A meeting regarding the Certificate of Need (CoN) hospice services rules convened on March 28, 2017. The meeting was held at the Department of Health, 111 Israel Road SE, in Town Center 2, Conference Room 158, Tumwater, WA 98501.

PRESENT:
- Cristi Keith, Continuum Care Hospice
- Lori Ayoama, HFPD
- Mark Rake-Marona, Franciscan Hospice
- Candace Cheney, Assured/LHC
- Leslie Emerick, WSHPCO
- Chris McFaul, Horizon Hospice
- Gina Drummond, Hospice of Spoke (by phone)
- Kathy Katzenberger, Evergreen Hospice (by phone and in person)

STAF PRESENT:
- Nancy Tyson, Executive Director
- Kathy Hoffman, Policy Analyst
- Beth Harlow, Analyst
- Jan Sigman, Program Manager

9:10AM – Meeting opened with introductions, brief agenda overview.

Presentation of Draft Rules

Department has considered all of positions presented and discussed during this rulemaking process.

Today we’d like to address ALOS, ADC, exceptions and the rule set in general. Very close to 102 phase, please make comment as group reviews draft rules today.

Discussion re Subsection 1: Definitions

Begin review with tart redline version, department invites questions or comments related to definitions section.
Page 1, subsection (1)(b): ALOS. Currently placed holdered pending further discussion during this
meeting.

Page 2, subsection (1)(c): “Current supply” definition: we will not be counting any licensed only hospice
agencies. Might want to include that in definition – “does not include state licensed only hospice or
volunteer hospice services.”

25 ADC is where the department is leaning at this time, but we’ll talk about that a little later, along with
the spreadsheets shared last week.

Page 3, subsection (1)(d)(iv): What is the time period? Why was this put in here? We were looking at the
three year look back; if someone changes ownership, we may not know about it, or they don’t have the
historical data. Do we want to clarify when an agency that an agency that has changed ownership during
this three-year historical period? Thinking about trying to avoid argument in future. Want to capture
hospice volumes accurately. When we produce the numeric need methodology, we should use a
descriptor when posted, not in rule, but in posted methodology. Net is not lost. Nothing needs to
change in the language at this time.

Department reduced/revised the size of description of planning area (sub f). Struck last half of
definition. Should we say planning area and service area have the same meaning? Jan suggests we
should. We took service area out entirely previously, and we don’t use it for projection purposes; used
when applicant is describing service areas; term would show up in application. Might not be a bad idea
to define it to make the distinction between a planning area that we’re doing the projection for and the
service area that an applicant is (operating in?) (00:15:17) So, add previously deleted sub g and modify.

Page 4, subsection (1)(g)(previously deleted): “Service area means the geographic areas for which a
hospice agency is approved to provide Medicare certified or Medicaid contracted services.” Remove
“for the purposes of certificate of need.”

Jan describes the differences between planning area and service area, and the reasons we’d want to
delineate between the two. If it does not increase confusion in the rule, then add it. Describes what a
hospice agency does, adds clarity.

Discussion re Subsection 2: No changes.

Discussion re Subsection 3: Concurrent review

Department landed on two review cycles. There was suggestion to remove concurrent review for
hospice entirely. RCW 70. 38.115(7) and (8) describes the requirement for concurrent review.
Department identified the two cycles similarly to nursing homes – certain counties apply in cycle 1 and
certain counties apply in cycle 2, but department seeks additional feedback on that. Dates are based on
availability of data.

Discussion re Subsection 4: Rule Transition Language

On subsection (4), Jan suggests that we add a time frame – LOI submitted 30 days in advance or 60 days
in advance – don’t want to leave this open.

Lori: If you don’t get it (the LOI) in within a 30 day window, then you are just out of luck?
Jan: We’re not doing the 30 day window anymore, we’re doing this like we did with dialysis where there is a deadline, or a date that it’s due. What we’re trying to avoid is people submitting letters of intent that would be sitting there for actually several years, and then they come back and say, “We submitted a letter of intent in 19 whatever, and now we want to act on it.” So it’s just a question of putting a timeframe on it as opposed to leaving it just open ended. Add language

Beth pulls up county breakdown for nursing homes for group’s consideration. Proposing that we follow this for concurrent review, unless anyone in the group opposes this. Discussion of how counties were split up as they were. Agree to add counties to table.

After further discussion, Jan suggests we rewrite sub (4) to be somewhat similar to what we have in kidney dialysis rules for applications that were submitted for review at the time these rules became effective. (00:29:51). But, does that still deal with the lingering LOI that goes back? No, because LOIs are generally good for six months. This section deals with transition as opposed to LOI. Might have to add something for those (applications?) that were submitted after the first review cycle if rules aren’t completed before then? Will add transition language to address first concurrent review cycle; there’s only one cycle now and it won’t impact the second review.

Discussion re Subsections (5) and (6): No changes.

Discussion re Subsection (7):

How will the department determine financial feasibility? Not defined in this rule, although department relies on WAC 246-310-220. How should we measure financial feasibility? Originally department had a requirement that if an applicant needed to demonstrate that they could hit a certain ADC and that would demonstrate that they were financially feasible. Then, through discussion we (workgroup) decided that if somebody hasn’t reached that number of patients, why penalize that if they are meeting their financial goals?

Workgroup also discussed the scenario of when you have an existing provider in one county that was proposing to expand into another county that did not have a need for additional services and could show that they were financially viable. But if looking at just that county alone, that would be hard to do. That was one of the reasons we took out the definitive definition. Do we have other rules that address this? Possible model language in kidney dialysis rules?

Discussion re Subsection (9) and (10):

Technical edits: add “calendar days” after fifteen, and strike “the beginning of” in both sections.

Discussion re Subsection (8) and ALOS:

Methodology. Beth presents spreadsheets shared with group. Spreadsheets describe steps 5 – 8 since group previously agreed that the methodology was doing what it was supposed to do in the previous steps. Beth compares options A, B and C from Frank Fox’s spreadsheets, each for planning area capacity. Beth prepared models A1 and A2 to factor in the different types of ALOS. We end up with six options. Option A, 1 and 2 uses three-year lookback (what we’re doing now), where we take the average capacity for a county for the last three years and hold that constant in the projection years. Option B is where only the most recent year’s data is used. So if running methodology in 2017, only counting capacity from 2016 and carrying that forward, static. Not changing value. Option C, is where you trend the three year
lookback. So, whatever happened between year one of the three and year three of the three, you take that pattern and carry it forward. When calculating capacity, realized it needed to be done differently every time because we had to modify the default values for counties that had new providers, and that is why there are so many background calculations because the default admissions changed for every single one of these.

In summary, spreadsheet shows which county has numeric need based on which option we use, and this is with an ADC of 25. Across the board, option 1 has that average days of covered care per patient - that is the original ALOS that we were getting from CMS. Option 2 is the episodic length of stay, and that’s the second definition – hope you all say the emails between Beth and CMS defining the two difference ALOS. Option 1 is 56.88; option 2 is 66. Spreadsheets demonstrate that there are always going to be some counties that show need. But we noticed that is was pretty volatile in options B and C. Option B is if we’re using just the most recent year and need can change drastically based on what providers actually did, so even the most recent year, it’s going to be a volatile statistic, so that’s going to result in a methodology that’s not very predictable. What we found with Option C is because we’re going from one year to the three year, that second does not get factored in very well, and sometimes that percentage can have a huge change, like their average annual growth or lack thereof. Linear trend from years one to three. Shows drastic changes and is not very predictable. Might not be accurate representation. Describes how this affects Pacific county (as an example). Trending capacity isn’t really representative of what is going to happen.

Methodology didn’t structurally change at all. Beth describes her calculations using varying inputs.

If capacity is based on average of three years of admissions, and length of stay is based on episodic length of stay, is that apples to apples? Want to make sure you are capturing all of your patients that are cared for during that episodic length of stay. Three year look back smooths “ups and downs” in capacity.

Discussion of impacts on capacity.

Chris suggests option A1 is a better choice; apples to apples. 25 ADC and three year lookback on capacity. Need may have been understated before, but population is aging and projecting higher population need is reasonable. At last meeting we didn’t have confirmation from CMS about definitions for episodic vs. that average covered days per person, now we do and we understand them better. Group agrees that average days per person is preferable. Workbooks Beth shared were to demonstrate “what would happen if...?”

**ADC and period of lookback:** Lori indicates that 35 seems to make more sense given what we’re seeing in terms of need in just doing the two age cohorts and the need has been expanded a little bit that way, 25 is too small, and if we have exception language, that helps the smaller communities demonstrate, or potentially apply for a hospice agency, won’t preclude anyone from applying if we keep exception language.

Jan: The department is leaning towards a 25 ADC. Understand and have heard the arguments for maintaining 35, (01:14:54) and the only way we can have some planned growth of hospice agencies is to have a methodology that allows for growth. With the 35 in our current methodology there has been almost no growth. That is not where the department would like to see us go, recognizing that 25 is the minimum.
Chris: Clarifying questions. Spreadsheets show there is a need of 8 at 35.

Gina: Fixing the age cohorts, not adding them back together, I’d like to highlight that that changed things quite a bit in terms of opening things up and I think it was the right thing to do, but I don’t want us to lose track of the fact that the methodology is less restrictive.

Chris/Jan: Discussion of need based on 25/35 ADC. Calculations show need for 13 at 25; 8 at 35. Shows need in counties where we haven’t seen it before. Are we trying to promote growth in specific areas? Some of the need is closed off in areas under 35 ADC, whereas with 25 ADC need is shown. Discussion of how other services, CoN and planning for future intersect.

Chris: Free market person. Understand the limits and benefits of free market. But there are limits and caveats. Provides EpiPen example. Using 25, ran up half of revenue in nursing, revenue and administrator. This is unlike home health; if someone needs assistant on a Saturday, you have to provide it. Access with 25 absolutely, but what about quality? Can we guarantee quality of care at 25? Nurses are a shortage; we don’t want to reduce nursing. The demand for us to see people more often is increasing. Not sure how we validated 25; but, this is very real to me.

Mark: Agree with Chris on quality. There is so much variability in the level of hospice care across the country. Our calculations showed there were a certain number of providers that were viable at 25. But my point, after the fact, is that we don’t know anything about those providers, whether they were in business the next year, what kind of quality they had. What we do know is that at 36 we haven’t had any issues with quality so, Chris’ point is great about the kind of services the state allows.

Chris: I would rather have 8 programs in the state that provide great service than 13 that I’m not sure of.

Kathy K: What Chris said is really true. I’ve been that nurse. You’re on call Monday – Friday and you are on call at night trying to take care of patients and you’re exhausted. And what kind of care you can really provide is that standard of care because you are exhausted as a nurse and it’s not really what we want produce for our patients. They deserve better than that; they are dying. This is it for them and we want to make sure that the care we are giving to them is what they deserve and is the best that they can possibly get. And I think if we cut this too close and we go too small then we’re not doing service to those patients. They deserve better than that.

Neither 25 nor 35 are a guarantee of quality. But, you have a higher degree of quality of 35. From a planning perspective, you don’t want someone coming in and then going out of service. If the department wants to see potential new agencies in counties, we could have different ADC factors for small counties? Different standards for different sized counties? Or exception language that would allow an applicant to put forth an argument that the department could evaluate that would help us promote making sure that everybody has access to hospice.

Group revisits spreadsheets and resumes capacity, length of stay, and lookback discussion. Beth and Jan assist, group works through additional questions. Several clarifying questions and robust discussion. Beth provides several examples and further explains spreadsheets. There are confounding influences to capacity. Jan indicates that that is why we’re doing a three year lookback as opposed to a single year because an applicant that isn’t an existing provider should not have to try and figure out what happened in any one give year to existing providers that caused an increase or a decrease in their services. This levels it out. Mark asserts that counter argument is that a lot can change in a year, and if it happens that
agencies have invested in growth, and now capacity is significantly higher, they have now made that investment, and the next year, because you are averaging the prior two years, it’s going to look like institutional capacity. Jan notes that we’re projecting three years out into the future and thinks that the decision that granted the individual agency’s ability to do hospice care was based on the need for that hospice agency’s need for a hospice care center. It’s all based on that agency’s existing patient load. What this does is allow you guys to keep serving what you are serving, and this is assuming that you are going to maintain that. But also allows for someone else to potentially come in and serve some of the new patients. That does not mean that you aren’t serving any of the new patients, but it says you are going to be serving at least as many as you have been. Using a one-year, volatile number is harder on the new provider, because you have two years or longer to impact that new provider’s ability to serve patients.

Why do other areas of CoN only do a one-year lookback? Jan describes how other CoN reviewed services/facilities projection horizons are determined, and that determination is largely based on features unique to the service/facility. Not all settings are the same. Department understands that some folks want a one year look back, others three year lookback. Three years makes it a little more predictable. Gina likes three year. Chris sees benefits in both one year and three years, Mark agrees.

Either you stay the same, shrunk or grow. If you grow, years one and two underweight that, so using volatility either way.

Gina: I know the record shows I voiced concern about the threshold of 25 before we were presented the information in terms of how it would impact organizations and counties in our state because I think that has been one of the department’s concerns, is that our issue with that threshold wasn’t raised until after we had the information on how it would impact counties in our state. I raised concern about that before I knew what the impact would be.

Jan: I understand.

Gina: It was completely based on what we considered to be viable. And we never defined what viable was, was it an organization that could break even or an organization that could provide the quality of services that would (unintelligible) of Washington.

Additional clarifying discussion of spreadsheet data elements.

**Discussion re Subsection (11):**

Lori had question about what “improved service” meant. Proposed language is what the department came up with because no other language was proposed. Will be up to department to evaluate under the proposed criteria. Additional questions about what “minimum impact” meant, as well as “historical provision of services.” Struck cost-efficiency out of this section since it has not been a really good measure for superiority.

Jan: Add a new [subsection (13)] “Any applicant granted a certificate of need for hospice services shall provide services to the entire county for which the CoN was granted.” Move current subsection (13) to new subsection (14)

Leslie: What if an agency isn’t serving the Medicaid and Medicare population?
Jan: if we know about it, we will send them a letter, then escalate response if necessary. Medicare/Medicaid is usually a condition of approving CoN. Can address is rule.

Discussion re Subsection (12):

Department revised exception language because no new language was proposed. Lori asks what use rate means in (12)(iii). Should re-write this section consistent with methodology. Counties can have great internal variance – some data makes King County look like it’s thriving, but that isn’t true of the entire county.

Lori will get exception language to us by next Monday, April 3.

Mark indicates we should have clarifying language around use rate referred to in proposed language. Currently sounds like we’re referring to combined use rate. Change the “and” between (ii) and (iii) to “or.”

Next Steps:

Lori will provide exception language by Monday, April 3.*

Department would like to discuss comments on three year look back and ADC configuration, ALOS.

If there is specific language the department would like to run past group for comment and clarification, we will. Similar to our process in the kidney dialysis rules, once the department has a rule set that is more solidified based on this conversation and the department’s internal discussion, we will circulate a final draft rule set for the workgroup to review before we finalize the CR102. If we need a follow up telephone conference, we will schedule one, but at this time, the department is not scheduling any further meetings.

Current timeline for getting revised draft to group is six weeks. Department would like to allow stakeholders about three weeks for review. Timeline for CR 102 hearing is currently mid-summer. The department does not wish to rush this process to assure a solid, durable rule set and want to assure that all stakeholders are involved and heard in this process.

CONCLUSION

*Deadline extended to Monday, April 10.