



Hospice services ~ Issues Outline ~ November 5, 2010
(New discussion from 11/5 is highlighted in "green" below)

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

B) DOH Policy overview:

- Ensure patients have access to high quality, affordable hospice services in a timely fashion.
- Ensure that the viability of existing providers are not undermined by the addition of competing providers.

C) Access to care:

- What is the definition of access?
 - Ability of patient's having access to hospice care within a reasonable amount of time (within 24 or 48 hours).
 - 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.

- Barriers to access:
 - Are there waiting lists in a given community to receive hospice services? If so, this may be an indicator that another provider may be needed.
- Measures:
 - One way to measure if a provider is engaged in public education / outreach is for a provider to show that they have staff that have public awareness duties as part of their official job description. Staff employed to do outreach?
 - A general, clear and simple measure would be to measure “utilization.”
 - Look at performance variations (ranges) within our state? Why? There are providers in certain areas that, for one reason or another, are not meeting the norms. Currently, the rules look at averages, not ranges.
- Approving additional providers:
 - For communities that have only one existing provider, the addition of one more provider raises the community’s awareness of hospice services and encourages both providers to raise the bar on patient care / the way they conduct business.
 - Should we give exceptions for at least two providers in a community?
- There are efficiencies that come with providers that reach a certain size.
- Multiple providers may impact the ability of all providers in a planning area to reach a level of efficiency (due to inequitable referral patterns).

D) Data Sources:

- Should we adjust the rules to utilize the data that is available from CMS?
- CMS cost reports for all patients by agency (organized by Medicare, Medicaid and private – not age-cohorted)
- CMS claims data (aka – standard analytical file; Medicare 65 and older)
- CMS data will not show licensed only hospice patients
- Timing issues with using CMS data
 - cost reports data is available on fiscal years
 - claims data is available on calendar years
 - Data often comes in quarterly batches.
 - Have to determine what data to pull and how to line them up?
- Surveys (including expectations/consequences regarding participation):
 - Numbers can be unintentional skewed.
 - Numbers are only as accurate as the provider who is submitting it
 - Some claim that survey data ranges in accuracy 20% either direction compared to CMS cost report data.
- Survey data elements. Some providers have had difficulties being able to pull out certain DOH data elements from their data information systems. This has made it difficult to collect and respond accurately to some of the survey questions.

- Use the same data elements that the National Hospice & Palliative Care Organization (NHPCO) collects and tracks in its surveys. Request data that providers are currently reporting and are familiar with accessing.
- Consider using NHPCO definitions?
- NHPCO customer satisfaction survey data?
- WSHPCO will organize a sub-group to put together a sample survey template of reliable data and then present this sample at the August 26, 2010 hospice workshop.
- At 8/26/10 meeting, sub-group changed recommendation to: review and validate CMS data to use as a reliable source for methodology. CMS data includes Medicaid data & claims data (claims data may be available at zip code level?)
- Note: this topic will be revisited once a methodology is determined.
- CMS Claims data – gives data on Medicare qualifying participants, typically 65 and older only. This represents 84% of the total hospice population (provider based).
- Option # 1 - Use Medicare claims data for 65 and over and then ignore the under 65 population since reliable data is questionable.
- Option # 2 – Use Medicare cost report data to capture 65 and under. This data is inclusive of all people that agencies provided services to regardless of age. The data is statewide.
- Discussion about using a “Medicare Denominator Data File.” Everyone who received service. The Cost report comes out of this larger file. Death data reported to Medicare by county of residence.
- As of 2008, hospice agencies have been reporting location of service to Medicare.
- Claims data is given by county, Cost report data (limited data set) is given by provider, Denominator file is given by county of residence.
- State death data – 65 and under population, take out accidental deaths and calculate the remainder.
- If using a survey, have CEO / designee attestation that data is accurate.
- Median LOS
- Suggestion: Approach NHPCO and see if they would agree to release their data?

E) Minimum volume standards:

- Ideally, there should be a minimum of 2 providers per county? (Unless a second provider would jeopardize the viability of the established provider). Drawing them down below some number (35?) would jeopardize a provider’s viability.
- Need to be able to address when minimum volume (35?) standards cannot be reached / maintained through an exception process – identifying the specific circumstances where the volume standards would not have to be met.
 - No provider

- Existing provider is providing services in a connecting county and they want to go into that county and the census does not support 35
- 35 by county or service area?
- 35 volume per county or volume per agency?
- Financial feasibility exceptions.
- There is no direct tie of the 35 to financial feasibility in the CN application.
- Instead of using counties, can we use larger planning areas?
- General consensus of an ADC around 35.

F) Capacity issues:

- The common approach is the “franchise” concept whereby providers are allowed to grow into the expanding capacity of their planning area – No caps!
- Should there be a cap on the current capacity of existing providers beyond which there is room for adding additional providers?
- What kind of follow up by DOH will be done when a new provider is approved to ensure that they are providing complete services? – not just targeting specific services.
- At what point does “choice” play into “need?”
- Instead of using a cap, simply demonstrate that there is a need for a new 35 and that a new provider can meet this. Should we encourage the addition of new providers who can demonstrate that they can provide a minimum standard of 35 (or whatever number we choose)?
 - Once all established providers in the planning area are at the minimum volume standard of “35,” additional providers can come in if they can demonstrate that they can meet “35” unmet need.
 - The number of hospice agencies in a community should be determined by how many total projected patient admits, divided by the minimum volume standard of “35” – resulting in the maximum # of agencies that would be approved.

G) Penetration rates:

- Methodology needs to address differences between urban and rural realities.
- 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).
- For the past 10 years, Washington has been in the bottom 10 in terms of length of stay compared to the entire country.
- CMS does not encourage increasing average length of stay.
- Suggestion – The statewide use rate for 65 and under is going to be the same in all planning areas. Projections of people likely to use hospice in future years. Rather than ignore the 65 and under, the smaller use rate is presumed to be relatively normalized across the planning areas for that age population.

- Develop a use rate that would apply to populations under 65 against Medicare total data.
- Consensus - We will use some type of a use rate per thousand. Group was leaning toward a use rate per thousand deaths (as opposed to per general population)
- Suggestion to use a statewide use rate – general support for this.
- Use national data?
- ALOS calculation example – For 2009, what were your total admits? Now forget 2009, what were the days associated with those admits? Now do the math.
- Use rate - Admissions over deaths (09 data)? discharges over deaths (08 data)?
- Death data - WA state vital statistics – 2 year lag time
- If using discharges over deaths, trend the older data – validity test – R square of .7
- Admits over deaths would be using more current data and easier to calculate. CMS Cost Reports - Admits would give statewide data, not by county
- Run scenarios
- Many more people are going to be on Medicare soon, but they're too young and healthy to die. The use rates are going to plummet. The percent of people on Medicare using hospice is going to go down and it will appear that Hospice use is dropping. This means there are many more younger, healthier people on the Medicare rolls. So a use rate that is a percent of Medicare rolls is going to mask what is really happening. As a result, death data winds up being the better target group.

H) Population projection sources:

- Should there be a difference between urban and rural projection methods?
- Apply appropriate trending capabilities to the methodology
- OFM medium series & most recent data that is available at the time the methodology is prepared and posted
- Claritas population data if planning area is smaller than county level
- Trendlines correct themselves pretty quickly. We could look at a minimum of five years history, and look out 3 into the future at the furthest, by the end of the third year of operation here's what we would expect – target year. Perform a rate history and then decide whether to run averages or trendlines. Exponential vs linear regression? Closest fit for R squared. Are trendlines going to be more predictive? Trendlines probably make more sense.

I) Planning horizon:

- Single planning horizon that would be used for both need and financial projections? [Example: 2010 submission of application; CN decision released in 2011; Methodology based on 2007, 2008, & 2009 data (2009 is base year); Four year projection is 2014.]

J) Planning areas:

- Distinguish between service area and planning area?
- If applicant not intending to provide services in the entire county, must have cooperative agreements with another agency to serve the remaining portion of county. [submit copy of cooperative agreement in application?]
- Determination of planning area will be based, in part, on data sources.

K) Age & diagnosis cohorting:

- Methodology-currently has four sub-groups, then step 4 combines them; is this still what we should do?
- Methodology-collapse cancer/non-cancer?
- Do we need to identify cancer vs non-cancer? Cost report will not break these down. This distinction is not as important as it was when the rules were first adopted in 2003.

L) Exceptions:

- Exception for specialty services (ie, pediatric)?
- No provider in the planning area.

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
- Existing quality provider that wants to expand into adjacent planning area where there is demonstrated need should be given preference? [CN to obtain AAG review on this concept]

N) Concurrent review timeline:

- Needs to match data sources, including death data
- Time for CN to complete methodology and post on website before letters of intent are due

O) 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.

P) 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)