



Hospice services ~ Issues Outline ~ June 29th, 2010

A) Underpinnings:

- The steps within the methodology need to be sequential
- Level of statistical validity
- Perform an initial test of the revised methodology before adoption of the rule
- Reliable / available data sources
- Patient choice
- Rapid changes in health care systems
- Is the methodology cut and dry or should there be additional factors that should be looked at to approve a CoN?
- What are we trying to accomplish? Access? Choice? Financial feasibility?
- Need a clear understanding of what Medicare requires and make sure the rules reflect this and not contradict it.
- "Right to die" expectations from the public
- Medicare reimbursement issues
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B) DOH Policy overview:

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C) Access to care:

- What's the definition of access? Ability of patient's having access to hospice care within a reasonable amount of time (within 48 hours). Can people get a referral from their physician and get hospice services?
- The rule should be clear that providers must serve all clients within their designated county / planning area. Consequences for not serving all clients?
- Informal alliances between providers in order to adequately serve people throughout a planning area. This is especially helpful in rural areas.
- Using new technologies such as "telehealth"

- Do we need better mapping of where hospice care is currently being provided and where it is lacking?
- What may be preventing access? Lack of public awareness? Part of access is public communication from providers and physicians about available hospice services. Efforts to inform the public is important but does informing the public belong in rule?
- How can you measure if a provider is engaged in communicating its services to the public? One way is for a provider to show that it has staff that has public awareness duties as part of their official job description.

D) Data Sources:

- Should use CMS as a data source.
- CMS claims data?
- Surveys (including expectations/consequences regarding participation):
 - Numbers can be unintentional skewed.
 - Numbers are only as accurate as the provider who is submitting it
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E) Minimum volume standards:

- Should you be able to create an alliance in order to meet the 35 ADC requirement?
- Financial viability – what number equates financial feasibility? 35? Higher? Lower?
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F) Capacity issues:

- Should there be a cap on the current capacity of existing providers beyond which there is room for adding additional providers?
- When is a new hospice provider needed in a given planning area?
- Turn the question around - When / why would we keep a new provider out? On what basis do we keep competitors out?
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G) Penetration rates:

- Methodology needs to address differences between urban and rural realities.
- “Penetration rates” are synonymous with “use rates.”

- Can we have too much hospice usage?
- Average length of stay issues with CMS
- Mixing large population areas with small population areas and then applying an average “use rate” is problematic because it does not benefit smaller areas that are needing improvement in access. There needs to be some kind of a leveling in that field (The formula for determining the use rates needs to be looked at especially as it relates to use rate expectations for rural areas).
- Under the current methodology, the higher performing areas drive up the use rate for the lower performing areas.
- Use a median length of stay (may be more valid than average length of stay).
- Washington has always been in the bottom 10 compared to the entire country.
- CMS does not encourage increasing average length of stay.
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H) Population projection sources:

- Should there be a difference between urban and rural projection methods?
- Apply appropriate trending capabilities to the methodology
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I) Planning horizon:

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J) Planning areas:

- Distinguish between service area and planning area
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K) Age & diagnosis cohorting:

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L) Exceptions:

- If a provider cannot service an entire planning area they should submit to CoN its rationale for not being able to do so and request an exception.
- If we create such an exception, there needs to be specific criteria that would qualify – not subjective.
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M) Tie breakers:

- “Preference points” for a provider who wants to serve in rural areas
- Alliances with various providers in applications
- If a provider is not “providing” the services that they are supposed to, when a new applicant in that county applies, make additional allowances for a new provider to gain access
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N) Concurrent review timeline:

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O) Source of hospice standards:

- National standards?

P) Revoking / suspension of a CoN:

- What would be those things that would be tied to a revocation / suspension of a CN?
- Misrepresentations in a CN application.
- You said you were going to do some things in your application and you have shown that you are not.
- Instead of revocation, a more legally sound approach could be: If you are not doing what you stated in your application, that should weigh against you in some way when a new applicant comes in.

Q) Others?

- Access issues for specialty care services (ex. Pediatrics).
- Need to look at how HMOs are treated in the methodology.
- Listing of hospice in every county (licensed only list & CoN list)