (Tape 2, 01:19:02).

Catherine: The one thing that I find kind of confusing is where it shows "unmet" but then below it almost makes it look like...(describes portions of worksheet that are unclear – "unmet" is in parenthesis and leads the reader to look at a different cell within the worksheet).

Jody: What she's saying is put unmet need on the top...take the parenthesis out.

Discussion of parenthesis usually indicating a negative, but in this case, because the "unmet" in a certain area it gives a different meaning. Strike unmet.

Kathy: Going back to the rule, everything that Beth has presented to you is laid out in subsection 8, in both written and table form.

Steve: You're going to keep it that way?

Kathy: Yes.

Group: Cancel July meeting; reconvene on August 30. This will allow Jody and Nancy time to prepare proposed language. Brief discussion of when revision of CoN hospice application and survey will be revised to reflect rule changes; brief discussion of rulemaking process. Suggestion to present rulemaking overview at August meeting when attendance at workshop may be higher.

****END****