A meeting regarding the Certificate of Need (CoN) hospice services rules convened on October 06, 2016. The meeting was held at the Department of Health, 111 Israel Road SE, in Town Center 2, Conference Room 148, Tumwater, WA 98501.

PRESENT: Barb Hansen, WSHPCO
Leslie Emerick, WSHPCO
Dixie Randall, WSHPCO (by telephone)
Chris McFaul, Horizon Hospice
Gina Drummond, Hospice of Spokane
April Hansen, Hospice of Spokane
Nancy Field, Field Associates
Stephen Pentz, Providence
Frank Fox, Providence
Catherine Kozar, Providence
Lori Aoyama, HFPD
Mark Rake-Marona, Franciscan Hospice
Gary Castillo, Chaplaincy Health Care
Candace Cheney, Assured/LHC
Kathy Katzenberger, Evergreen Hospice

STAFF PRESENT: Nancy Tyson, Executive Director
Kathy Hoffman, Policy Analyst
Beth Harlow, Analyst

1:10: Meeting began with introductions, agenda overview.

1. **Presentation by Continuum Care Hospice: Washington State Hospice Underutilization in the African American Community**

   - Presenters: Cristi Keith, Administrator and Gail Ferguson, RN
   - Christie began with a personal introduction; described her role and experience in hospice care.
   - Provided background of core Medicare hospice benefit, described what Continuum’s program does to provide the benefit. Continuum is centralized in California. Operates as freestanding hospice, but partners with local hospitals.
• Hospice utilization is growing nationally; asserts that there is room for growth. Average lifespan of a hospice patient is 29 days longer than someone who is not pursuing hospice at end of life.
• Brief statistical discussion. Nationally, in 2013, 45% of Medicare beneficiaries were dying on hospice. 47% of the white beneficiaries are dying on hospice; 35% of the African American beneficiaries were dying on hospice. Asserts that the gap is not narrowing between groups.
• Hospice utilization between white and African American groups is different; benefit is being used, but there is still disparity (nationally).
• In WA, 43% of Medicare beneficiaries died on hospice; 44% were white, 32% were African American. Data suggests that trending is going in the wrong direction.
• Comparing national statistics to Washington data, Continuum would like to see the numbers go us to reduce disparity.
• Statistics are based off utilization and total population as opposed to days or admissions. Length of stay for whites vs. African Americans? For their agency, shorter length of stay, based on their specific findings. Average length of stay is 45; median is 17.
• Multiple reasons why African American population are less likely to use hospice benefit, even though they suffer from inequitable rates of the most common diagnosis (cancer, heart disease and stroke) and one would expect them to be over-represented, but they aren’t. As utilization declines, Continuum is working toward remedying situation.
• Describes clinical staff and experience levels of that staff.
• African American population approaches healthcare and services in a way that does not fully utilize benefits. Asserts that Continuum is seeing results in an area where there’s a big gap in California. 4.7% in the past vs 11% currently. Asserts that exceptions in rule language will help patients fully use benefits.
• Gail Ferguson begins her portion of the presentation. Describes specific program components. Notes that Continuum has found that patients really don’t want to be in the hospital, ER, etc. Prefer to be at home, but there are trust issues with use of healthcare services and providers. Healthcare systems and those who represent them are generally associated with government, heightening levels of distrust.
• Continuum has engaged in patient education - Gail reaches out to communities, health care providers, etc. to bridge and close trust gap. Wants to build trust before a time of individual patient and/or family crisis. Describes working with families and discussing access and crisis issues. Inadequate insurance, lack of advance directives, lack of diversity in staffing (clinical and otherwise). Gail tries to reach out and establish common interests and relationships; clinicians and caregivers.
• Solutions: move forward. Increase access to hospice for African Americans. Will help to reduce hospital costs, strengthen relationships and increase use of benefit.
• Believes exception is needed to address these issues, regardless of race. Reduce gap of accessibility to all races. Need to create access, understand cultures.
• Provided several handouts - will provide in e-copy as well.

2. Exception Language Discussion

• No proposed exception language was received from or proposed by any of the workgroup members. Department shared proposed language developed in late August 2016 as a starting point.
• Nancy F. objects to the word “circumstances,” believes should not be a specific demographic, indicates that it is troubling to her that down the line that can be a group
located in OFM data. Asserts that the phrase group settled on is “special circumstances” describing a situation not being addressed rather than a population not being served.

- Beth recalled that look back to OFM data was used in the context of pediatrics only.
- Further discussion of special circumstances vs. an identifiable group of people.
- Group agrees that at no point did the group decide to use the phrase “special circumstances.” This is confirmed by way of the consensus document.
- Frank: The difficulty with exceptions is that the department faces difficulty being transparent and replicable with the rule; likes the words “specific population” because that does tie to something. If group make it more generic than that, then the department does not have good direction.
- Nancy F. asserts death with dignity argument. Asserts that “Jan said let’s not be specific, let’s be vague; now we’ve gotten specific again but inappropriately specific.”
- Steve: Consider another alternative: under existing CoN regulations, one has the ability to argue for special circumstances. The need statutory provisions say that first, the department determines whether the population served or to be served has a need for the service, and second, whether existing providers are available and accessible to meet that need. One option is to not have exceptional circumstances language. One could make an argument that this satisfies the need for an exception. Looked at the consensus doc, and no, we did not agree on specific language; rather, we agreed conceptually that exceptions were preferred, and pediatrics were identified as important. We plugged in language from Florida as a starting point. Leave the regulation as it is, it’s broad.
- Many in group agree that striking the exception language might be preferable since there are already mechanisms in rule, including need criteria that address exceptions. (52:27)
- Discussion of prior unsupported assertion that hospices are penalizing staff or not offering patients their opportunity to participate in death with dignity. Evidence to support assertion is: “All I know is that an employee has filed a complaint” and “We also have statements in the newspaper.” Copies of complaint and statements in newspaper are requested.
- Language reviewed in current WAC. (56:38) 246-310-210 - Group reviews WAC together. Offers a two-part opportunity. Concerns discussed that exceptions may complicate existing WAC.
- Show of hands: all but one attendee recommend striking proposed subsection 12.
- Candace asks about the frequency of exceptions. General response: rarely.
- Discussion turned other need criteria, including ADC. Group redirects focus to discussion of exceptions.

3. WSHPCO Position Paper re ADC

- Nancy F. objects to WSHPCO letter, indicating that it should be treated as public comment. Objects to this being on the agenda. Asserts that letter was not distributed to group and was not on agenda.¹
- Leslie: To say that a public comment should be rejected out of hand is not correct or acceptable. This is a public process. We are in the developmental stage of this rule making process and public comment is welcome at workgroup meetings.
- Kathy/Steve: Reiteration - it’s a DRAFT regulation. The department will make the final decision as to rule and policy.
- Gina (on behalf of WSHPCO): Don’t have a formal presentation. Felt concerned about viability, and what constituted a viable threshold. Break even does not seem viable. Concern that an ADC of 25 would struggle; and that patients could receive marginal care. Could impact existing providers in terms of stability in some service areas, there
would be room for multiple providers. How would financial feasibility be evaluated? Rule says that has to be established by the third year of operation. Department has denied projects based on financial feasibility even when there was a need because if something happened, got up and going and then had to close, what happens to patients? Want to make sure threshold is reasonable? In a large community, that seems small, so before we rush forward with 35/25, we want to make sure we have number that is financially feasible and will allow an agency to be successful.

- Frank: Financial feasibility is more likely to be met at 35 than at 25; that's clearly true. (1:15:34)
- Group discussion: Hard to take care of people in low thirties; 50 was good for them; 25 would be hard and could not give care. Practical perspective.
- Providers in workgroup share experiences regarding quality of care at reduced ADC. Can't imagine operating with a consensus of 25. Burnout, patients on higher levels and volumes of medication, need a way to spread costs. Manpower is going to be an increased cost.
- Nancy F. points to MedPac report and suggests that providers now object to lower ADC since this will allow market entry. Suggests that group move ADC to financial feasibility.
- Group: Maybe consider two different numbers. Not something we can't re-discuss. Providers offer ideas based on experience. Group would like to think about this. Group questions validity of one page presented out of a 35 page report (MedPac).
- Mark: Big difference between service delivery and size. Want to see what is being provided. That's the problem we had when doing analysis; no idea of depth and breadth of services or quality; entire population was not represented. CMS reports are very different than what Nancy F. reports.
- Department will consider WSHPRO request.
- Quick group vote: ADC of 25 or 35? Most prefer 35.
- Does the group want to open up the question of whether we really want to move to 25?
- Candace indicates she didn’t vote, not sure what to go with. 25 is a challenge. Would it be possible to set a threshold for startup with trust we're going to grow? Can we use a different number? Would that be a compromise with a chance for entrance?
- Threshold is reasonable for existing providers as well. What number will be best to create access?
- Consider a different number for rural vs. urban. 35 might not be the number; maybe goal would be somewhere in the middle.
- Does OFM define rural vs urban? Pat Justus may be able to help with statistics - what would be a good cutoff? Anything under 25 for rural is not going to be financially feasible.
- Barb finds and reads the definition of rural from OFM. Can be located at [www.ofm.wa.gov/pop/popden/rural.asp](http://www.ofm.wa.gov/pop/popden/rural.asp)
- Nancy F. asserts that the group should use her interpretation hospital occupancy rates for comparing ADC and the number of people who are “turned away from hospice” in WA every year. “We’re letting 35 people every day of the year go without care.”
- Group, generally: imperfect comparison.
- Chris: There is a world of difference between turning away and what we’re suggesting the numbers indicate for hospice. Has anyone that has ever worked in a hospice here said no to anyone? (Response: no). It’s a huge part of the point here. Not the same staffing in hospice. We’ve served 95 people in late December of last year, and we served 142 very recently. We’ve said no to zero people. To suggest that this methodology indicates that we are turning people away, it’s night and day. There is no comparison between hospitals and hospice.
• Gina: For states with higher penetration rates, keep in mind that some of the small organizations are possibly admitting people who are not appropriate for hospice because they are trying to keep their doors open. What we do in WA is take the states average and compare it to a county’s average. Nancy F. proposes that more organizations are better, and big organizations are not good.
• Nancy F.: WA has horrible hospice care; this chart says WA has worst record of visits in the last two days of life.
• Steve: If you read the *entire* report that Nancy (F.) continually cites to, not just the chart she keeps referring to, the first page reads, this article does not conclude that size has anything to do with the amount of visits in the last five days of life.
• Kathy: Need to move on; department will consider this discussion and these arguments.

4. Average Length of Stay Presentation – Nancy Field

• This is about where we get the CMA ALOS that is part of the methodology. Matter of sourcing that CMS number. That just got harder because the sources have been changing.
• For the first ten years, we didn’t have CMS LOS. Department didn’t access cost reports or CMS data. Department used survey. Methodology divided total days by admissions.
• A new source was found, report displayed on last two pages of handout, showing days per patient per year. Nancy F. was concerned about this at the time because instead of using deaths and admissions it was using patients and wasn’t clear to her what was a patient and what was an admission.
• Has come to a head now because they (CMS?) are not publishing the table anymore, and we need a CMS ALOS according to the rule. Where do we get that now?
• Contacted someone at CMS. Beth and Nancy F. contacted the same people at CMS. Wrote an email to “us” (Note: non-original email content cut and pasted into handout is provided, and addressed only to Nancy Field; department not copied or otherwise included in email string). The ALOS is key.
• CMS contact discusses differences in past table and current table in cut and pasted email. Language used is “single episode,” and “unduplicated episode.”
• Currently, the total number of days for the year are being divided by every person who had any care for that year. If length of stay is 60 days, you’re going to have a lot of people who were seen in the prior year and this year, or this year and the next year. So, the longer the length of stay, the more people you’ll have counted twice. (Refers to graph in handout, describes handout).
• Asserts that CMS contacts said, don’t use the current table because it understates the length of stay because we’re throwing people in from other years when we divide the days by “patient” because patient means anyone who had any service that year and the longer your length of stay the worse it gets.
• As a result, this wasn’t clear the way the rule was written. It is right, it’s just not clear. Proposes language changes; contends that this changes no standards, but establishes “where in the bureaucracy to find these numbers.”
• Recommends that group accept her language wholesale; that department start accessing the CMS episode ALOS that was offered by CMS. Further indicates that CMS has offered to run this for WA every year, data source is Medicare, based on individual patients and their experience of care. Department must then make data public, even though may not be publicly available.
• Beth and April discuss data sources; NHPCO sources. Days of care over any year. Would be the same.
• Mark: Not clear if this would be same. Disregards patients that are currently on. This is saying an “episode” could be a live patient.
• Frank: Prefer episodic lengths of stay with unduplicated counts. Appears current number that we’re using is not giving us that.
• Beth: Specific question about when data would be available. Unanswered.
• Department provides feedback. Proposed language problematic, uses words that are not defined in rule (i.e. “complete episode,” “individual entire stay,” “recognizing,” patient episode of care,” etc.). Refers back to definitions as opposed to WAC. Also suggests specific data elements that may change over time. Department requests copy of original email string from CMS as opposed a cut and pasted version provided in handout. Questions to Beth about operationalization of publication deadlines proposed, specifically absolute date. Department does not put data publication dates or deadlines in rule. Question about survey: proposing to not rely on hospice survey?
• Nancy F.: Jan something about kidney dialysis – “we’re not supposed to say CMS data, we’re supposed to say reported to CMS”
• Kathy: We’re not proposing that in the rule set, and that’s not what was proposed in the kidney dialysis rules. The idea is to remove specificity of exact data elements to ensure longevity in the rule.
• Beth recommends reaching out to CMS with additional questions. She can make sure contacts go out to group. They are data custodians, so great resource.
• Department will consider proposal and associated discussion.

5. Conclusion:

• Next meeting to be held first part of January to accommodate holiday schedules and start of legislative session.
• Providence has some additional issues they’d like to discuss at the next meeting. Not prepared to discuss today. May be able to provide an issue paper between this meeting and next. Target for end of November.
• Nancy F. wants to talk about sources at next meeting.
• Next meeting January 10.

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1 Agenda and associated meeting materials, including the WSHPCO letter discussed at this meeting were provided to all members via email on September 30, 2016.
Good morning,

Attached are a meeting agenda and the materials I’ve received so far for presentation at the upcoming hospice workgroup meeting. I will provide additional materials when they become available.

The agenda is very full. I have structured our time as efficiently as possible, although I recognize some of the topics may conclude earlier or run longer than others.

No comments, other than the attached WSHPRO letter, were received by the department regarding the last proposed rule set sent to the workgroup in August.

Please contact me with any questions you may have. See you next week.

Sincerely,

Kathy Hoffman
Policy Analyst
Washington State Department of Health/Office of the Assistant Secretary
360-236-2979
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Kathy Hoffman
Policy Analyst
Washington State Department of Health/Office of the Assistant Secretary
360-236-2979
Certificate of Need – Hospice Rules Meeting

Town Center 2 – 111 Israel Road SE – Tumwater WA 98501
Room 145
October 6, 2016 – 1:00pm – 4:00pm*

Agenda:

1. 1:00am – Welcome and Introductions. Purpose and goals for workshop – Kathy Hoffman

2. 1:05pm – Presentation: Washington State Hospice Underutilization in the African American Community. Cristi Keith and Gail Ferguson, RN, Continuum Care

3. 1:45pm – Discussion: Exception language

4. 2:00pm – Discussion: WSHPRO position paper re ADC

5. 2:55pm – Presentation – ALOS: Nancy Field

6. 3:55: Conclusion: roundtable, next steps – Kathy Hoffman

7. 4:00pm - Adjourn*

*Meeting may adjourn earlier or later than scheduled.
September 9, 2016

Dear Department of Health Certificate of Need Program,

This letter is one of support for much of the work that has been accomplished in the Certificate of Need Task force this year. We, the Board of WSHPCO, would also like to share our concerns with one of the proposed changes to the rule.

It is our understanding, that the C of N task force was convened to address ambiguities in the existing methodology used to determine need in the state of Washington for new Hospice providers. The task force agreed that there were some issues that needed clarification. There was no charge made to the group, to change drastically, the methodology or the outcome of the use of the methodology. There was no consensus that the rule was too restrictive nor that it was too inclusive.

It is our understanding that the following areas were discussed and adjustments were proposed accordingly. The projection horizon was clarified (when it starts and how far it projects forward). Discussion took place regarding which data set should be used (survey vs CMS). A proposed adjustment was made in the methodology that applies population growth rates, of two distinct groups of people (under 65 and over 65 years of age) to each of these groups. Other topics were discussed at length (programs that don’t serve children, programs that serve partial counties etc.)

There was also discussion around what volume of patients would be required to support a viable Hospice agency. The number 25 was proposed (vs the existing threshold of 35 patients). It is the consensus of the WSHPCO Board that this threshold is not adequate to support a viable Hospice agency. With the regulatory mandates that have come into play in the past few years, coupled with rising health care costs (manpower, drugs, durable medical equipment) it is our position that an agency this size would struggle. An agency this size (census of 25 patients) would have difficulty breaking even let alone producing a slim margin. When an agency is faced with financial challenges, patients and families are at potential risk for receiving marginal care; not the standard of care one has come to expect in the state of Washington. Destabilization of existing providers is also a concern to us as some counties could show need of not one but several providers if the proposed threshold of 35 is changed to 25. It is our opinion that the threshold (currently 35 in our existing methodology) should not be changed to 25.

We also have concerns that there is growing demand for Hospice care without any corresponding growth in the capacity of existing providers, in the current methodology. We feel that Washington hospice providers have repeatedly demonstrated capacity to grow along with need. We look forward to further discussion on this.

Thank you for this opportunity to share our concerns.

Sincerely,

[Signature]

Dixie Randall, Chair, WSHPCO Board of Directors