Certificate of Need – Hospice Services
Notes for Stakeholder Meeting – January 10, 2017

WAC 246-310-290

9:05 AM – Meeting opened with introductions, agenda overview,

1. **Presentation – Brief Overview of Rulemaking Process**

   - **Kathy** opened with rulemaking presentation. Please refer to PowerPoint presentation attached.
   - Discussed where the group was currently positioned in the rulemaking process, still in the developmental phase but moving toward CR 102 phase.
   - Explained statutory basis for rulemaking process, differences between phases and work associated with each phase. Described public hearing, formal comment period and statutory authority for each phase.

2. **Presentation and Discussion: Providence Issue Analysis: Steve, Frank, Catherine**

   - **Steve**: Four issues for consideration today; Technical issues (1 and 2) – Frank; issues 3 and 4 – Steve
   - **Frank**: Issue 1: recommend setting the planning horizon two years as opposed to three years; effect of this based on how the methodology is actually used by the dept is probably negligible based on how the methodology is used by the department. Longer planning horizons used for projects with higher capital costs; hospice services typically have lower capital costs, providers need less time to recover from fixed investments and capital. That’s the theoretical rationale for longer vs. shorter planning horizons. Recommend that terms be defined, and in definition section, that base year be defined as the year in which the hospice application is filed and then project year be defined as the second year after the base year. Compared to what we do now, for example, in the sample methodology, if we were using 2014 data, 2015 is called the base year and then 2018 is called the projection year and neither one of those terms were defined but instead, we’re recommending that, for example, if you filed in 2017, that would be the base year and then the projection year would be two years thereafter or 2019, so we’re recommending that a standard set of definitions be used.
   - Quick discussion of order of presentation; decide to go through all Providence issues, then discuss.
   - **Frank**: Issue 2: More complex, but rationale is that is current methodology, capacity is defined as the most recent three years of actual data on admissions. What we’re proposing is that rather than holding hospice capacity constant as the rules currently dictate, we allow the capacity to be defined based on the most recent three years of overall average annual growth in provider admissions across all counties. We think that looking at it in aggregate would be more reasonable and just by way of analysis, if we were to look at 2012, 2013, 2014 data, admissions by age cohort would show that the 0-64 admissions actually fell by a little over 4% on average per year, and admissions for the 65+ cohort actually went up by a little over 4 percentage points per year, so on average across both of those age cohorts the average annual growth would have been 3%. So, we’re recommending that rather than holding capacity constant as the methodology does right now, in the step of the methodology where you compare estimated gross need in admissions, you compare that to an estimate of provider capacity using the state average, and that capacity figure would be extrapolated forward at the rate of growth of the most prior three years of admissions. What that does is appropriately reflect the ease and the low cost in which existing hospice program providers can flex staffing because that really is the resource that hospice providers utilize and it seems more reasonable and efficient to allow that to flex based on the low cost of changing the resource to accommodate changes in admissions. You do see some amount of volatility, so this would be a rolling three-year average, it would not be constant. We think that’s a better reflection of the market circumstances.
• **Steve:** Issue 3: Whether the dept should maintain a concurrent review cycle for hospice applications. As we all know, the volume of hospice applications is not great, and part of that is because the way the need methodology has played out over the years there’s not much need shown, but this is not a service like kidney dialysis where you have for-profit providers primarily with large concurrent reviews throughout the year. Nursing home industry was similar at one time. We think doing this would give more flexibility to someone who wants to enter the market to be able to file an application whenever they wish to. Concurrent review is not mandated in the statute or the CoN regulations for hospice applications, and our conclusion was that given the small number of applications, and we believe that trend will continue even with the changes to the methodology, we believe that it’s more appropriate to have the concurrent review process removed from the regulation, and if two people decide to go into a particular area at the same time, the dept still has the ability to perform a comparative review of those two applicants. Given past history and future of hospice growth, we believe concurrent review cycle is not needed.

• **Steve:** Issue 4: Good time to update application; separate process maybe? Have interaction between dept and providers reflective of current industry. Propose working collaboratively to develop a model hospice application. Does not have to occur during this rulemaking; could occur outside of it.

• **Discussion (Issue 1):** Correct to say that for existing providers to adapt really is a matter of having staff and thinking of all the things that go into expanding capacity...staffing, staffing availability are the primary drivers. So much can and does happen in a three year period. A totally new provider (hire staff, develop marketing) would need that three years to establish themselves; two years would serve those of us that are already here, but may be hard for those who are brand new. Seem to be two separate questions: what does the hospice need methodology define as the projection year and what does the over financial feasibility analysis require. We’re talking about the projection year for hospice to determine whether there is need, but the department looks at, in the financial feasibility criteria, three years post-implementation, so they are really different.

• **Jan:** Here’s why we use three as opposed to two years: you do have the base year from whenever the application is submitted. It takes approximately a year to go through concurrent review and then the applicant has two years to implement the project. So by the time you get through the review, you’ve eaten up one year of the projection. We look at the outside date – two years – to get it started. Hospitals have different projections for different reasoning.

• **Base year is not currently defined; base year is the year after actuals. In our case, 2014 was the actuals, 2015 was the base year and then go three years out (2018) so actually same effect. Defining base year would be appropriate.**

• **Clarifying discussion. Base year would be the most recent year of actuals (2015); application year would be 2016; (Tape 1, 00:29:40 death data discussion)**

• **Final death data didn’t come out until letters of intent; we know that puts everybody in a bad place.**

• **Should discuss now; if base year is last year data is available, but applications are submitted later, we have a concern about the lag time between when data is available and when the application is submitted. Works regardless of when the data is submitted. So, base year is the last year of actual data, and then the projection year is three years thereafter. Use an actual date example in rule – very helpful.**

• **Kathy** will send out timeline for everyone to review once program staff have confirmed.

• **State growth vs. county growth? Could do it at a more granular level, but there is a significant amount of variability particularly in counties where there are few providers. In larger counties, not much variability.**

• **Lori** has slides on capacity too. What would starting point be?

• **Frank:** Three years of most recent actuals, and a rolling three year average. You would look at overall admissions across the two age cohorts and aggregate them together and then calculate.

• **Discussion of what growing need means. Methodology currently grows it by population but holding capacity flat. So if population is growing, why isn’t capacity moving?**
Jan says holding existing capacity steady is appropriate because it allows for the potential for new providers to come in to provide services (Tape 1, 00:37:23). We’re looking at not creating barriers, we understand that adding staff helps to create capacity but we also want to encourage new providers as well. Most methodologies assume that new providers will take up the capacity that’s there, but in reality that’s not going to happen overnight.

In that context, why would we chose average instead of most recent actual? That’s uncharacteristic of other methodologies. When we started this process, we talked about what we were trying to accomplish. The idea that we want to allow for new providers – has that been discussed before? Thought CoN was to match provider population to need for service, not new/old providers, but about trying to match the ultimate service need with providers, not distinguishing between new and existing. Is it misquoting to say this is not the certificate of want but certificate of need?

Bart: The concept of adding providers is the only thing CoN can do. The only thing that CoN can do to improve penetration to hospice care is to add new providers (00:42:09). That might mean that an existing provider is moving into a new county to serve, and to that county they would be new. There is nothing else CoN can do other than add new providers. We’ve had this discussion. Agree with Jan fundamentally, that when we project need it does two things: in those methodologies where there is a (unintelligible) restriction, an existing provider or a new provider competes for that physical projected need. In cases where there isn’t any constraint, it is adding a new provider that addresses need. If there is unmet need in a county, it means that the existing providers in that county have not, for whatever reason, addressed or expanded services to that population because there is no barrier for them to do that. So the logical outcome is that we’ll add a new provider.

Frank: Not necessarily logical but trying to balance a number of competing priorities, one is choice, the other is access and efficiency.

CoN does not control those other behaviors of providers, such as the level of outreach. CoN has no mechanisms to do that. The only thing CoN can do is approve another provider. But by holding the capacity of current providers steady while growing the need based on population you are saying that the providers should meet the future need now before it is even there – it is artificial. Use an average.

Frank: But isn’t it artificial to inflate demand but not supply? Because the methodology does that.

Bart: One is based on some objective observation of population, projecting the expected demand based on some observable, predictable change. The one that you are talking about doing now is I observed this organization change, and we can assume that that change is likely to go into the future, and so I think it’s less predictable to try to start predicting what the behavior of a provider is, do they want to take on that additional and is there enough demand for them to take on additional staff.

If inflating it makes sense, then it’s presumed that there is always growth, unless you are projecting that there will be less (aggregate provider population is going down for some reason) safe to presume that you can use the last year and it will be most reflective of what there is really is. More comfortable with that than the average idea. Using statewide growth across all counties is something that we’d want to consider (Tape 1, 00:49:44).

Jan: We would be using the last years actual than the three year average. (Tape 1, 00:50:47)

Won’t try to inflate that by some statewide rate. If you’ve done an analysis across the counties and found that the lowest growing and highest growing hospices don’t show much difference, then using a statewide average makes sense. If variance between areas is nominal, then using an average statewide growth rate makes sense. But if you want to have a defensible reason why we did this, if you had high growth rates in King County why wouldn’t you grow the capacity of those providers by the reflected rate in King County it by what is actually happening in that county; the same thing with counties with low growth counties. If looking for precision, do it at the county level.

Chris: As far as observable and predictable, if we say population trend is observable and predictable for the last few years, it seems to me that we can say capacity has the same capability to grow and trend in
the same – neither one is certain but they both have predictability and durability, and history is going to help predict the future. Secondly, agree with state level being more smooth, but I agree with the granularity of the county level. Seems to me that an underperforming county could hide if you had an artificial statewide growth rate. Makes more sense to have individual counties.

- Think about constraining growth rates that they are non-negative. Some counties are experiencing population reduction.
- Philosophical discussion: What is capacity really telling us? Originally we said let’s average three years, the reason you had a decline is something other than a business motive. To look at capacity and say, what decisions have you made to reduce your capacity, even if the population remained at the current growth rate? The demand for hospice should not have changed, but there’s less provision of hospice services.
- Not reasonable for us to cherry-pick.
- Gina clarifies current practice as to capacity; Jan notes that currently department does not include a growth rate for existing providers. Held constant in what you have been providing at the average capacity of the three years at the individual county level. For future growth of hospice services in a planning area, you get to assume that what you’ve been doing for the past three years is what you’ll do in the future – consistent with other methodologies. Either the most recent year reported is capacity, don’t use a three year average.
- This and home health are unique in that neither are bricks and mortar.
- Steve: Need methodology should be reflective of service provided, so need methodology should be reflective of how hospices are staffed. Second, not aware of anything in CoN statute or judicial decision that says the purpose of CoN law is to make sure that new providers enter the market. Made many arguments that competition should be considered, and not prevailed in Supreme Court. We want methodology to be reflective of how hospices actually work.
- Bart: In non-bricks and mortar cases, if you project that there is an unmet need, how does CoN address the need without recognizing that the tool they have available is to add a new provider?
- Mark: But you should be evaluating whether the existing providers have demonstrated the ability to meet that capacity and in many cases, exceed that capacity for the prior three years, and holding them flat while growing need. Why not consider expanded capacity over that three years?
- Steve: go back to RCW 70.38.115(h): Criteria, efficiencies. Not saying that existing providers should be able to expand without limits, we’re asking to be evaluated based on actual data.
- What would carrying data forward two years do? Frank: It only matters in counties where we’ve seen significant population growth because hospice admits follow population. So, in counties where you see the age 65+ cohort grow 5% per year, you’ll see hospice admits growing in a comparable rate. More rural counties, where that age cohort hasn’t grown much, you’ll see little growth. You’ll see significant difference.
- Take total admits regardless of age and do an analysis. If they are showing grown, could be explained by one population growing faster than ever. (Tape 1 01:09:17). No one at table wants to create barriers.
- Steve: To summarize, agree with Bart that capacity adjustment would be appropriate if we look at last year of actual data on a county basis. And the question is how to articulate that in the rule. Also agreed that using the last year of actuals at the county level for hospice admits can be extrapolated forward at the average annual growth of the most recent 3 years admits in that same county.
- Jan: We need to run the methodology and see what we come up with. Really concerned if that shows a reduction in need because we know that in some counties, consistent with current rule, is that you have a projection one year, and you don’t have a projection in other years, so what you have is a lock on the market for all of them and only in rare instances can someone apply when there is a projected need. Don’t want to see that happen.
- Kathy: What I’m hearing is that we want to test what’s been proposed.
• **Mark:** Be clear with what we’re testing. I’ve heard most recent year, period. Then I heard that the recent year would be projected forward with no adjustment, and then I thought I heard from Frank that you take the most recent year by the county’s growth or decline rate that is projected forward.

• **Frank:** Test both.

• **Beth:** Can you provide a model?

• **Frank:** Will work with Beth.

• Broke up age cohort population drivers in the methodology. That alone caused us to move from a net need in the prior methodology to around three hospices to a net need methodology of seventeen. And that seems tremendously inflationary. What is being proposed here is taking that number seventeen down to maybe fifteen or so. The net effect has been a very large increase of need for new hospice agencies. Letting capacity float is a reasonable option.

• **Candace:** Think about rural America. Would love growth; but as a consumer, I’d rather have another option available to me. Don’t want protectionism. Should we add this to rule?

• **Steve:** Methodology should be reflective. Let’s run the numbers, test and see how it works. Need to figure out at the end of all this the rural vs urban interpretation.

• Prefer choice.

**BREAK**

3. **HFPD Presentation – Lori**

• **Lori/Mark:** The way the methodology works now, we’ve increased the need. Changing need methodology really changes need in counties where 65+ population is projected to grow. If we’re going to make more need, should we balance the capacity issue? Another way to look at it is that the need was always there because the 65 and older population was going faster than we were accounting for in methodology. Now that we’ve done that, have to give some benefit to existing providers that have also grown to meet that need, to a certain extent.

• **Frank:** And what we’ve suggested will move toward that direction. Not sure that it will offset it. Does not fully adjust but splitting up the age cohorts really increased the demand.

• **Mark:** That demand was there all along.

• **Lori:** Will talk about ADC of 25. HFPD has not been able to replicate ADC data and the way the methodology (first few steps) really increases need, at the same time, why would we reduce the threshold to gain entry – might be overstating net need. Think in an urban market, from what I understand from providers, does not seem viable, seems like it might be compromising, actually. Changing steps 1 – 4 in King County, just comparing the current methodology and proposed is about 750 more patients, just by growing age cohorts – huge difference. Maybe the current methodology understates need while the new methodology overstates need. Do we want to reduce the threshold, then, to get in without really understanding what the consequences are, particularly in urban markets where we already have choice? Describes examples in slides. Meaningful services are included in services, not just clinical staff – can do that if you are in a large provider. But small providers could be challenged to provide the same services. Might not have the same level of programming. In an urban market, you’d want everyone to be able to provide these services. Maybe different thresholds between urban and rural. Providers indicate that ADC of 25 would be challenging – hard to be viable. Could not provide as many services. If you have choice, if ADC reduced to 25, what do people in planning area get by bringing in new providers?

• **Steve:** This is helpful. Confirms what was heard at last meeting – if we listen to providers, this confirms what providers said. We’ve voted on this.

• **Jan:** Understand that group would like to go back to 35; can’t guarantee that we’re going to go back to that. The agency ultimately has the decision authority on this, but not sure that we’re going to agree to go back to 35. Again, for some of the same reasons that we discussed earlier, including the impact that had on the previous methodology. We will take this into consideration.

• **Lori:** With current methodology we’ve increased the need.
• **Discussion**: Providers discuss 25 vs 35. Resources, financial investments. Discussion of how 24 came about – find information that shows when agency is viable. Our research (Frank and Mark) didn’t show anything about the programs. 25 came about because of the analysis done. Through discourse in group, that number probably didn’t meet a lot of validity tests, holding on to 25 seems, in light of quality discussion, seems like we’re holding on the analysis of 25.

• **Chris**: What Gina said about the pediatric care/cost. Also think about staffing levels and what happens – stress. (Tape 1:01:36:27) You’ll have turnover; staff working constantly. That is underappreciated. Blood transfusions, radiation therapy, tube feeding – not all hospices cover these things. Hospice organizations focused on survival won’t make these choices. Unless you are a provider, the choices hospices make to survive – level of care – is reduced when trying to survive. When a hospice grows, the services increase. Increased regulation over the years increase the cost of hospice care. Financial pressures are hard, but so are philosophical issues. Life-prolonging and palliative services have changed over time; now services once considered life prolonging are considered palliative and hospices are expected to provide those services. Can’t provide those services if all that an agency is focused on is survival. These services help patients and families.

• **Lori**: Reading slide: If we keep lower threshold, consider exception language. Burden would be on applicant to demonstrate need outside of methodology or minimum ADC. But would not be norm; would be exception to counter-balance keeping ADC at 35 or some other minimum threshold number.

• **Frank**: Has tested changing age cohort in current need methodology, resulting need from two or three to roughly seventeen, and that’s with an ADC of 25. Change the ADC to 35, and it changes that net need of 17 down to about 13. So it does take the net need and move it down.

• **Jan**: Will take a look. Have other suggested changes department would like to look at.

• **Lori**: Returns to slides, discussion of capacity (which group has already had today).

4. **Exception Language Follow Up**

• **Lori**: Believe it’s important for an applicant to have the opportunity to put forth an argument for exception. Burden on applicant to make argument for an exception. Exists in other CoN rules. Believes Jan mentioned exception language needs to be in rules. Dialysis exception language sets high bar, but exceptions need to be in rule. Before we discussed relying on 246-310-210, but we find that is not sufficient for the exception language, and we need to have exception language in the rule.

• **Frank**: But in dialysis, bar is so high the department has never approved it.

• **Lori/Jan**: Department has approved exceptions dialysis before (Gig Harbor, Enumclaw) Jan describes circumstances related to granting of these two exceptions.

• **Jan**: I think it is advantageous to have some hospice exception language. Needs to be high bar with some parameters around it.

• **Steve**: Discussed this at last meeting, and group voted it was not needed with the exception of one vote. Under the CoN need criteria regulations which reflect the statute, the question is, does the population served or to be served have a need for the service, and are existing services available and accessible. Seems to us that with that language, someone can come in and make that argument that the existing services are not accessible for their, let me use the words, “special population” and that therefore, even though there might not be a numerical need, the department has the authority under those two criteria to approve their application. Are you saying that the department under those two criteria doesn’t have the authority to grant their application because there is no “numeric need” in that county?

• **Jan**: Once we have developed a set of rules for evaluating a particular type of project, if they don’t explicitly identify exception language, it has not been looked upon favorably by the health law judges that we are granting exceptions to it. And so, we have learned from that and tried to incorporate, if we are looking at having to have some exception language, what are the parameters to have an exception when
there is no numeric need associated with that. That’s the basis by which we’re looking at potentially including some exception language.

- **Steve**: It was voted at the last meeting, although that does not bind the department. Are you saying that the language that is proposed in the rule right now is the language the department is happy with that a specific population is not being served? Mind you, the source of that language is a Florida regulation.

- **Jan**: I understand that. We had the language in there because no one offered any other language and we needed something to start a discussion.

- **Steve**: Which is my next point. In June, Nancy Field and Jody Corona were raising the issues that you are raising now. And I said, in order to get us off the mark, why don’t you folks at the August meeting bring some language in, because the group doesn’t like the language that’s in there now. The August meeting was cancelled, we had a meeting in October, and I’ve never seen any language from Jody or Nancy (F) about what they want to put in here. The provider group is saying we don’t feel an exception is necessary. So, I don’t think the language that is in there, from the point of view of this group, is acceptable and nothing else has been proposed and the department hasn’t to my knowledge, solicited anything from Jody or Nancy (F). Our feeling was that if you are going to come up with exception language, the group didn’t feel that this language was appropriate, and it was voted on in the last meeting. So, I don’t think it’s appropriate to move forward with this language in the regulation as it currently stands.

- **Jan**: Have we had any other conversation with Nancy (F) or Jody?

- **Lori**: I’ll take that on.

- **Kathy**: We haven’t heard anything from either and it has been brought up in previous meetings. So please provide us with your language otherwise we’re using this Florida model sort of as a springboard, not because it’s perfect, but because nothing else has been provided to us. So, if you’d take that on, that would be greatly appreciated.

- **Frank**: Why wouldn’t you have something so generic that it essentially deflects back to 246-310-210? That’s as good as it gets really. If you go down the road of specificity, I think you’re going to be spinning your wheels.

- **Steve**: The alternative is to keep, and say, and I’m just spouting off words, in the event there is no numeric need, an applicant may make an argument under 246-310-210(1) and (1)(a)(b), that available services are not efficient or available. Why not tie the two together? Your mention of rulings by HLJs, I know that well, we’ve just finished a big case and that’s exactly what happened so why not have the department take advantage of an existing regulation and say, if there’s no numeric need, an applicant is entitled to make an argument to the department under existing regulations because it’s really a slippery slope when you start to define special populations. We were talking about Kline Galland, they got a legislative exemption, that wasn’t through the department or through a regulation. So that’s one alternative. Rather than overcomplicating things just put a provision in the rule. Why make it more complicated?

- **Jan**: I understand your argument, but don’t necessarily agree with the broad scope because those are generic ones where if you don’t have specific criteria or evaluation points, those apply. And, as we’re developing the need methodologies, and when I say need methodologies, the decision making criteria for the type of project, it’s not just the numeric need methodology, it is looking at the financial feasibility and those types of things that would go into developing a decision. I mean, our rules also say that it’s not specified in our rules, that we look to other established pieces that have been developed by other national boards or recognized entities. When we tried to do that for an ambulatory surgery center because there was no numeric need based on the surveys that we got back and it was a paltry response that we were turned down because we had a methodology in rule that did not include any ability to consider anything else. Those are ones that have been established and the methodologies that we put together are further defining how (Tape 1, 01:59:49) you go about implementing those pieces. So, while looking at defining exception-type language is to all of our benefit, rather than doing a circular argument
back to the rules that already exist, that the whole rule process is designed to further clarify for that particular type of process that we’re reviewing.

- **Steve:** If you start considering “special population” language, it’s Providence’s view that we’re opposed to any sort of exception language but if you start going down that road, and someone comes in and makes an argument that they are entitled to a CoN because they are serving a special population they should be limited to treating that special population because otherwise, that is used as a pretext to get in the door. And if you’re going to go down that special population route, you should limit them to serving only that special population, whatever that special population is. And that’s akin to what was done by the department with respect to segregating, for lack of a better word, nursing home beds or ethnic/cultural groups. They are limited to serving those populations. So I don’t think that should be used as a pretext to getting someone’s foot in the door.

- **Jan:** We approved a pediatric hospice years ago, and they were limited to providing services to pediatric patients. When they wanted to expand, they had to come back in for another CoN so they were limited. It’s not something that is unprecedented that we’ve done. But I don’t know what potential language that there is, but it’s something we can consider. As you all know, the project descriptions on the CoN’s are more descriptive of what you actually are stating in your applications of services that you are going to be providing and to whom. We’ll certainly take that into consideration. The existing exception language, I agree with you, but if Lori wants to propose something that we can discuss, and see what that would look like, then that would be to our advantage to do that.

- **Frank:** As opposed to more broadly deflecting back to the broader statutes and giving the department the flexibility to make decisions on an individual basis?

- **Jan:** Yes, right.

- **Frank:** Our fear is that you’d be headed down a rabbit hole, but we’re happy to look at language.

- **Jan:** We don’t want to be going down a rabbit hole either, but having something so broad that anybody can make any argument that we’re then in an appeal because somebody didn’t agree that there was special circumstance or that the applicant had done a good enough job, not that they didn’t do a good job of documenting that there was a need for their service because folks weren’t getting care but they didn’t do a good enough job because, be honest, that’s what some of them get in to, not a good enough job at showing that, that we get into a very lengthy appeal process for that. We’re ultimately trying to reduce those costs for everybody.

5. **ALOS Follow Up**

- **Kathy:** Distributed full text of email string to group for review. Group didn’t make any decisions last meeting on this issue; wanted to follow up in case there was additional discussion or comment. Beth had follow up.

- **Beth:** The way that I recall, at the end of the last meeting we landed on the realization that the tool on the CMS website does not allow us to just pull this information. What we need to do, at least for the time being, is contact CMS with a specific question to get that average length of stay. But the issue is that we haven’t yet landed on our definition.

- **Frank:** It was unduplicated, right? Unduplicated admissions.

- **Beth:** Okay, so unduplicated admissions. I know originally we were starting to look at deaths, and we had decided as a group that deaths weren’t appropriate because there are a number of live discharges that are perfectly appropriate for hospice and that capacity needs to be included.

- **Steve:** So what Frank said was, “prefer episodic lengths of stay with unduplicated admissions.”

- **Beth:** Okay, so it would be average length of stay by episode not by person.

- **Frank:** Correct.

- **Steve/Frank/Beth:** Did I accurately state what you said? Is that ringing true with the group?
• **Mark:** The only complicating factor for that is back to one of Steve’s original points about the instructions, so that we all know exactly how to report that because episodes span years, so if you count an admission or an episode for a patient who was admitted in 2016, who lived all of 2016 and some of 2015, do you include the 2015 days or not. Does that make sense?

• **Frank:** It’s that same issue Nancy Field brought up – do you truncate them or do you include them and it seems to me that you have to include them.

• **Mark:** I think so. But then are you reporting them in 2015 and 2016?

• **Lori/Beth:** No, because they aren’t admitted in 2016, correct?

• **Other:** Correct.

• **Mark:** Yes, but if you do it in 2015, then you are understating their length of stay because you are only including the 2015 admission.

• **Frank:** You’re right, but we just have to catch them now.

• **Jan:** Yes, but doesn’t it balance out? Because you have, you know, that bell curve in Nancy’s presentation showing that some start here and will end here, but you’ll have that on an on-going basis, you’ll have some that will come in and you’ll follow through and the first time that we do that, that will certainly make a difference, potentially make a difference the first time that we do that, because we’re counting them a little bit differently. But overall, on an on-going basis, it should balance itself out because we’ll have some that will fall into the next year and some that won’t follow over, I mean, it’s not an ever growing number, I don’t think it’s going to be an every growing number that follow into the next year, is it?

• **Beth:** Since we’re going to be using unduplicated admissions we wouldn’t be double counting an admission so any overhang days would be picked up by that.

• **Mark:** No, they wouldn’t because if you are reporting unduplicated admissions for 2015, and you are looking at the length of stay, or length of service I should say, and they were admitted on January 1, so their length of stay would look like it’s 365, but actually they lived through all of 2016 too and they are just a long length of stay patient so you would report them as an unduplicated admission in 2016, would you?

• **Frank/Beth:** You don’t want to double count them. That would be a double count.

• **Mark:** But then what are you doing at the end of the year? Because in 2015 you wouldn’t report the days for anybody who was admitted in 2014.

• **Frank:** Correct.

• **Mark:** Right, but then you are understating the length of stay. You’re saying that maximum length of stay would be 365.

• **Frank:** I thought we already solved this.

• **Beth:** I’m wondering if CMS can even give us data this granular.

• **Catherine:** Sorry to go backwards, but I don’t remember why we weren’t doing discharges, based on discharges because I thought that’s what we typically use for average length of stay was discharges because then it’s clear so why did we decide we weren’t going with that?

• **Beth:** But then we’d have to change what we’re asking for in the survey, I believe we landed on admissions because that’s what we use in the survey. It needed to be comparable.

• **Catherine:** Maybe we change the survey then.

• **Jan:** Can folks go back and give us three years of historical data? Do we have to have the three years of historical data to do that?

• **Beth:** We do need three year historical data.

• **Lori:** But you’re getting the average length of stay for the state from CMS, correct, for admissions?

• **Beth:** Correct. But we’re getting the admissions.

• **Steve:** I think that was the issue – what can CMS give us.
• **Frank**: The issue with CMS was duplicated not unduplicated, so the number that we were pulling was 57 days but it really should have been 64 days.
• **Mark**: Okay, but remind how CMS is...
• **Frank**: The number that we were pulling was duplicated and we wanted unduplicated, so the number we were getting from them had duplications in it, and if you go to unduplicated lengths of stay, then it would have been different.
• **Jan**: Unduplicated admissions, so that you then have whatever days that person had for the episode is counted against that one admission, not multiple admissions for that same person.
• **Beth**: And what we were getting previously from CMS in an annually produced, published table that was very easily accessed, it was average covered days of care per person, which is clearly different than what we are looking for here.
• **Catherine**: I wonder if they will have it now, because now we’re being paid based on the 1 to 60, and then the last 7, so maybe that will be new data that they will be able to get for us. Because that’s new as of this year.
• **Mark**: I’m still confused. What is CMS giving you?
• **Beth**: That’s the issue – we haven’t asked CMS for what we need.
• **Steve**: What Beth wants to know is what should we ask CMS to get the average length of stay?
• **Jan**: If they don’t regularly publish average length of stay in a document, and the document that we were pulling average length of stay apparently is not what we all want, and so as a result of that we’re now just trying to make sure that we’re asking CMS since we have to ask them to provide it to us.
• **Mark**: And we want that as opposed to self-reported data.
• **Chris**: So if we want accurate average length of stay, I don’t know how it isn’t discharges. It’s hard to imagine how you would really understand exactly what you’ve talked about.
• **Mark**: Discharges would fix it because it would look at their total episode regardless of whether it spans a new year or not.
• **Chris**: Unduplicated discharges.
• **Mark**: And could you get that historically?
• **Beth**: What we would have to do is survey the existing providers for their discharges so we could do the whole methodology and have it be apples to apples as opposed to admissions to discharges.
• **Lori**: Because CMS would only give you the admissions.
• **Beth**: Correct. So if we want to go to discharges, then we have to ask the providers to do a three-year lookback and provide us with their discharges and I can’t speak to what level of time investment that would be for providers to do that. And it would be by county. So if we want to do discharges from CMS, then it stands to reason that we would want to do discharges from the providers as well.
• **Frank**: Can’t we just ask for unduplicated episodes from CMS?
• **Jan**: Average length of stay by unduplicated episode?
• **Mark**: But those aren’t necessarily done yet, that is the problem.
• **Catherine**: Yes, so you’ve got people that are live and you really don’t want them in the average length of stay because you don’t know that yet.
• **Frank**: You just want unduplicated data, though. Can’t we just specify that? Because that’s the confusion with the data that we have been getting from CMS versus the data that Nancy Field pointed out.
• **Chris**: The challenge is you don’t get an accurate number until they discharge. So if we’re all back to that, you don’t get an accurate number until they complete service, live or not.
• **Lori**: Like Jan was saying, it will kind of wash itself out on an overall basis if we’re looking for the entire state. Is it changing that much every year?
• **Catherine**: It can.
• **Lori**: I mean for the overall average for the entire state.
• **Catherine:** I mean, they’re looking at MedPac and all this stuff, so CMS has to be looking at this data. They’ve got to have this data.

• **Frank:** I’m willing to go back and look at this again to resolve this question. I thought we solved this.

• **Beth:** Maybe what we could do is come up with a couple of questions to ask CMS, like can you give us this statistic, and this statistic, because we also need to ask them, can you just run this off and give it to us every year or do we have to pay for it, do we have to, there are a lot things going into this. There haven’t been charges when we’ve done previous asks, but I can’t speak to what CMS may require going forward.

• **Catherine:** But I don’t think it makes sense to look at average length of stay or median on anything except discharges.

• **Others:** Agreed.

• **Candace:** Why would CMS use anything other than discharges? What’s their rationale for using admits?

• **Beth:** We’ve only asked them in terms of admissions; they may very well use discharges, but we’ve never posed it from that perspective before.

• **Steve:** I would suggest that Frank go back and look at his notes, give Beth a call, and then decide what questions Beth should ask CMS.

• **Catherine:** And as providers, we know what average length of stay is, and it’s based on discharges.

• **Frank:** But I thought we sorted this out in October. Based on all the data sets that we looked at.

• **Kathy/Beth:** We didn’t have consensus on this – lots left up in the air – looking at transcript from last meeting.

• **Beth:** We had told everybody that we would come up with some questions that the group agrees to and then ask CMS the questions. And that’s why I think it makes sense to ask more than one question for more than one statistic, because what if the one that we all land on for whatever reason, what if that is the one statistic that they can’t give us? So I think it would be smart to have a couple of options.

• **Lori:** And then you’ll also ask them about the timing of when they would be able to give us data and what year that would typically...

• **Kathy:** So do you (Beth) want to work with Frank on developing those questions?

• **Jan:** Yes, because I’m just looking at the MedPac 2016 report, and they are saying that the average length of stay among decedents remained at about 88 days in 2014, and about the same level as the prior two years. The median length of stay for hospice decedents was 17 days in 2014 and remained stable at approximately 17 or 18 days for more than a decade.

• **Catherine:** So you’re going to have some variances by county, and there are going to be variances by region and geography.

• **Jan:** I know, but I was just looking at what they were identifying and so far in MedPac I have not seen how they find average length of stay in this.

• **Beth:** And just to reiterate from the providers in the room and on the phone, would it be unreasonable ask for us to say, can you give us your discharges for the last three years, 0-64, 65+, by county, is that a big ask?

• **Catherine:** Well certainly the total. I don’t know about the 0 – 64 and 65+ which is not to say that we can’t do it, but I know we could definitely do the...

• **Beth:** Because we do need it by the 0 – 64 and 65+ because we can’t run the methodology without that – for the first part of the methodology. Not for the average length of stay.

• **Mark:** And not to confuse it, too, my system will report length of stay based on the current admission. Now, a patient may go on and off service three times over the course of their care. My system only counts the last one and in reality based on some of the conversation we’ve had, what was their length of stay in the course of the year. They’re on and off three times in 2016, is it the aggregate of those three periods of service or just the last one?

• **Jan:** And I think that’s why we were looking to Medicare for the average length of stay.

• **Beth:** That way it’s just one language that we’re trying to pull it from.
Frank/Beth: Will bring questions to the next meeting.

Concurrent Review Discussion (Conclusion Agenda Item #2 - Providence Issue Analysis)

Jan: Steve, I think we have a difference of opinion as to whether or not the statute requires concurrent reviews for healthcare facilities. And this is defined as a healthcare facility. As we read the statute, it would require us to develop a concurrent review cycle for development of hospices. We have done a one year concurrent review, doesn’t mean that we can’t do more than one, and we have done that and seen that in kidney dialysis, we previously had four general concurrent reviews, and in the proposed rules we’re looking at two general and two special circumstance. I think that’s where we’re coming from, and it gets to planned projections and planned development of the facilities, as well. That’s why we were looking at doing something better in terms of making sure that the data we have available, people have an opportunity to see what the methodologies look like, and then be able if they want to plan to submit a letter of intent and then go on. Now again, as with all of our concurrent review cycles that we’ve developed, if there isn’t somebody else that comes in during a concurrent review cycle and if there aren’t multiple applications that come within the same planning area, we convert it to a regular review. So, that’s our standard practice and that’s something that we would continue to propose to do.

Steve: I hear what you are saying, but in practice that does not really happen. For example, the department has never had a concurrent review schedule for new hospitals that I’m aware of and they’ve never had a concurrent review schedule for new hospital beds.

Jan: You’re right. We haven’t developed the methodology in rule yet. So, those that we have been developing the methodologies, will see that they’ve all had concurrent review cycles set up.

Steve: I’m looking at you concurrent review schedule that was last updated in 2005, and it includes CCRCs, nursing homes, (unintelligible) surgery, cardiac surgery, hospices and hospice care centers.

Jan: And dialysis has its own four cycles...

Steve: I’m just saying what’s on your website.

Jan: That’s fine, and as we’re going through and updating our rule sets, we’re moving toward concurrent review cycles for all of the facilities.

Lori: Jan, do you have a thought of the timing for hospice?

Jan: You know, I hadn’t really thought about that and I think we’re trying to get a better handle on the death data that is coming out because that’s been our limiting factor and then for CMS, we do need to have a little bit of time to put the methodology together so that we can do that, and also give folks a reasonable amount of time to develop applications if that is what they would like to do. Have you thought about it? (to Beth)

Beth: I think we had thought about pushing out a month or two just to accommodate vital statistics. I will say that I had a telephone conversation with the folks at vital statistics this year, and the major hold up for death data was just the coding from ICD-9 to ICD-10. So it took them so much longer because the switch was in October so that had to reconcile three months of data and it took them a lot longer. We won’t know until next year if there’s a lag for the data to adjust, but we do know it won’t be available until November. That shouldn’t be the norm, before we were able to get data by the end of August, early September, so that should be considered the norm.

Lori: I know you usually get it a little earlier than it is publically available.

Beth: And I know if you are on the listserv for them they send out this huge raw spreadsheet.

Jan: If you have some suggestions whether you want one or two cycles, we can do that. The four cycles we used in kidney dialysis has been a bit challenging. We’d entertain timing.

Lori: And what’s different from dialysis is because of how the methodology works in dialysis, the need changes throughout the year, whereas with hospice I don’t think the need would change.

Jan: We would only run the methodology once.
• **Discussion**: Differences between kidney dialysis and hospice cycles and methodology. In the interest of flexibility, multiple cycles would be better.
• **Steve**: Not a top of the list issue, but gives people flexibility.
• **Jan**: We’ll take a look, pencil out concurrent review cycles, and see how they intersect. An option is that we could have two concurrent review cycles for different geographies.
• **Catherine**: If we did two concurrent, we won’t be able to adjust the need between the years worth of data, but you have an organization that is ready to enter and they just missed it and then they have to wait another year. It just gives more flexibility to organizations if it was twice a year.

**Roundtable**

• General: Thanks for the productive meeting.
• Great discussion.

**Conclusion**

• **Kathy**: Homework:
  o Frank and Beth are going to run the methodology based on the variables of 25 and 35, as well as ADC. Test the quantitative difference. If we’re going to be trending, might be a different picture. Work will go into trending.
  o Lori will provide proposed language for exceptions.
  o Frank and Beth are going to work on questions for CMS.
• **Next meeting**: Frank requests mid to late March – group agrees that this works best with workload and tasks assigned at this meeting.
• **Steve**: request that data be distributed a couple of weeks before hand.

**END**
Brief Overview of Rulemaking Process
Kathy Hoffman, MPA
Department of Health/Certificate of Need
January 10, 2017
Basic Rulemaking Process

The standard rulemaking process is divided into three stages:

• Stage 1: Pre-proposal Statement of Inquiry (CR-101)
• Stage 2: Proposed Rule Making (CR-102)
• Stage 3: Rule-making Order (CR-103P)

Each stage consists of specific tasks and processes.
CR-101 Statement of Inquiry
Filed May 4, 2010
WSR #10-10-14

Stakeholder work

Rule Drafting, Analyses

CR-102 Proposal

Public Hearing/Comments

Respond to Comments

CR-103 Final Adoption

Basic Rule Making Flow Chart

Start

We are here

Finish
Statement of Inquiry (CR-101) – RCW 34.05.310

Purpose: Describes the issue(s) being addressed by rule

- The pre-proposal is filed with the Office of the Code Reviser and published in the Washington State Register. This is the formal document that identifies the purpose of rulemaking.
- The scope of rules created through this process is controlled by statutory authority and must be compatible with existing requirements.
- Most rulemaking work is done after the filing the pre-proposal statement of inquiry.
- The department works with stakeholders to develop draft rules.
- The department begins internal development of required analyses required by chapter 34.05 RCW, Administrative Procedures Act and chapter 19.85 RCW, Regulatory Fairness Act.
Proposal (CR-102) – RCW 34.05.320

Proposed rule language and impact analysis.

• The department creates the proposed rulemaking order, CR-102.
• This filing establishes the **formal** review and comment process, including the date, time and location of the public hearing.
• The public hearing is typically held at the end of the review period.
• At the hearing, public testimony is taken and written comments are submitted on the proposed rule(s).
Final Adoption (CR 103P) Order – RCW 34.05.360

Final rules are adopted

- After the public hearing and review period ends, the department compiles all comments received and makes a decision whether the proposed rules should be changed or adopted as proposed.
- If the department makes substantive changes, a supplemental CR-102 must be filed and 2nd hearing held. This substantially extends the timeline of the process, and is uncommon in most rulemaking projects.
- If the department adopts the rules as proposed, the department files the rulemaking order, or CR-103, and the rules typically become effective 31 days later.
- All comments and the department’s responses are complied into a Concise Explanatory Statement and are provided to all commenters shortly after the adopted rules are filed.
Simple flow chart of the rule making process
Why does rule making take so long?

Most HSQA rules take 12 to 18 months (and sometimes more) to develop and finalize.

• Waiting periods are set by law.
• Public involvement and deliberative dialogue take time.
• No two rule sets are exactly alike; some rules are very complex and/or controversial and require substantial time and work to develop.
• Data collection, research and economic analysis can, and often is, time consuming.
• DOH Internal review process is lengthy.
Resources

Washington State Office of the Code Reviser:
http://leg.wa.gov/CodeReviser/Pages/default.aspx

Department of Health Rule Making – General:
http://www.doh.wa.gov/AboutUs/RuleMaking

Department of Health Rule-Making Activity – Specific:
http://www.doh.wa.gov/AboutUs/RuleMaking/RuleMakingActivity

Department of Health – Certificate of Need Rule Making Activity:
http://www.doh.wa.gov/LicensesPermitsandCertificates/FacilitiesNewReneworUpdate/CertificateofNeed/RulemakingActivities

Washington State Administrative Procedure Act – Chapter 34.05 RCW – Part III Rule-Making Procedures:
http://apps.leg.wa.gov/RCW/default.aspx?cite=34.05