West Virginia Hospice Services Workgroup

Final Report
September 2019

Certificate of Need Program

Pursuant to W. Va. Code § 16-2D-1, *et seq.*, West Virginia's Certificate of Need (CON) program was created and jurisdiction over that program is vested in the West Virginia Health Care Authority (Authority). W. Va. Code § 16-2D-1(1) states the offering or development of all health services shall be accomplished in a manner which is orderly, economical and consistent with the effective development of necessary and adequate means of providing for the health services of the people of this state and to avoid unnecessary duplication of health services, and to contain or reduce increases in the cost of delivering health services.

The statutorily mandated CON review process primarily includes the determination of need, consistency with the State Health Plan, and financial feasibility. Need is determined using CON Standards, which generally include population-based quantifiable need methodologies. Financial feasibility includes the evaluation of the reasonableness of proposed charges to patients and the determination as to whether the expense and revenue projections demonstrate fiscal viability for the proposed project. Other review criteria include quality, accessibility, and continuum of care.

Formation and Duties of the Hospice Workgroup

On March 8, 2019, the West Virginia Legislature passed Senate Bill 537, which established W. Va. Code § 16-29B-31. W. Va. Code § 16-29B-31 charges the Authority with forming a workgroup to review the provision of hospice services in West Virginia. The Code defines the composition of the workgroup and charges it with performing the following duties:

(1) Establish a model for data collection to best predict the future needs of hospice services in West Virginia and collect the necessary data;
(2) Review the access to hospice services in West Virginia as well as future needs;
(3) Examine how West Virginia serves its population with hospice services;
(4) Examine the financial condition of the current delivery system;
(5) Recommend a need methodology to the Authority for the development of new hospice services; and,
(6) Make other recommendations the workgroup deems appropriate.

The Code further requires the workgroup to hold a public hearing in each of the congressional districts in West Virginia as it relates to the provision of hospice services in the state. The workgroup is required to develop and approve a final report by September 30, 2019, and a copy is to be submitted to the Joint Committee of Government and Finance of the Legislature, the Governor, and the Authority. The workgroup sunsets on December 31, 2019.

Composition of the Hospice Workgroup

W. Va. Code § 16-29B-31(a) outlines the composition of the workgroup. Below are the members as defined by the Code and the individual chosen to represent each person/organization is indicated in bold font:

(1) The Chairman of the West Virginia Health Care Authority or designee, who shall also be the chair of this workgroup;
(Robert Gray, Chairman of the Health Care Authority Board)

(2) The Secretary of the Department of Health and Human Resources (DHHR), or designee;
(Emily Hopta, Designee for Secretary Bill Crouch)

(3) The Dean of the West Virginia University School of Medicine, or designee;
(Karen Bowling, Designee for Clay Marsh, M.D.)

(4) The Dean of the Marshall University, Joan C. Edwards School of Medicine, or designee;
(Dr. Larry Dial, Designee for Joseph Shapiro, M.D.)

(5) Six hospice providers chosen by the Hospice Council of West Virginia:
(A) One of whom must be a for-profit service provider;
(B) Two of whom must operate a free-standing inpatient hospice facility; and
(C) An equal number of providers selected pursuant to this subsection shall reside in each congressional district;
District 1: Cynthia Bougher and Mary McCartney
District 2: Larry Robertson and Margaret Cogswell
District 3: Melanie Hall and Janett Green

(6) One member chosen by the West Virginia chapter of the American Cancer Society;
(Juliana Frederick Curry later replaced by Shauna Shafer)

(7) One member chosen by the Alzheimer's Association of West Virginia;
(Sharon Rotenberry)

(8) One member chosen by the West Virginia Rural Health Association;
(Debrin Jenkins)

(9) One member chosen by the West Virginia American Association of Retired Persons;
(Kathy Merrill)

(10) A hospital-based hospice provider chosen by the West Virginia Hospital Association;
(Linda Carte, WVU Medicine)

(11) One member chosen by the West Virginia Nurses Association;
(Angela Smothers)

(12) A physician chosen by the West Virginia State Medical Association with a practice treating terminal diseases;
(Dr. Jack Kinder) and

(13) A physician chosen by the West Virginia Osteopathic Medical Association whose practice includes geriatric patients
(Dr. James Stollings – later resigned from the workgroup due to his work schedule but did provide his thoughts on hospice services in West Virginia).

Hospice Workgroup Meetings

The workgroup met three times at the offices of the West Virginia Health Care Authority, 100 Dee Drive, Charleston, WV 25311 on the following dates:

June 12, 2019
July 31, 2019
September 11, 2019

The minutes to each meeting are included in this report as Attachment A.

Public Hearings

As required by W. Va. Code § 16-29B-31(c), the workgroup conducted three public hearings in each of the congressional districts in West Virginia as follows:

Congressional District 1 – Held on July 9, 2019, at the Morgantown Public Library, Morgantown, Monongalia County.
Congressional District 2 – Held on July 24, 2019, at the West Virginia Health Care Authority, Charleston, Kanawha County.
Congressional District 3 – Held on July 16, 2019, at West Virginia University Institute of Technology (Beckley Campus), Beckley, Raleigh County.

The minutes to each of the public hearings are included in this report as Attachment B.

Data Collection

Prior to the first meeting of the workgroup, the Authority conducted a survey of all hospice providers in West Virginia. The survey requested data for calendars years 2017 and 2018. Data requested includes the number of unduplicated patients served by county. County level data was collected in two ways: (1) by age cohort (age < 65 and age 65 and over); and (2) by location of services provided (skilled nursing facility, assisted living facility, all others). Total hospice deaths were also collected based on the patient's county of residence. There was a 100 percent response rate to the hospice survey and the compilation of the survey results is included in this report as Attachment C.

While reviewing the current need methodology for hospice services in West Virginia, the workgroup asked the Authority to conduct a review of hospice need methodologies in other CON states. It was determined that 17 states review hospice services as part of their CON oversight. The hospice need methodologies from 10 states were reviewed in-

depth and a synopsis of those need methodologies was provided to the workgroup. This synopsis is included in this report as Attachment D.

Through the workgroup's discussions, it became evident to the group that using "total deaths" in the calculation of need is not the best practice since there are numerous deaths included that would never be eligible to receive hospice services. Any person dying as a result of a drug overdose, automobile accident, suicide, murder, or any other type of "sudden death" could never be served by hospice. As a result, the Authority contacted the DHHR's Health Statistics Center, where the data for the number of total deaths in the state is currently obtained, and asked for its assistance in obtaining total deaths excluding "sudden deaths." The staff at Health Statistics determined the data that is needed by the workgroup could be achieved by utilizing total deaths by county excluding "external causes." Deaths by "external causes" would include those deaths resulting from occurrences such as transport accident, falling, drowning, electrocution, fire, intentional self-harm, assault, and poisoning, just to name a few. Included in this report as Attachment E is a table showing the total deaths by county for calendar years 2017 and 2018, and the total deaths excluding "external causes" by county for calendar years 2017 and 2018.

Hospice Workgroup Findings for Consideration

As a result of its research, meetings and public hearings, the workgroup has discussed and taken into consideration the following findings or observations with regard to hospice services in West Virginia:

- The Medicare.gov Hospice Compare website allows consumers to access quality of care information for hospices nationwide. In a comparison of the most recent hospice data, Hospice Analytics, a hospice data analysis firm, observed that West Virginia ranks first in the nation in the quality of overall hospice care.
- There is no evidence that patients in West Virginia in need of hospice services are unable to obtain such services.
- The data shows that more hospice providers does not result in more patients receiving hospice services.
- The average length of stay for patients receiving hospice care has declined from earlier years as patients are not being referred to or are not accepting hospice care until the very end-stage of their illness.
- More education needs to be provided to both patients and health care providers on hospice care.
- There is a percentage of deaths that cannot be served by the hospice providers in West Virginia because these patients are in the Veterans Affairs (VA), Federally Qualified Health Center (FQHC) or prison health care systems.
- There is a percentage of deaths that cannot be served by the hospice providers in West Virginia due to the nature of the death. Anyone who dies suddenly, no matter what the cause, would never be eligible for hospice services.

- There are several counties in West Virginia that just have one hospice provider leaving patients without the freedom of choice when needing to utilize hospice services.
- There is currently a "gentleman's agreement" among hospice providers in West Virginia that if a patient or a patient's family expresses that they do not want to be served by the hospice agency approved for their county of residence, the hospice agency will make arrangements for another hospice provider to come into the county to provide the needed services.
- With the aging population of West Virginia, more patients will need hospice services in the future.
- Most hospice agencies rely on donations and support from their communities to survive financially.
- Hospice providers are mandated to take care of all needs of a terminal patient regardless of cost.
- Hospice providers are reimbursed a flat, fixed rate regardless of the cost to provide services.
- Hospice agencies that have an inpatient facility rely on the services provided to home-based patients to offset or subsidize the cost of the inpatient facility.
- The addition of a new hospice provider serving only home-based patients in a county with an existing inpatient facility could result in a reduction of home-based patients served by the hospice provider that operates the inpatient facility. This could result in insufficient revenue to subsidize the inpatient facility, and it would not be able to financially survive.
- Federal law requires that when a Medicaid patient in a skilled nursing facility becomes a hospice patient, Medicaid can no longer directly pay the nursing home but instead will begin paying the hospice provider. The hospice provider will receive 95 percent of the room and board rate, which it then must pass to the nursing home. This delays the payment to the nursing home.
- A Medicare patient utilizing the skilled nursing facility benefit cannot access the Medicare hospice benefit at the same time.

Hospice Need Methodology Analysis and Development

Current Need Methodology

The current Hospice Services Standards state that the methodology for determining need for the approval of an additional hospice provider requires a survey to be conducted to obtain current utilization by county. Once the number of unduplicated patients served by the hospice providers in each county for a given year is determined through the survey, the Authority calculates the need methodology. This survey was conducted by the Authority until the law changed in 2017, eliminating the Authority's ability to collect this data.

The current need methodology takes the total number of deaths per county in a given year and multiplies the total deaths by 25 percent. The product of this calculation is the number of patients in a county that are expected to use hospice services. The number of

unduplicated patients served in the county (as obtained through the survey) are then subtracted from the expected users of hospice services for that county. If the total number of expected hospice users exceeds the current utilization by 25 patients or more, then an unmet need exists, and the county is considered open for a new hospice provider.

Need Methodology Evaluation

In evaluating the current need methodology and determining if a change is needed, the workgroup took into consideration all of the findings stated above in the section entitled "*Hospice Workgroup Findings for Consideration.*" A lot of discussion took place regarding possible changes to the need methodology. The first area of discussion was the current use of total deaths in calculating the need for additional hospice providers. There are a number of deaths that occur suddenly, and those individuals would never be eligible for hospice services. As previously discussed, the number of deaths excluding external causes by county was obtained from Health Statistics. The majority of the workgroup felt that using deaths excluding external causes was the best data to use for calculating the need methodology.

The workgroup then looked at the use of "unduplicated patients served" in calculating the need methodology. This number is being compared to the total deaths in the county; however, there will always be patients who are served by hospice who do not die in that year. It was determined that a better comparison would be to compare the total number of hospice deaths in a county to the total number of deaths excluding external causes in the county for a given year. The workgroup agreed that this would provide a more accurate comparison and decided to adopt this practice into the recommended need methodology.

Next, a recommendation was made that a three-year average be used for each data element in the need methodology calculation instead of using just one year of data. This would result in a better reflection of actual hospice utilization and deaths per county as it would smooth out anomalies that may have occurred in a single year.

The workgroup then looked at the percentage of patients that are expected to utilize hospice services. The current methodology uses 25 percent. Some members of the workgroup expressed that that this number needs to remain fairly low due to the fact that there are a number of deaths that occur that aren't eligible for hospice care or will never be referred to or will never accept hospice care. One member of the workgroup had a differing opinion and felt that this number needed to be much higher. A number of calculations were performed using varying percentages to see the effects on the need methodology.

Finally, the workgroup reviewed the number of expected hospice users needed to exceed the current utilization before a county is considered open to a new provider. The current threshold is 25. The majority of the hospice providers in the workgroup felt that the threshold of 25 is much too low because it is not possible for a new provider to survive financially with only 25 patients. This would work out to an average daily census of about

five patients. All of the components of care provided by a hospice provider could not be delivered in a financially feasible manner with only five patients per day. One member disagreed and felt that hospice should be handled in the same manner as home health. Currently, the Authority will approve a new home health provider if there is an unmet need of one or more. This member felt that there should be an adjustment factor in the need calculation when a new provider has been approved to allow it to become fully functional before another provider could be approved. This is also done in the home health need methodology. A number of calculations were performed using varying thresholds to see the effects on the need methodology.

Need Methodology Recommendation

After the workgroup's discussion of the current need methodology and possible changes to the current need methodology, the Hospice Council of West Virginia made a recommendation for a revised need methodology for hospice services. The recommendation includes the following changes to the current need methodology:

(1) Use the number of hospice deaths in the calculation instead of the number of unduplicated patients served;
(2) Use total deaths excluding external causes to better represent the number of deaths that were eligible to receive hospice services;
(3) Use 30 percent instead of the current 25 percent in calculating the number of expected hospice users;
(4) The unmet need threshold should be increased to 75 before a new provider can be approved for a county; and,
(5) A three-year average should be used for all data elements in the need calculation.

With the recommended changes to the need methodology incorporated, the hospice need methodology was calculated. A two-year average was utilized for the data elements instead of a three-year average since only two years of data were collected for the purpose of this workgroup. Other options were also calculated for the workgroup's review and consideration.

After presentation of the recommended need methodology and other potential need methodology calculations, a discussion was held to obtain the members' thoughts and opinions. Two members expressed concern that the recommended need methodology is more complicated than the current calculation. These two members also expressed concern for patient choice as the recommended need methodology doesn't require more than one provider in each county, which may require a patient to move to receive care from a provider not approved to serve his or her county of residence. Other members of the workgroup felt that providing choice just for the option of choice does not support a financially feasible system and the CON program does not require any other health care service to have more than one provider of that type of service in a county. Therefore, the need for a new hospice provider in a county should be based solely on a need methodology.

A vote was taken by the workgroup members present, with one member voting by proxy, regarding the need methodology recommended by the Hospice Council of West Virginia. Eleven members voted for and two members voted against the recommended need methodology. The recommended need methodology was adopted as the workgroup recommendation for this report.

Hospice Workgroup Recommendations

After holding three public hearings, three meetings of the workgroup, reviewing data, and much discussion, the hospice workgroup makes the following recommendations:

(1) The need methodology for hospice services should be calculated by comparing the number of hospice deaths in a county to the total deaths in the county, excluding external causes, using a three-year average of data. The number of expected hospice users in a county should be calculated by taking 30 percent of the total deaths in a county excluding external causes. The average number of hospice deaths in the county excluding external causes should then be subtracted from the calculated number of expected hospice users. If there is an unmet need of 75 or more, the county is open for the approval of a new hospice provider.

(2) The Authority should conduct an annual hospice survey to collect the needed data from current hospice providers. The workgroup recommends state law be amended to allow this to occur.

(3) Education of the public and health care providers on the benefits and services provided by hospice care is desperately needed. Hospice services are currently underutilized due to patients either not being referred at all or being referred too late into their disease progression to hospice care. The way to increase utilization of hospice services is through education, not additional providers.

(4) There is currently a cumbersome payment process when hospice care is provided in a nursing home. This may be the reason why many nursing homes are not referring patients to hospice care. Currently, federal law requires that when a patient in a skilled nursing facility becomes a hospice patient, Medicaid can no longer directly pay the nursing home but instead will begin paying the hospice provider and the hospice provider then has to pass the room and board rate to the nursing home. This delays the payment to the nursing home. This is difficult for both the nursing home and the hospice provider. Therefore, the workgroup recommends the legislature approve a waiver for this Medicaid requirement.

Compliance with Legislative Mandates

The hospice workgroup provides the following with regard to each of its mandates outlined in W. Va. Code § 16-29B-31:

(1) Establish a model for data collection to best predict the future needs of hospice services in West Virginia and collect the necessary data;

The workgroup recommends that the Authority conduct an annual hospice survey to collect the total hospice deaths by county from each hospice provider. The Authority

should also request and receive the total number of deaths excluding external causes by county from Health Statistics on an annual basis.

(2) Review the access to hospice services in West Virginia as well as future needs;

The Authority compiled a list of the hospice agencies serving West Virginia and the counties each are serving. The list is included in this report as Attachment F. Every county in West Virginia is served by at least one hospice provider. In addition, the workgroup met on three different occasions and conducted three public hearings to gather information on the current access to hospice services as well as future needs.

(3) Examine how West Virginia serves its population with hospice services;

The Authority conducted a survey of all hospice providers in West Virginia with a 100 percent response rate. The survey collected data on the number of unduplicated patients served by county for calendar years 2017 and 2018. County level data was collected in two ways: (1) by age cohort (age < 65 and age 65 and over); and (2) by location of services provided (skilled nursing facility, assisted living facility, all others). Total hospice deaths were also collected based on the patient's county of residence.

(4) Examine the financial condition of the current delivery system;

The workgroup did not have access to financial statements of the hospice providers in West Virginia since the Authority no longer has the statutory authority to collect this data. Through discussions with the current hospice providers, the workgroup found that most hospice agencies rely on donations and community support to survive financially. Hospice providers are mandated to take care of all the needs of a terminal patient regardless of cost and are reimbursed a flat, fixed rate regardless of the cost to provide services. Hospice agencies that have an inpatient facility rely on the services provided to home-based patients to offset or subsidize the cost of the inpatient facility.

(5) Recommend a need methodology to the Authority for the development of new hospice services; and,

The need methodology for hospice services should be calculated by comparing the number of hospice deaths in a county to the total deaths in the county, excluding external causes, using a three-year average of data. The number of expected hospice users in a county should be calculated by taking 30 percent of the total deaths in a county excluding external causes. The average number of hospice deaths in the county excluding external causes should then be subtracted from the calculated number of expected hospice users. If there is an unmet need of 75 or more, the county is open for the approval of a new hospice provider.

(6) Make other recommendations the workgroup deems appropriate.

Education of the public and health care providers on the benefits and services provided by hospice care is desperately needed. Hospice services are currently underutilized due to patients either not being referred at all or being referred too late into their disease

progression to hospice care. The way to increase utilization of hospice services is through education, not additional providers.

There is currently a cumbersome payment process when hospice care is provided in a nursing home. This may be the reason why many nursing homes are not referring patients to hospice care. Currently, federal law requires that when a patient in a skilled nursing facility becomes a hospice patient, Medicaid can no longer directly pay the nursing home but instead will begin paying the hospice provider, and the hospice provider then has to pass the room and board rate to the nursing home. This delays the payment to the nursing home. This is difficult for both the nursing home and the hospice provider. Therefore, the workgroup recommends the legislature approve a waiver for this Medicaid requirement.

Conclusion

The Certificate of Need program in West Virginia is charged with preventing unnecessary duplication of services and ensuring the financial feasibility of health care providers. There is currently at least one provider of hospice services in every county in West Virginia. The Certificate of Need program in West Virginia does not require there to be at least two providers in every county for any other health care service and hospice should not be any different. Though patient choice is important in the provision of health care services, providing choice for the sake of providing choice does not support a financially feasible system. Data shows that additional hospice providers does not result in additional hospice utilization.

West Virginia is currently ranked #1 in the nation in the quality of overall hospice services. There is no evidence that patients in West Virginia are having difficulty obtaining hospice services when needed. There is not a problem in West Virginia with patients being underserved with regard to hospice care; there is a problem with underutilization. The problem with underutilization can only be solved through efforts to better educate West Virginia residents and providers on the services and benefits of hospice care.

It is the opinion of the majority of the hospice services workgroup members that the recommended need methodology will allow the West Virginia Health Care Authority to better fulfill its responsibility to prevent unnecessary duplication of services and ensure the financial feasibility of health care providers.

Attachment A

Hospice Workgroup Meeting Minutes

West Virginia Health Care Authority Hospice Workgroup
Wednesday, June 12, 2019
11:00 A.M.
Meeting Minutes

PLACE OF MEETING:

The meeting of the Hospice Work Group was held at the West Virginia Health Care Authority (Authority) and via conference call on Wednesday, June 12, 2019 at 11:00 a.m.

MEMBERS PRESENT: (In Person or Telephonically):

Robert Gray (Authority Board Chair)
Cynthia Bougher
Linda Carte
Margaret Cogswell
Dr. Larry Dial
Juliana Frederick
Janett Green
Melanie Hall
Emily Hopta (For Rae Bates)
Dr. Jack Kinder
Kathy Merrill
Larry Robertson
Sharon Rotenberry
Angela Smothers

MEMBERS ABSENT:

Karen Bowling
Debrin Jenkins
Dr. James Stollings
Mary McCartney

NON-MEMBERS PRESENT: (Authority Staff and Board Members)

Barbara Skeen
Tim Adkins
Jennifer Douglas
Mary Fitzgerald
Cheryl Henry
Charlene Farrell (Board Member)
Darrell Cummings (Board Member)
Sandy Dunn (Board Member)

CALL TO ORDER:

Robert Gray, Board Chair for the Authority and Chair of the Hospice Work Group, welcomed the attendees and called the meeting to order.

MEETING BEGAN AT 11:02 A.M.

INTRODUCTION: Senate Bill 537, passed March 8, 2019 and went into effect June 6, 2019, laid out what the Legislature hoped the body (Hospice Work Group) could accomplish in the revision of the Hospice Standards. Notebooks containing reference materials were presented to all members that attended in person. Those participating via phone were provided the materials by email.

TOPIC: Purpose of the Hospice Work Group and Important Deadlines

DISCUSSION: The law states that the Hospice Work Group is tasked to do the following:

- Establish a model for data collection to predict the future needs of hospice services
- Data Collection
- Review access to hospice services as well as future needs
- Examine how WV serves its population with hospice
- Examine the financial condition of the current delivery system
- Recommend a need methodology to the Authority
- Make other recommendations that the work group deems appropriate

The work of this body is a limited duration assignment. The Hospice Work Group will sunset on **December 31, 2019.** There must be three public hearings held in each congressional district to solicit public comments on hospice services, access and need. The Authority, by law, will staff the committee/work group and do the work. **The final report must be completed by September 30, 2019** and submitted to the Joint Committee on Government Finance, the Governor and the Authority. The Authority will develop standards from the findings of the report no later than **December 1, 2019.** Prior to sending to the Governor, a draft must be provided to the Legislative Oversight Committee on Health and Human Resources before **December 31, 2019**. The Governor cannot approve the Hospice Standards prior to **December 31, 2019.**

TOPIC: Hospice Standards

DISCUSSION: The last hospice task force was formed in 2016 to develop new hospice standards. This group came up with the revised standards with information gathered from the Authority, stakeholders and the public. The Authority Board approved the draft standards and presented them to the Governor for approval/signature. The Governor declined to sign the draft standards; this action spurred legislation in the 2019 session and called for the creation of the present Hospice Work Group. The legislation stipulated who the members of the Hospice Work Group would be with specific deadlines and missions.

TOPIC: Hospice Data Collection

DISCUSSION: The Authority used to collect hospice data annually through Financial Disclosure and with this information, the need methodology was revised as needed. Due

to legislative changes, the Authority no longer has the ability to collect this data. The last data on file was received in 2015. In preparation for the work group meeting, hospice providers were surveyed, and the data collected for 2017 and 2018 are being used for this work group.

TOPIC: Goal of the Hospice Work Group

DISCUSSION: Chairman Robert Gray asked that the group take the proposed standards and provide written comments. The goal of the Hospice Work Group is to provide a set of standards that works for the State as well as the providers. Mr. Gray also charged the Hospice Council to reconvene their working group and review the proposed standards once more and provide written comments. The Hospice Council and any other member of the Hospice Work Group that would like to submit his or her written comments on the topics discussed at the meeting, should submit those to Barbara Skeen, CON Director, on or before July 10, 2019, and the comments will be shared with all members of the work group.

THE MEETING WAS ADJORNED AT 12:24 P.M.

West Virginia Health Care Authority Hospice Work Group
Wednesday, July 31, 2019
11:00 A.M.
Meeting Minutes

PLACE OF MEETING:

The meeting of the Hospice Work Group was held at the West Virginia Health Care Authority (Authority) and via conference call on Wednesday, July 31, 2019 at 11:00 a.m.

MEMBERS PRESENT: (In Person or Telephonically):

Robert Gray (Authority Board Chair)
Cynthia Bougher
Karen Bowling
Linda Carte
Margaret Cogswell
Janett Green
Melanie Hall
Emily Hopta
Debrin Jenkins
Dr. Jack Kinder
Mary McCartney
Kathy Merrill
Larry Robertson
Shauna Shafer
Angela Smothers

MEMBERS ABSENT:

Sharon Rottenberry
Dr. Larry Dial

NON-MEMBERS PRESENT: (Authority Staff and Board Members)

Barbara Skeen
Tim Adkins
Jennifer Douglas
Mary Fitzgerald
Cheryl Henry
Charlene Farrell (Board Member)
Sandy Dunn (Board Member)

CALL TO ORDER:

Robert Gray, Board Chair for the Authority and Chair of the Hospice Work Group, welcomed the attendees and called the meeting to order.

MEETING BEGAN AT 11:03 A.M.

INTRODUCTION: Senate Bill 537, passed March 8, 2019 and went into effect June 6, 2019, laid out what the Legislature hoped the body (Hospice Work Group) could accomplish in the revision of the Hospice Standards. Notebooks containing reference materials were presented to all members that attended in person. Those participating via phone were provided the materials by email.

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TOPIC: General Discussion of Participants

DISCUSSION: This is the second Hospice Work Group meeting that was scheduled. There were three public hearings held in the three Congressional Districts (District 1 – Morgantown, District 2 – Charleston, and District 3 – Beckley). There were some good comments that were provided by the public, hospice providers, and interested parties at all three public hearings. The attendance for each is as follows:

- July 9, 2019 – Morgantown (7)
- July 16, 2019 – Beckley (5)
- July 24, 2019 – Beckley (8)

The public hearings provided a good perspective of the hospice community's position. The themes throughout the public hearings were common: (1) patient choice and (2) too much choice may not be a good idea.

TOPIC: Need Methodologies From Other States (Presented by CON Analyst, Timothy Adkins)

DISCUSSION: Previously Tim Adkins (HCA Analyst) was asked to review need methodologies from other state that had CON and provide a summary to the group. His findings were as follows:

- There are 17 states that review hospice services in some way. The majority review hospice for in-patient services for hospice beds. A few do not review the out-patient home-based services.

- For those that do review out-patient hospice services, no methodologies are the same. There was a difference in need methodology and there are some definite differences from ours. West Virginia's need methodology takes the number of deaths in the county and subtracts the number of patients that you are serving. The other states use the hospice deaths. To calculate, take the total number of hospice deaths in the county and divide that by the number of total deaths in the county to get the hospice penetration rate. This is something that West Virginia has never done. The others would then add the penetration rate to the population to make a projection. Where West Virginia uses one year (current) of data to calculate need, other states tend to use a three to five-year average to get the penetration rate and to make projections.

- Many of the states also use age cohorts – (0-64) and (65-up). They also use diagnosis; cancer versus non-cancer. All findings were broad, no two states were exact. There was one state that had a policy specifically dealing with patient choice and in a county where there was only one provider.

- Kentucky is unique in that it has a general need methodology but then they break it down into the rural areas versus urban areas. The urban area population is for 100,000 or more.

- Other states do have floors; pertaining to what it would take to bring in another provider. Arkansas had a floor of 25, but used hospice deaths versus county deaths to come up with the penetration rate.

- In North Carolina, to have a hospice, the need must be 90, the population must be 100,000 or more and have at least three providers.

- West Virginia is the simplest compared to other states. The state also has one of the most user-friendly websites pertaining to CON.

- The research showed no state that has CON requires there be more than one provider in a county.

The floor was then open for questions.

Question (1): Of the number that do analysis, was there any consistency with a state that was densely populated compared to a state dynamic like West Virginia? **Answer - No** Tim looked at Mississippi and Rhode Island, but Rhode Island only reviews in-patient. They were all different.

Question (2): The methodology that was used to compare hospice deaths, was there any consistency? **Answer – They were all somewhat consistent. They used total county deaths and divided that into the number of hospice deaths to get the penetration rate. During the research, there were some states that had a moratorium on in-patient hospice beds. Of all the other states that were reviewed, West Virginia has the simplest calculation. For West Virginia, take the calendar year, total number of deaths and subtract from total number of hospice users during that year.**

Question (3): Just because the methodology is simple and easy to understand, that does not always indicate that it is the most appropriate model; what did your findings indicate? **Answer – This model has worked for West Virginia for years. The West Virginia Health Care Authority (Authority) has always worked with the Council and providers to develop standards. It is apparent that the state is being covered. There may be some areas of the standards that need to be revised, but still think that the hospice providers are doing an excellent job in the county. The research also showed there are several states who do not have any openings for new hospice providers, even using how they calculate their need methodology.**

Question (4): Was there any consistency pertaining to deaths and sudden deaths? **Answer – The standards reviewed by other states did not go into that. It was deaths versus hospice deaths. There is uncertainty on how to capture this information.**

The one state that required patient choice, had a policy that stated it had to be a contiguous county. If there were multiple providers in the county, all providers had to be given the opportunity to serve the patient population. West Virginia currently has an unwritten "gentleman's agreement" that works similarly, but there is no formal agreement/process in place.

Question (5): Chairman Robert Gray asked if all states collected hospice data and asked if West Virginia collected this data. **Answer – Yes, all states do, but West Virginia (the Authority) is no longer allowed/required to collect this data.**

Question (6): In the other states, is there a breakdown of how many hospice providers are non-profit and for-profit? **Answer – That was not reviewed during the research. Need methodology was the sole focus of the research.**

When CMS looks at data, often they lump West Virginia, Arkansas, and Mississippi together for comparative reasons. The Authority also has used these states when reviewing other standards. Kentucky is also used because of its location to West Virginia even though Kentucky has much larger cities than West Virginia.

TOPIC: Continued General Discussion of Participants

Chairman Gray posed several questions: What is the average length of stay in a hospice within the last six months of life; do hospice providers get patients later than that? **Answer – The average length of stay is way shorter than six months. This varies from program to program. One provider stated that theirs was in the high 50's, but the median length of stay is approximately eight days. Three percent of patients usually die within three days of admittance.**

The Chairman then asked if the system waited for the last week of life for hospice referrals. **Answer – Yes**

Like 20 years ago, there are still physicians that are not well versed in palliative or hospice care. To combat this, would like to see medical and nursing schools add these elements to their curriculum or have these students do a rotation in hospice. This would promote what hospice provides.

Authority Board Member Charlene Farrell ran a hospice facility in Huntington for over 30 years. She stated that her agency had a program with Marshall University's medical school over 20 years ago that continues today. Every third-year medical student that went through a rotation had physicians trained in palliative care. This was expanded to the residency program as well. Also, the nursing students from Marshall and St. Mary's were offered the opportunity to shadow. The hospice benefited from the program because a few students ended up being palliative care physicians that went on to work for hospices. This did not change the average length of stay. In fact, the length of stay is lower today than it was 15 years ago. If you follow the money, as the hospital and doctors got squeezed in their reimbursements, the referrals in anecdotal observations got shorter and shorter.

WVU does something very similar with their med school and nursing students.

There is an emphasis on this in teaching because many recognize that end of life care is extremely important. With the reimbursement model, we are going to have to look at how we take care of patients in the post-acute world.

Often it is not just the physician that causes barriers to care, it is the family dynamic. Sometimes in the health care world, we try to get patients and families where they need to be. The doctor can be on board, but it is difficult to get the family to agree to move their loved one into hospice care or there are barriers in the home that can prevent this.

There are a multitude of factors that impact the length of stay. It is also a cultural issue. It is family's denial of death. A referral to hospice means that you are dying and for some families, that is hard to accept.

In very rural communities, there is an outsourcing of the youth; when most get of age, they move away to pursue employment opportunities and what is left is the very elderly taking care of the very elderly. This too is a barrier to hospice care.

There was a time that the Legislature thought that end of life care needed a law to require CEU's. In 2004, the Legislature passed a bill that required physicians to have six hours of continuing education in end of life care. This was in place for two years and the physicians felt it was a waste of time and the Legislature cancelled the bill.

Chairman Gray stated there has been approximately a 30 year, robust history of hospice care in West Virginia, but it appears that like in 1989 when hospice providers received patients with seven days to live, not much has changed in 2019.

The trend nationally is that hospice is serving more patients, but you'll see that it's a nationwide crisis that the length of stay is often less than 7 days. It appears there is more hospice care being delivered; there are more individuals being "touched" but for a much shorter time.

Most physicians do not have the time to discuss end of life care in the approximate seven minutes they may spend with you during a visit. It is not just about the reimbursement rates, it is the lack of support; the hard work that is needed to be done pertaining to the end of life care.

Patient choice is a positive but too much choice may be a negative thing. We need to reeducate our population. Most would like to see a nationwide campaign that focuses on hospice education and end of life care. Many do not understand the aspects of hospice and or hospice care. Some do not realize that if you choose hospice care and you get better, you can come out. People know what hospice is but many may not fully understand the concept.

Board member Farrell said the percentage of patients that had cancer and utilize hospice was greater in the beginning, but as treatment evolved, the number of cancer patients is a lot fewer. As other diagnoses began to be taken care of by hospice, CMS saw the expansion of other diagnoses and more non-cancer patients starting to utilize hospice services. As more physicians and the public started realizing the benefits of hospice, there was a rise in the cost of providing hospice care as part of the budget for CMS. Then they started to create rules to tamp down utilization and started denying claims for people who obviously had six months or less to live but because you could not prove there was enough of a decline in their health, claims were denied. You would have physicians that you would educate, and they would refer patients for hospice care and then a month later the hospice provider would have to discharge the patient because of CMS denial. This caused some doctors to stop referring patients early and referring them later and later because they did not want the patient to be accepted into the program and then be discharged. The constant evolution of the CMS rules to tamp down the total number of dollars spent on hospice is yet another barrier to receiving hospice care.

The way CMS looks at post-acute services, our state is underserved. There is going to be a greater need. If more people are educated, the need for more hospice providers would be warranted. Due to the increase in cost, CMS may take another look at how things are handled on the post-acute side. Over the next five years, regulations and rules from CMS may change and may open home care. The trend will be to move things in another direction.

Mr. Gray asked if hospice is a mature industry after 30 years, where is the education? How do you do it? **Answer – Hospices across the country have worked diligently to provide education, but that is the issue. Only hospice providers are providing this education. The public needs to hear another voice in this matter.**

Quality of life is better and longer when hospice services are used.

Physicians do not want to give up on their patients. They will do whatever they can to prolong life. There is not an answer on how you can change the attitudes of the physicians pertaining to hospice. Primary care physicians and nurse practitioners are usually the individuals that make referrals for hospice. The education needs to start there.

The terminology pertaining to using "post-acute" when referring to hospice care needs to be changed. It's a problem that most only see hospice care as post-acute. The system needs to be penetrated earlier to get patients to use hospice services sooner.

Most families have a hard time letting their family members go. They want the medical professional to do everything possible for their loved ones. Sometimes it is a family issue that hospice services are not provided earlier, but it is mostly a system issue.

There needs to be a conversation about end of life care the moment a patient is diagnosed. The treatment could be laid out but also discussions need to be had centered around what steps to take when treatment is no longer working.

Chairman Gray stated one of the things that came up in the public meetings pertaining to patient choice was the "gentleman's agreement". If a patient is somehow opposed to the hospice provider in a county that only has one, but referrals can be made to a surrounding county provider. The question posed was is there a formal process in place. **Answer – It is an informal process. A formal process has been drafted, but not implemented. There are parameters put in place that ensures that a patient/family must have a valid reason to seek services elsewhere.**

TOPIC: WV Need Methodology (Presented by Director of CON, Barbara Skeen)

Mr. Gray asked Barbara Skeen if Vital Statistics can stratify deaths; can they provide how many overdose deaths, automobile accidents; can they provide cause of death? **Answer – I think they do, but do not know how accurate and timely the data is. In the past when the Authority was developing a need methodology and have requested data**

for the current year, the data received is not up to date or it is incomplete. Most data received is at least a year old.

Chairman Gray stated that if you are using a formula to capture data tor hospice need, you cannot count overdose deaths, automobile accidents, sudden deaths, murders or suicides. These are not hospice eligible. There are also regulatory barriers such as the VA, federally funded health clinics, prison deaths, etc. Mr. Gray asked if it would be practical to exclude those persons that you will never be able to serve from the data to get the need. Barbara stated she was not sure if those things could be removed from the data source.

The data provided probably comes from the death certificate. How a death is captured on the death certificate affects the numbers as well. The numbers reported by the hospice providers were larger than those of Vital Statistics.

TOPIC: Continued Discussion of Participants

The Chairman asked if hospice margins were good, ok, thin or nonexistent. Answer – They are beyond thin, they are nonexistent. Without funding from the community, most hospice providers would not be able to exist. This differs between for-profits and not for-profits. If you look at margins nationwide, the numbers are higher than what we experience in West Virginia because of the large number of not for-profit hospices on average than the rest of the country.

The question was asked what does a for-profit do differently? **Answer – First they target their market to assisted living facilities and nursing homes which house a lot of dementia patients. They use less resources and are on service for a longer amount of time. These patients will receive services approximately six months instead of the typical seven days. They also do not provide the intensity of services as the services in the last seven days of life and do not provide inpatient facilities unless there is a large census. There are practices that makes them more profitable than the typical not for-profit. The for-profit business model is centered around making shareholders money and the not for-profit is there to provide adequate services. If a not for-profit wanted to operate like a for-profit, it would close the inpatient facility, get rid of bereavement staff, cut the social work staff, would not have a Chaplin. It could do services very minimally and make a profit like that.**

Mrs. Farrell asked if there was data on the average distance to travel to a patient in West Virginia versus other places due to the rural nature of our state and condition of the roads. Does it take longer to make in home visits? **Answer – There is data nationally that ranks West Virginia as a rural state. This is due to population per square mile. There are only approximately 12 states that are considered rural.**

There is some confusion pertaining to for-profit and not for-profit. That is not the only indicator for a positive bottom line, it is size. If you look at all hospitals in West Virginia that are not for-profit; if they had a zero margin or a deficit every year, they would not be

providing services. When you are a small community based hospice, you have a very small base to spread your overhead and that is one of the things that really increases cost. If you are part of a much bigger system, regardless of whether it is for-profit or not for-profit you have a large base over which to spread your overhead.

Choice just for the option of choice does not support a financially feasible system. To have more than one provider in every county just so that everyone can have choice, even though there is an option for doing that in another informal way, brings more harm than good.

With regard to choice (of hospice providers), universally saying that every county must have at least two hospices, defeats the financially feasible model of care and brings more harm than good. This decreases services overall to everyone because those hospices would have to scale back if they are going to have that form of competition.

Everyone deserves a choice. CMS has adopted this position as well. They intervened in choice several years ago by saying that hospitals had to provide choice.

Board Member Farrell stated the CON process stipulates that the Authority is charged with eliminating unnecessary duplication of services. When you look at choice, you must also measure that against financial feasibility. The Authority is also charged with looking at the financial health of agencies that exist. In addition, you must look at the financial wellbeing of the organizations. If they do not have the ability to sustain an organization, they will fold. These are charged to the CON. The state of West Virginia has a CON law to remove unnecessary duplication of services and to ensure the financial feasibility of the organizations that exist.

Of the other 17 states that has hospice standards, there is not a requirement that would automatically grant a CON because there is only one hospice. They are all based on a need formula and not a choice formula.

Chairman Gray posed a question to Barbara Skeen pertaining to the timeframe of current hospice standards. Barbara replied that the process of developing a draft of new hospice standards was taken up two years ago to replace the 2006 standards. The Hospice Council was involved as well as other providers. The Authority hosted a stakeholders' meetings where multiple parties were represented. Chairman Gray said the Authority approved the standards and sent them to the Governor in November of 2018 and he did not sign them. When they were returned, there was no guidance and then the legislation (SB 537) was passed.

Barbara Skeen said the proposed standards that were sent to the Governor in 2018 had the following changes:

- More descriptive definition
- The Methodology – The Need Methodology in the current standards state that you take the total deaths per county (data provided by Vital Statistics), multiply that by 25% and that is the total projected hospice users. If the total projected hospice

user exceeds the current utilization by 25 patients, then an unmet need exists. That would open a county for another provider.

- Changes to the section that states how this will be determined. The Authority no longer can conduct surveys nor collect and calculate utilization data. (The Authority used to conduct an annual hospice survey and then would calculate the hospice need methodology). The new standards state that if you are a provider and want to expand into another county, you must conduct the survey yourself. This entails surveying all providers, gather utilization data from Vital Statistics, and providing this information to the Authority in a CON application to demonstrate an unmet need exists in a county. The instructions are provided in the standards on how this should be done and what should be stated in the survey.

Pertaining to the need methodology, there was no change made to the actual formula. The proposed revised standards were simplified.

If the need methodology formula was changed from:

25% to 30% - No change
25% to 35% - No change
25% to 40% - Opens three counties (Mason, Nicholas and Wayne)
25% to 45% - Opens eight counties
A total of 11 counties would come into play if the formula is changed to the suggested number put forth by the Governor

There has been no evidence submitted to the Authority that suggests there are patients that want/need hospice but are on a waiting list or who were not served when a referral was made.

With the aging population in the state, there is a growing need for more hospice care. Cancer is mentioned and associated with hospice, but there are more illnesses that could be served by hospice care; dementia being one of them. There are a lot of patients in the state eligible for hospice care but the services are not being utilized. We are underserving people in the state. This all goes back to education. There are more patients out there that have not been identified. Charlene Farrell said that CMS removed the diagnosis of debility, which is a common problem in the aging population from the hospice diagnosis.

There is not a problem with patients being underserved in the state, it is a problem with underutilization.

Most hospice providers in the state can "gear up" if the need for service increases in the future. The capacity for future need does not necessitate more providers.

There is no data to support the addition of more providers. The data supports the opposite. There are counties in the state that have multiple providers but have a smaller utilization rate than counties with only one provider.

Every county in the state of West Virginia has at least one hospice provider.

One of the outcomes of the Hospice Work Group is further discussion on education for providers and the public is needed so that they can understand the importance and value of hospice.

Question posed: Has there been a model established for data collection that could predict the future needs of hospice services? **Answer – That ability has been removed from the Authority by actions from the Legislature**.

None of what has been discussed thus far can happen without data. The law changed and because of the change, the Authority can no longer collect hospice survey data. To have a need methodology that is acceptable and valid, there must be good data available for use. There needs to be a common data source used.

Right now, the data received from Vital Statistics is the most accurate data available, but there is no perfect source for data collection.

The current formula compares the number served to total deaths, but what has been discussed is deaths to deaths. When you use the deaths to deaths formula, you cannot capture the "experience" of hospice. The data reporting does not capture the patient that moves to another hospice. Only the hospice that was serving the individual when they died can count them. Death to death collection gives you clean data.

To revisit the formula, if the percentage (25%) is going to be raised, then the minimum unserved at 25 needs to be raised as well. There are instances where this number can be 99 or 100.

Chairman Gray charged the work group to reconvene after the Authority is in contact with Vital Statistics about data collection methods.

MEETING WAS ADJOURNED AT 12:55 P.M.

West Virginia Health Care Authority Hospice Work Group
Wednesday, September 11, 2019
11:00 A.M.
Meeting Minutes

PLACE OF MEETING:

The meeting of the Hospice Work Group was held at the West Virginia Health Care Authority (Authority) and via conference call on Wednesday, September 11, 2019 at 11:00 a.m.

MEMBERS PRESENT: (In Person or Telephonically):

Bob Gray
Larry Robertson
Mary McCartney
Kathy Merrill
Melanie Hall
Janett Green
Margaret Cogswell
Emily Hopta
Debrin Jenkins
Linda Carte – via telephone
Cynthia Bougher – via telephone

MEMBERS ABSENT:

Karen Bowling
Dr. Larry Dial
Dr. Jack Kinder
Sharon Rotenberry
Angela Smothers

NON-MEMBERS PRESENT: (Authority Staff and Board Members)

Sandy Dunn – WV Health Care Authority Board Member
Charlene Farrell - WV Health Care Authority Board Member
Darrell Cummings – via telephone - WV Health Care Authority Board Member
Barbara Skeen
Allen Campbell
Tim Adkins
Jennifer Douglas
Mary Fitzgerald

CALL TO ORDER:

Robert Gray, Board Chair for the Authority and Chair of the Hospice Workgroup, welcomed the attendees and called the meeting to order.

MEETING BEGAN AT 11:05 A.M.

Chairman Gray stated that at the last workgroup meeting, a big part of the discussion was around removing from death statistics those deaths that would not be eligible for hospice care. We weren't sure we would be able to get this information through Vital Statistics, but we talked to them and they were able to provide death statistics striking those deaths that wouldn't be eligible for hospice care. Barbara Skeen explained the in-depth conversations that occurred with the staff at Vital Statistics about obtaining death data that would exclude those types of deaths that wouldn't be eligible for hospice care. After discussions among the staff members at Vital Statistics, they determined that providing death statistics excluding "external causes" would provide the data we are requesting. Vital Statistics providing a copy of the ICD-10 codes that were included with "external causes". Excluding the "external causes" will cover the types of deaths previously discussed such as suicides, drug overdoses, car accidents and will include other categories such as frostbite, burns, drowning...anything cause by an external force. Based on the previous discussions, these death statistics would provide what we are looking for with regard to better capturing deaths eligible for hospice care.

A table was provided to the workgroup members showing the difference in the number of total deaths per county and the total deaths excluding external causes per county.

Chairman Gray asked Margaret Cogswell with the Hospice Council to explain the proposal submitted by the Hospice Council, which was previously distributed to the members of the group. Margaret provided the following explanation:

> First, she stated that she had requested and received a copy of the "external deaths" and is in agreement that these are appropriate exclusions for patients that couldn't be serviced by hospice. The letter provided to the Authority by the Council is a proposed need methodology. The proposal includes a change to the formula to be total deaths for the county minus total sudden deaths (at the time the proposal was developed, the data regarding deaths due to external causes wasn't available so the "sudden death" data used is slightly different than the deaths excluding external causes) times 30% will equal the total projected hospice users. If the total projected hospice users exceed the current utilization by 75 patients, then an unmet need exists.
>
> She outlined the proposed changes to the need methodology:
>
> 1st change - the recommendation is to use deaths instead of the previous method of using patients served. Using patients served results in problems such as duplication of patient counts when a person is under hospice care at the end of a year and into the new year, the person is counted twice, once in each year. There are also times when a person is served by more than one hospice provider, this same person would be counted by each hospice provider that provided service. Comparing deaths to deaths, makes the data cleaner because death only occurs once.

2nd change – using total deaths excluding "external causes" which will recognize the population that cannot be served by hospice.

3rd change – the percentage used in the need calculation currently takes 25% of all deaths and this proposal would take 30% of a smaller population since deaths would exclude "external causes". This still won't capture all the patients that hospice cannot serve such as patients in the VA system or patients that come out of an FQHC. The percentage needs to stay low due to the fact that there are a number of patients that will never be eligible to receive hospice services, but the deaths of these patients will still be included in the deaths excluding "external causes".

4th change – the unmet need threshold currently is at 25. Through the conversations that have occurred in this workgroup, it has become clear that 25 is way too low. This is not a financially feasible number whether a hospice agency is adding a county or is new. This would work out to an average daily census of about 5 patients. All of the components of care that hospice providers provide could not be provided in a financially feasible manner with only 5 patients per day. The Hospice Council recommends that the number of unserved needs to be increased to 75 before a new provider could come into the county. 75 is still a low number for a hospice to serve and still be viable. 75 is ¾ of the average number of deaths for a county.

5th change – utilize a 3-year average for all data statistics used in the calculation of the need methodology in order to take into account what is happening over a period of time. We need to use a broader data set if we are looking to bring a whole new hospice agency into a county.

Hospice data collection is not currently done by the Authority due to the changes that occurred a few years ago with the financial disclosure laws. For the purposes of the workgroup, the Authority did a hospice survey and there was a 100% response rate. The burden of collecting the data now falls on the entity applying to become a new hospice provider in a county. Ideally, the hospice providers would provide the data to the Authority instead of individual applicants.

There has been a lot of discussion in the workgroup about a patient's right to choose a provider of hospice services in counties where there is currently only one provider and whether something should be included in the methodology to account for this. It is the Hospice Council's recommendation that the CON process should be based on need alone and not on the fact that there is only one provider. If we are to require that there be more than one provider in every county, we would be negating the purpose of the CON process, which is to be sure that financially viable

providers are available. No other state that does CON for hospice services requires there to be more than one provider in a county without showing a "need" for an additional provider. The recommendation is that there should not be a CON granted for a new provider in a county for the sole purpose of having a second hospice provider.

Public education is greatly needed for our society and providers to really understand the benefits provided by hospice services. There are a lot of barriers that exist out there in society that result in the underutilization of hospice services. This is not the responsibility of the Authority, but the legislature asked us for "other recommendations" and the need for continued public and provider education should be included.

Having and preserving the right to defend so that when a new provider is interested in providing services in a county, the current providers need to have a voice in the Authority granting a new CON.

A discussion occurred about the "right to defend" and how the current CON statute allows an affected party to request a hearing and contest a request for a CON. If there is a specific need methodology and the need methodology shows an unmet need, the Authority's board cannot say there is not an unmet need.

Since the Hospice Council has recommended the Authority be allowed to collect the hospice data, which would require a law change, Chairman Gray asked the other members of the workgroup if they agreed with this. There were no objections from any members of the workgroup to putting in the report that the Authority needs to collect the hospice data.

Calculations of the proposed need methodology were done and provided previously to the workgroup members. In addition to the proposed methodology, the need calculation was run using four other combinations of percentage of deaths and thresholds for the determination of "unmet need" to see if there was much impact on whether counties were open or not. These calculations were discussed with the group. Only one calculation, 40% with a floor of 50, opens up one county, Mason. Interestingly, Mason already has 3 providers. The number of providers in a county doesn't mean utilization will go up, it just means there is more choice.

A discussion occurred about what a patient is to do if they don't want the only provider in the county to provide services. It was explained that the "unwanted" hospice agency would reach out to the next closest hospice provider to arrange for services.

Debrin Jenkins with the WV Rural Health Association raised the question of why residents of nursing homes aren't being given the choice of hospice care and how the relationship works between hospice and nursing homes. It was explained that for a patient to be served in a nursing home, the nursing home has to have a written agreement with a hospice provider. If the nursing home chooses not to have an agreement with a hospice

provider, hospice services can't be provided at the nursing home. It was stated that this is a "choice" that needs to be made available to all patients. If the option of hospice isn't being explained to patients and their families, an educated decision cannot be made.

Hospice will always face the obstacle of families not wanting to give up hope on their loved one and just can't accept hospice care.

Chairman Gray stated that one of the most important tasks that needs to be completed by the workgroup is to determine a recommendation to the Authority for a need methodology. He stated that we have one recommendation currently from the Hospice Council.

Linda Carte, WVU Medicine, expressed concerns that having to perform the proposed need methodology calculation on an annual basis would be too cumbersome for the Authority. It all seems like a complicated approach. She asked for the Authority's staff to give an opinion on the ease of this approach. Barbara Skeen explained that the determination of the death statistics would come from Vital Statistics. The current methodology requires death statistics obtained from Vital Statistics, so the proposed approach may require the Authority to obtain death statistics with different parameters, but it won't be more difficult for the Authority. The other change will require the Authority to use a 3-year average for the calculation. The Authority has already collected 2017 and 2018 data for the workgroup so with the collection of the next year, calculating the 3-year average won't be difficult. The biggest change for the Authority would be collecting the hospice survey data since it currently doesn't collect this data. This will require a law change.

Barbara Skeen stated that she received a call from Karen Bowling, WVU Medicine, because she wasn't going to be able to attend the meeting of the workgroup, but she wanted to express her concerns. Karen stated that she feels the proposed need calculation is more complicated than the current calculation and that we haven't done anything except make it more complicated. She is against the proposal made by the Hospice Council. Her biggest concern is providing patient choice and she doesn't feel that the current providers should be concerned about competition. She stated that the only option in place currently for patient choice is a "gentleman's agreement" and the proposed methodology does nothing to formalize this agreement.

If the group is going to make a recommendation regarding the need for education on hospice service, it was suggested that nursing homes need to be specifically mentioned as needing to provide education to patients in their facilities.

It was suggested that there is currently a cumbersome payment process with regard to hospice care being provided in a nursing home that may be a big part of the problem. Currently, federal law requires that when a patient in a skilled nursing facility becomes a hospice patient, Medicaid can no longer directly pay the nursing home but instead will start paying the hospice provider and then the hospice provider has to pass the room and board rate to the nursing home. This delays the payment to the nursing home. This is

difficult for both the nursing home and the hospice provider so the Hospice Council plans to ask the legislature to pass legislation for a waiver from this Medicaid requirement.

Chairman Gray asked for a recommendation for a need formula. Margaret Cogswell made a recommendation of 30% of deaths, excluding external causes, with a floor of 75, using 3-years of data. Linda Carte expressed concerns that the floor of 75 is really, really high and wants to know why it needs to be different than home health. Home health is open if there is a remainder of 1. Linda agrees there should be a floor, but only if a new provider has come into the county in the past 12 months. This is how the home health methodology works. It was then asked how it makes financial sense to allow a new provider when there is only an "unmet need" of 1 person. Linda explained that she feels that normally a new provider will just be expanding serve from a contiguous county. She again expressed her concern with making the process more difficult and more restrictive than what we currently have. Regarding patient choice, hospice services have to be provided in the home, so the patient doesn't have a choice with only one provider. She is concerned that the proposed formula has made it more restrictive and she doesn't feel that was the premise on which this workgroup began.

A discussion then took place of what the legislation requires the workgroup to accomplish.
(1) Establish a model for data collection to best predict future needs of hospice services in WV and collect the necessary data – we have accomplished this in agreeing to use Vital Statistics death data excluding external causes.
(2) Review access to hospice services in WV as well as future needs – this has been accomplished through 3 public hearings and 3 meetings of the hospice workgroup.
(3) Examine how WV serves its population with hospice services - this has been accomplished through data collection and information obtained through the workgroup.
(4) Examine the financial condition of the current delivery system - we are legally unable to do this as the Authority cannot collect financial data from hospice agencies. We have obtained a lot of information from the hospice providers about the financial struggles due to the reimbursements for hospice services. Hospice agencies normally have to rely on community donations to survive.
(5) Recommend a need methodology to the authority for the development of new hospice services – we are currently working to decide this.
(6) Make other recommendations the workgroup deems appropriate – we've discussed some recommendations.

The only remaining item to decide is the recommendation of a need methodology. Everyone keeps saying the Governor wants hospice care opened up to more providers, but nobody really knows that. It was suggested that the Governor recommended that the percentage be raised to 49% which may suggest he wants it opened up but he did not provide the Authority with a reason, so we can't speculate what his reasons are. There is no evidence that more providers will result or more people utilizing hospice care. There is no evidence of complaints regarding availability or provision of hospice services. According to the data collected by CMS nationally, WV ranked #1 in overall quality of hospice care. A concern was raised about patient choice and whether a patient should have to move in order to have choice. A review of the legislation shows that the

workgroup is charged with certain duties, including studying hospice data and recommending a hospice need methodology, but it does not state that the goal is to open it up to additional providers.

A motion was made by Margaret Cogswell that the recommended need methodology would utilize a 3-year average of data and the calculation would be 30% of total deaths in a county, excluding external causes, less the total number of hospice deaths in the county. If the difference is 75 or more, the county is considered open to a new provider. Melanie Hall seconded. The motion passed with 11 votes in favor, 1 vote against and 1 proxy vote against. The workgroup has accepted the recommended need methodology as the methodology that will be recommended in its report.

The workgroup's report will be written by the chairman and Barbara Skeen and then distributed to the members. The chairman thanked the members for their attendance and participation in the workgroup.

Meeting adjourned 12:25.

Attachment B

Public Hearing Minutes

West Virginia Health Care Authority Hospice Work Group
Congressional District 1 (Morgantown, WV) Public Hearing
Tuesday, July 9, 2019
1:00 P.M.
Meeting Minutes

PLACE OF MEETING:

The meeting of the Hospice Workgroup Public Hearing was held at the Morgantown Public Library on Tuesday, July 9, 2019 at 1:00 p.m.

PRESENT:

Robert Gray (Authority Board Chair)
Dr. Darrell Cummings (Authority Board Member)
Barbara Skeen (Interim Executive Director)
Mary Ann Ferris
Margaret Cogswell
Sonya Bailey-Gibson
Cynthia Bougher
Rochelle Plywaczynski
Latisha Cummings

CALL TO ORDER:

Robert Gray, Board Chair for the Authority and Chair of the Hospice Work Group, welcomed the attendees and called the meeting to order.

MEETING BEGAN AT 1:00 P.M.

The floor was opened for comments. Each participant was told that they could speak to the Hospice Standards, hospice services, accessibility and/or their own personal experience. They were also instructed that they could provide written comments as well.

INTRODUCTION: Senate Bill 537, passed March 8, 2019 and went into effect June 6, 2019, laid out what the Legislature hoped the body (Hospice Work Group) could accomplish in the revision of the Hospice Standards.

TOPIC: Purpose of the Hospice Work Group and Important Deadlines

DISCUSSION: The law states that the Hospice Work Group is tasked to do the following:

- Establish a model for data collection to predict the future needs of hospice services

- Data Collection
- Review access to hospice services as well as future needs
- Examine how WV serves its population with hospice
- Examine the financial condition of the current delivery system
- Recommend a need methodology to the Authority
- Make other recommendations that the work group deems appropriate

The work of this body is a limited duration assignment. The Hospice Work Group will sunset on **December 31, 2019.** There must be three public hearings held in each congressional district to solicit public comments on hospice services, access and need. The Authority, by law, will staff the committee/work group and do the work. **The final report must be completed by September 30, 2019** and submitted to the Joint Committee on Government Finance, the Governor and the Authority. The Authority will develop standards from the findings of the report no later than **December 1, 2019.** Prior to sending to the Governor, a draft must be provided to the Legislative Oversight Committee on Health and Human Resources before **December 31, 2019**. The Governor cannot approve the Hospice Standards prior to **December 31, 2019.**

TOPIC: **General Discussion of Participants**

DISCUSSION: There has been growth in the hospice industry in West Virginia over a period of years. There is also licensure compliance for all hospice providers as well as Medicare certification which brings another level of regulatory structure.

West Virginia has had a CON law since the 1970's. The current formula is written with two major components: the number of deaths served and minimum number of patients. The number of deaths served used to reflect cancer deaths because this is the population that was served most by hospice care. This changed in 2006 when the Hospice Standards were revised.

There are some populations of deaths that hospice will never be able to serve: sudden cardiac deaths, opioid overdoses, vehicle accidents, etc.

There was real advocacy, to leave the percentage of deaths served at a low level (25%), when the initial revision of the Standards was done. The number of deaths served should be left at a lower number because the numbers vary by county; it allows hospice to understand there is a percentage of deaths that cannot be served or measured. There is advocacy to keep the percentage low at 25%.

Medicare does quality standards. West Virginia ranks fifth in the nation in hospice quality care. This supports the original proposed standards that the Authority put forth last year. It was said that the majority would like to service more patients with hospice care, but do not think that the formula should change to accomplish this. With one exception, the Hospice Council of West Virginia has proposed that the minimum standard for the approval of a new hospice provider should be raised to 100.

There are concerns with a radical change in the methodology. Those involved want to be sure that services are not duplicated to the point where current hospice facilities cannot provide the care that they are accustomed to.

Ms. Mary Ann Ferris attended the hearing as a consumer advocate. Ms. Ferris stated that she used hospice services for her husband, but was not made aware of the services through her husband's physician. She was provided information for respite care, but needed more than the assistance that was being offered. She herself contacted Right at Home in Morgantown, and they connected her with the hospice provider that was used to care for her spouse. After his death, hospice offered grief counseling to her as well as to her family. She stated that she would recommend hospice to anyone facing this type of situation and said that the hospice care that her husband received was excellent. Ms. Ferris would like to see more physicians refer hospice care when it is applicable.

On the other side of the coin, it was stated that the threshold be changed to provide families with more choices when it came to hospice providers.

West Virginia Health Care Authority Hospice Work Group
Congressional District 2 (Charleston, WV) Public Hearing
Wednesday, July 24, 2019
11:00 A.M.
Meeting Minutes

PLACE OF MEETING:

The meeting of the Hospice Workgroup Public Hearing was held at the West Virginia Health Care Authority on Wednesday, July 24, 2019 at 11:00 a.m.

PRESENT:

Robert Gray (Authority Board Chair)
Sandy Dunn (Authority Board Member)
Charlene Farrell (Authority Board Member)
Barbara Skeen (Interim Executive Director)
Timothy Adkins (Authority Analyst)
Cheryl Henry (Authority Executive Secretary)
Jane Marks
Pricilla Bass
Chris Zinn
Shellie Powell
Melanie Hall
Janette Green
Linda Carte
Drew Lewis

CALL TO ORDER:

Robert Gray, Board Chair for the Authority and Chair of the Hospice Work Group, welcomed the attendees and called the meeting to order.

MEETING BEGAN AT 11:00 A.M.

The floor was opened for comments. Each participant was told that they could speak to the Hospice Standards, hospice services, accessibility and/or their own personal experience. They were also instructed that they could provide written comments as well.

INTRODUCTION: Senate Bill 537, passed March 8, 2019 and went into effect June 6, 2019, laid out what the Legislature hoped the body (Hospice Work Group) could accomplish in the revision of the Hospice Standards.

TOPIC: Purpose of the Hospice Work Group and Important Deadlines

DISCUSSION: The law states that the Hospice Work Group is tasked to do the following:

- Establish a model for data collection to predict the future needs of hospice services
- Data Collection
- Review access to hospice services as well as future needs
- Examine how WV serves its population with hospice
- Examine the financial condition of the current delivery system
- Recommend a need methodology to the Authority
- Make other recommendations that the work group deems appropriate

The work of this body is a limited duration assignment. The Hospice Work Group will sunset on **December 31, 2019.** There must be three public hearings held in each congressional district to solicit public comments on hospice services, access and need. The Authority, by law, will staff the committee/work group and do the work. **The final report must be completed by September 30, 2019** and submitted to the Joint Committee on Government Finance, the Governor and the Authority. The Authority will develop standards from the findings of the report no later than **December 1, 2019.** Prior to sending to the Governor, a draft must be provided to the Legislative Oversight Committee on Health and Human Resources before **December 31, 2019**. The Governor cannot approve the Hospice Standards prior to **December 31, 2019.**

TOPIC: **General Discussion of Participants**

DISCUSSION: The current Hospice Standards that are in place, were approved in October 2006, by Governor Earl Ray Tomblin. Part of the charge of the Hospice Work Group is to update them to reflect the changes that have taken place in the hospice industry in the last 13 years.

The former Executive Director of the Alzheimer's Association, now affiliated with AARP, stated that during her time as the Executive Director, the Association covered the entire state of West Virginia in addition to six counties in Eastern Ohio and worked with many families that were availing themselves of hospice services given the health conditions of their family members. All feedback provided was always positive pertaining to the hospice care that was provided. On a personal note, there was a story shared about her own mother that was living in an assisted living facility and was able to enroll in a palliative care program operated by a hospice organization. After a medical scare at the assisted living facility, her mother was transferred to a hospice facility for the last week of her life.

AARP prides itself on being a data driven organization. The data is used to tackle problems and decide what issues/challenges AARP will take on. It was proposed that health care officials in decision making positions be given data that is properly designed, collected, interpreted and analyzed to be able to make informed decisions.

As we look at choice versus competition, it was suggested that data be used to determine need. If choice is going to be a factor, it should be broader than one entity of service. If that is the direction that West Virginia is going, the health care industry as a whole should be looking at this. To identify if there is an unmet need, it should be quantified.

There is an issue with education at the hospitals. As an example, in Nicholas County, if you look at the current data, it shows that there is an unmet need but there were only two referrals made. Staff from the hospice agency was sent in to speak with physicians in the area to see why the mark is being missed. Hospitals are supportive of hospice care, but patients that would be eligible for hospice care are instead being sent to skilled nursing facilities or other entities. Because of this, educating health officials is key.

The culture and referral practices needs to be reviewed. Providing education statewide pertaining to hospice services is key. There could be three or four hospice providers in a county, but if referral practices never change because of lack of knowledge; having more providers is not going to solve the problem.

There is a significant learning curve in some rural areas when it comes to hospice care. The providers that serve these areas should be trained pertaining to hospice and the care that it can provide.

There was a study conducted by CMS on hospice utilization. One of the findings showed there was a disparity in hospice use in urban versus rural areas. This is the case here in West Virginia. Rural beneficiaries are less likely to use hospice and home health services. It is not clear if this type of research has been conducted here in the state. Anecdotally, most patients end up in skilled nursing facilities and swing beds in rural hospitals. The study also showed that Medicaid cancer patients were less likely to use hospice services. As an example, the data showed there are 48% Medicaid patients in McDowell County, Webster County 43% and Mingo 45%; not sure of the exact date of the published data, but just wanted to provide a snapshot of what that population looks like.

One proponent of choice stated that it was important to discuss that the penetration is actually higher than 25% in West Virginia. That is an established piece in determining how much hospice use does occur across the state. There is not a concern to raise the level because we are already above it in many cases. As health care has progressed, freedom of choice is what is needed. Patients have choice in other health services, that should also be the case for hospice.

A hospice patient may have to relocate in order to receive services. It was proposed that services be looked at differently with counties that may only have one provider as opposed to counties with competition. Would like to see what is provided, how much is provided; see if there is value to look at those things.

Speaking on the other side of this, a participant that works in a county that only has one provider, stated that anytime they have a patient's family request that they want to be served by someone else, the agency makes arrangements with other providers to come in. The agency would never treat a patient that did not want the services offered. If this process needs to be formalized so that there is choice, the agency would be open to that. The agency has an in-patient facility that does not produce revenue. A competitor would lose money on an in-patient facility and would not want to offer these types of services.

They would want to offer home based services and that would jeopardize the services being offered by the already established agency. The agency needs the homebased patients to offset/subsidize the cost of the in-patient facility.

Every hospice must disclose to their patients that they have the QAIO process. There is a "gentlemen's" agreement when it comes to referrals to other agencies for care if satisfaction, location or having an established relationship with another provider is an issue. If this process needs to be formalized, then it can be. Patient care is not approached with getting by with the minimum, but to provide the best care possible.

Because of the advancements in medicine, patients are getting more aggressive treatment and hospice referrals may come rather quickly in the very end stages. Also, health care reimbursements are an issue. If you look at the way providers are being reimbursed, it affects how/if someone is referred or not referred to hospice. We need to help strengthen all providers in West Virginia; an integrated system would allow for that to happen.

Hospitals should be getting patients discharged and connected to hospice services earlier; this would help in the mortality rate reporting. We need to work as one entity to make sure that the patient is getting the best care and matriculating through the end stages of life receiving the best care.

There needs to be an integrated system that allows for a broader array of care for the patient whether they live in an urban or rural county. If one of the partners in the integrated system is not strong, that one partner could be identified and dealt with. This will move West Virginia forward as we try to work together with what we have. There are some strong pieces to the puzzle and we need to work together because patient choice is important. The importance of patient choice is that you are clearly communicating how the system operates pertaining to care and makes the patient and the patient's family know what their options are.

When you look at hospice utilization, you must look at the utilization and referral practices or referral sources and compare how you track that.

Chairman Gray stated that one of the themes that has been carried throughout the discussions is that patient choice is vital to a healthy health care system. Having options is good patient choice. On the other side of that, we have heard that too much choice means someone may not make it in the long run due to economic feasibility. There is not data out there to show whether having more choice makes a difference. The quality of hospice services in West Virginia are relatively high compared to the national averages. There is an example, Mason County, a relatively small county has three hospice providers and Kanawha County, the largest populated county in the state, only has one.

It was reported that one of the providers in Mason County is no longer operating. This is possibly due the inability to fiscally operate.

Board member Charlene Farrell stated that the margins are relatively small in hospice. This is due to the lack of control in pricing and costs. As a provider, you are mandated to take care of all the needs of a terminal patient regardless of cost. The payment amounts are flat and fixed rated and insurance providers go along with that. The hospice business model is not based on capitalism; it is a very tight managed care model. When there is competition for providing services and when the base is taken away that covers your cost, then you will not be able to provide more services due to competition. You may be providing less services because you will not be able to afford it. The major concern is that the service levels will go down. Many hospices report that they lose money annually and it is progressively getting worse.

Ms. Farrell continued to say that one of the functions of the Health Care Authority is to make sure the public gets the services that they need and that the providers can manage fiscally. That is why once the Certificate of Need is granted, the entity must provide financial reports for three consecutive years. We (the Authority) are not just charged with making sure the services are available and the quality is there in conjunction with OFLAC. Hospices are not on an equal playing field with other entities because they have no control over what they are paid or what they are responsible for paying for.

The "six-month prognosis" must also be looked at. The data shows that most physicians do not prognosticate well and that is affecting the timing of hospice referrals.

One participant visited a hospice in Lewisburg on July 22, 2019 and there were no patients. The unit is not being utilized by the public, but the hospice provider is ready and willing to take patients. There are several barriers present when dealing with the hospitals. Some patients admitted have a hospitalist and not a primary care physician so they often utilize the ER and they are not referring those patients to hospice. This is a county with only one provider. The rural issues must be looked at. Most elderly are going into skilled nursing facilities instead of hospices.

MedPAC data shows that the number of providers in an area does not equate to the higher number of patients served.

Dignity Hospice covers Logan and Mingo counties and is the sole provider in that area. 30% of patients to go outside of the state to die (live with relatives, etc.); 30% die unexpectant, that is 60% of patients that hospice cannot/will not serve. Because of these factors, that only leaves 40% of patient's hospices can serve. There is an in-patient hospice unit in Chapmanville, WV. If another provider came in, they would not build an in-patient facility because the patients and money are just not there to be able to survive fiscally.

TOPIC: Final Comments

- The position of the Hospice Council is that we are providing good quality care and to add more providers to counties that only have one, would dilute the services that are being provided.
- It needs to be looked at more broadly than just numbers and an increased variety of options is what is going to drive things.
- We need to look at how hospice is integrated with the rest of the health care delivery system and what are the needs and how they are served.
- Patient choice is always good. Wherever that patient's home is, is where they should receive service.
- If counties are opened, some agencies will no longer be able to take patients that have an insurance carrier that does not pay because the cost to serve those individuals would be unaffordable. If competition exists, you will no longer be able to serve a person that you would not make a profit on.
- Competition for competition sake is not good.
- Quality of care is very important.

West Virginia Health Care Authority Hospice Work Group
Congressional District 3 (Beckley, WV) Public Hearing
Tuesday, July 16, 2019
1:00 P.M.
Meeting Minutes

PLACE OF MEETING:

The meeting of the Hospice Workgroup Public Hearing was held on the campus of West Virginia University Institute of Technology-Beckley on Tuesday, July 16, 2019 at 1:00 p.m.

PRESENT:

Robert Gray (Authority Board Chair)
Timothy Adkins (Authority Staff)
Cheryl Henry (Authority Staff)
Mary McCartney
Ann Pauley
Chris Zinn
Karen Bowling
Janet Green

CALL TO ORDER:

Robert Gray, Board Chair for the Authority and Chair of the Hospice Work Group, welcomed the attendees and called the meeting to order.

MEETING BEGAN AT 1:00 P.M.

The floor was opened for comments. Each participant was told that they could speak to the Hospice Standards, hospice services, accessibility and/or their own personal experience. They were also instructed that they could provide written comments as well.

INTRODUCTION: Senate Bill 537, passed March 8, 2019 and went into effect June 6, 2019, laid out what the Legislature hoped the body (Hospice Work Group) could accomplish in the revision of the Hospice Standards.

TOPIC: Purpose of the Hospice Work Group and Important Deadlines

DISCUSSION: The law states that the Hospice Work Group is tasked to do the following:

- Establish a model for data collection to predict the future needs of hospice services
- Data Collection
- Review access to hospice services as well as future needs

- Examine how WV serves its population with hospice
- Examine the financial condition of the current delivery system
- Recommend a need methodology to the Authority
- Make other recommendations that the work group deems appropriate

The work of this body is a limited duration assignment. The Hospice Work Group will sunset on **December 31, 2019.** There must be three public hearings held in each congressional district to solicit public comments on hospice services, access and need. The Authority, by law, will staff the committee/work group and do the work. **The final report must be completed by September 30, 2019** and submitted to the Joint Committee on Government Finance, the Governor and the Authority. The Authority will develop standards from the findings of the report no later than **December 1, 2019.** Prior to sending to the Governor, a draft must be provided to the Legislative Oversight Committee on Health and Human Resources before **December 31, 2019**. The Governor cannot approve the Hospice Standards prior to **December 31, 2019.**

TOPIC: General Discussion of Participants

DISCUSSION: The current Standard that we are operating from, was approved in 2006 by Governor Tomblin. This is one of the reasons that the Workgroup is tasked with reviewing/revising new Standards.

Those in attendance wanted to ensure that the Workgroup is doing the right thing and wanted to guarantee that small hospice agencies across the state can thrive and continue to provide services for those that need it most. This includes the rural and poverty-stricken areas where accessibility may be an issue.

Chairman Gray stated that we have heard arguments from both sides There are some counties with only one hospice provider such as Kanawha, which is the largest county in the state while Mason County, a much smaller county has three or four hospice agencies servicing a very small patient population. Patient choice is very important, but on the on the other hand, if there are too many providers, it will keep them from flourishing.

It is very important not to allow a lot more competition in rural areas because there are very few patients eligible for hospice. It was discussed that the more hospice facilities there are, to survive, they may try to admit patients that are not true hospice candidates. This is something that has happened in other states. The quality of care in West Virginia is high because there is not "open season". West Virginia is ranked in the top ten in the nation for CAP scores. The satisfaction scores for the state are 84.45 compared to national score of 81.8.

In other states, there are providers that do not offer the level of care that is found in West Virginia. The Bowers Hospice House in Raleigh County offers four levels of care:

- In-Patient hospice care
- Continuous care
- Routine health care

- Respite care

If another provider was added, it would lower their census. If this were to happen, it could cause them to not be able to offer services in rural areas or worst-case scenario, close all together.

The concerns of the Hospice Council are to retain the quality and level of care provided by legacy providers. There are some good for-profit hospice providers in the state; they have come in and saved smaller agencies and allowed them to survive. Because there already are corporate hospice providers in the state, the consensus is there is a "good mix" of providers and therefore there is enough competition where it is needed.

In the Hospice Council comments provided to the Workgroup, it states there is lower utilization of hospice services in nursing homes. Many nursing homes do not feel like they need hospice; they feel that they can offer palliative care themselves. This is a barrier that needs to be addressed. That is why the Council feels raising the percentage of possible patients can be a problem.

On a personal note, one of the participants had personally used hospice care. Her father received in-home patient care and her aunt was one of the first patients admitted to the Bowers Hospice House.

There are few hospice houses in the state. This is a real opportunity for growth. There is a real value in hospice houses because some families would prefer that their loved ones receive care outside of the home.

Due to the geographic layout of the state, hospice services may be available, but timely coverage may be an issue. There needs to be a review to establish if there is an adequate number of providers. If you do a good job, your agency would not necessarily be in danger of losing patients or closing. People will utilize your services because of your reputation.

The Standards needs to be revised. There needs to be patient choice and adequate coverage. The state needs to make sure that we are not limiting ourselves. Statistically there will be more patients in the future that will need hospice services. We cannot just look at today, due to the state's aging population, we must plan ahead. We need to ensure that all the patients across the state needs are being met.

There are currently 36 states that have some form of CON. Chairman Gray asked Analyst Tim Adkins to contact ten of these states and request a copy of their Hospice Standards. If there is something to compare West Virginia's standards to, you can see where the state compares to others. Two of the states recommended were Kentucky and Florida.

Bowers Hospice House, which was founded in 1981, is a Legacy hospice. It is an in-patient facility built by community resources, i.e. donations, bequeathed estates, memorial gifts, fundraisers, etc. Bowers serves the counties of Raleigh, Fayette,

Wyoming and Summers. These are rural and metropolis counties. The issues in the rural counties are not the same as in Raleigh County. There is currently no competition in Raleigh County, but there is in the surrounding rural counties. The money that is being made in Raleigh County is being used to subsidize care in the outlying counties. If the field is opened, it could jeopardize the care to the outlying counties.

Bowers is the premium provider in the area. The Hospice Council did a great job summarizing the barriers of care. Bowers is in an area that has multiple rural health clinics and FQHC's. It is believed that Bowers is at the top volume of rural clinics and FQHC's in the service area. Physicians do not want to refer hospice services because they perceive a barrier in payment. Because of this, hospice is not able to serve multiple populations of patients. There are several jails, prisons and the VA Hospital in Bowers' service area where the deaths are being counted, but they are not being served by hospice care. These are all barriers of care.

At times the hospice house is at full capacity, but most of the time Bowers is operating below their active census of 12 beds. There are hundreds of thousands of dollars lost annually on in-patient units. This cost is offset by the home-based program. Because Bowers is a community built facility, there is a fear that what the community had invested in would be jeopardized to increase competition.

If services are going to be opened for competition, it was proposed that there be some form of level setting to ensure that quality of care is not compromised.

AARP is concerned about the aging population of our state. They want to ensure that adequate services are being offered state wide. The geographical area is a concern as well.

On another personal note, when one of the participants family members was going through significant health challenges, it was hard to get the services that were needed; would like to see more services offered more competition as well. If the latter will harm the citizens of West Virginia, opening the state up for more competition would have to be reviewed. The Standards must meet the needs.

It was proposed that the group look at other programs in the state that are already established and are successful and see how they could be tweaked to work in other areas of the state. There is a definite need to be proactive.

TOPIC: Final Comments

- Quality cannot be compromised
- If more providers are added, they will be competing for a population that is already being served
- The Standards should be revised to where they make sense and patient needs are being met. We must prepare for the future.
- The proposed formula is 49%; the Hospice Council supports 25%.

Attachment C

Compilation of Hospice Survey Data

2017 Hospice Utilization* - TOTALS

20 hospice agencies surveyed; 20 hospice agencies responded.

	Unduplicated Patients								
	By Age Cohort			By Location of Service Provided					
WV County	Age <65	Age 65 and over	Total	Skilled Nursing Facility	Assisted Living Facility	All Others	Total	Total Hospice Deaths	WV Resident Deaths by County**
Barbour	21	101	122	20	8	94	122	90	182
Berkeley	90	421	511	58	22	431	511	365	1,051
Boone	13	100	113	3	5	105	113	102	338
Braxton	39	73	112	10	0	102	112	58	178
Brooke	28	148	176	42	18	116	176	99	291
Cabell	91	468	559	64	76	419	559	466	1,360
Calhoun	5	20	25	0	0	25	25	18	98
Clay	6	48	54	0	0	54	54	38	118
Doddridge	8	26	34	0	0	34	34	31	83
Fayette	70	263	333	44	5	284	333	274	650
Gilmer	12	43	55	3	0	52	55	43	81
Grant	9	47	56	15	0	41	56	40	120
Greenbrier	28	148	176	3	7	166	176	147	500
Hampshire	21	99	120	11	1	108	120	84	289
Hancock	19	195	214	47	4	163	214	177	466
Hardy	7	33	40	1	0	39	40	29	137
Harrison	91	554	645	127	11	507	645	428	882
Jackson	22	158	180	23	24	133	180	143	393
Jefferson	33	252	285	48	0	237	285	210	540
Kanawha	264	1,147	1,411	145	26	1,240	1,411	1,152	2,599
Lewis	17	99	116	18	0	98	116	97	247
Lincoln	33	82	115	2	0	113	115	86	277
Logan	65	249	314	3	0	311	314	215	572
McDowell	25	89	114	13	0	101	114	64	294
Marion	57	383	440	95	25	320	440	257	705
Marshall	28	149	177	20	0	157	177	113	411
Mason	18	67	85	9	0	76	85	69	346
Mercer	58	474	532	79	28	425	532	352	950
Mineral	16	119	135	23	0	112	135	89	332
Mingo	23	97	120	1	0	119	120	65	371
Monongalia	85	477	562	128	3	431	562	319	723
Monroe	9	50	59	1	8	50	59	47	169
Morgan	22	83	105	9	0	96	105	74	238
Nicholas	33	76	109	0	0	109	109	95	358
Ohio	56	263	319	77	1	241	319	217	557
Pendleton	6	59	65	28	0	37	65	39	96
Pleasants	3	53	56	16	7	33	56	44	101
Pocahontas	3	29	32	0	0	32	32	20	103
Preston	23	228	251	54	11	186	251	149	395
Putnam	47	315	362	13	30	319	362	294	631
Raleigh	75	412	487	71	13	403	487	389	1,029
Randolph	34	255	289	81	55	153	289	198	355
Ritchie	3	41	44	1	0	43	44	35	133
Roane	20	58	78	12	0	66	78	60	208
Summers	21	87	108	35	0	73	108	79	232
Taylor	24	146	170	40	22	108	170	78	191
Tucker	7	44	51	13	0	38	51	31	76
Tyler	7	30	37	2	0	35	37	37	105
Upshur	22	151	173	17	5	151	173	138	293
Wayne	27	160	187	7	6	174	187	154	554
Webster	10	29	39	0	0	39	39	33	129
Wetzel	8	77	85	14	0	71	85	73	251
Wirt	6	17	23	0	0	23	23	16	67
Wood	83	545	628	126	53	449	628	407	1,094
Wyoming	29	110	139	3	1	135	139	111	344
Totals	**1,880**	**9,947**	**11,827**	**1,675**	**475**	**9,677**	**11,827**	**8,538**	**23,293**

*As reported by the hospice agencies in the 2017 hospice survey

**Source: WV Health Statistics Center, Vital Statistics System, June 2019

2018 Hospice Utilization* - TOTALS

20 hospice agencies surveyed; 20 hospice agencies responded.

	Unduplicated Patients								
	By Age Cohort			By Location of Service Provided					
WV County	Age <65	Age 65 and over	Total	Skilled Nursing Facility	Assisted Living Facility	All Others	Total	Total Hospice Deaths	WV Resident Deaths by County**
Barbour	16	115	131	22	8	101	131	88	197
Berkeley	109	416	525	63	26	436	525	380	1,099
Boone	30	111	141	0	8	133	141	100	328
Braxton	15	61	76	6	0	70	76	60	198
Brooke	27	183	210	33	42	135	210	122	306
Cabell	78	489	567	65	88	414	567	464	1,338
Calhoun	9	28	37	0	0	37	37	31	109
Clay	14	49	63	0	0	63	63	56	136
Doddridge	5	31	36	0	0	36	36	33	80
Fayette	54	279	333	54	10	269	333	268	620
Gilmer	13	37	50	21	0	29	50	41	94
Grant	5	51	56	10	0	46	56	30	145
Greenbrier	30	177	207	8	4	195	207	187	501
Hampshire	21	98	119	15	1	103	119	84	245
Hancock	23	188	211	33	5	173	211	158	445
Hardy	11	41	52	4	0	48	52	38	169
Harrison	93	560	653	115	17	521	653	454	869
Jackson	17	146	163	24	17	122	163	136	384
Jefferson	41	241	282	57	2	223	282	212	499
Kanawha	192	1,211	1,403	138	28	1,237	1,403	1,165	2,674
Lewis	24	101	125	5	0	120	125	103	247
Lincoln	32	84	116	2	0	114	116	92	307
Logan	44	246	290	6	0	284	290	214	555
McDowell	29	109	138	20	0	118	138	96	370
Marion	66	411	477	95	39	343	477	281	741
Marshall	29	151	180	22	0	158	180	123	398
Mason	25	88	113	17	0	96	113	89	371
Mercer	83	458	541	78	28	435	541	360	904
Mineral	25	105	130	24	0	106	130	101	347
Mingo	27	96	123	0	0	123	123	73	347
Monongali	77	488	565	141	5	419	565	315	732
Monroe	14	49	63	4	6	53	63	49	191
Morgan	24	93	117	9	0	108	117	89	230
Nicholas	15	75	90	0	0	90	90	90	317
Ohio	66	278	344	78	0	266	344	228	568
Pendleton	4	54	58	20	1	37	58	35	98
Pleasants	1	58	59	22	6	31	59	42	97
Pocahonta	7	30	37	1	0	36	37	30	107
Preston	30	224	254	48	9	197	254	144	387
Putnam	42	330	372	14	28	330	372	292	602
Raleigh	76	479	555	71	12	472	555	417	1,100
Randolph	30	252	282	67	47	168	282	199	356
Ritchie	5	42	47	7	0	40	47	32	136
Roane	21	88	109	14	0	95	109	94	236
Summers	32	80	112	29	0	83	112	79	183
Taylor	32	155	187	33	32	122	187	94	208
Tucker	5	44	49	11	1	37	49	21	98
Tyler	8	31	39	2	2	35	39	37	116
Upshur	31	128	159	6	4	149	159	120	255
Wayne	24	148	172	5	7	160	172	140	529
Webster	6	28	34	0	0	34	34	28	127
Wetzel	12	64	76	11	0	65	76	54	234
Wirt	5	21	26	1	0	25	26	19	64
Wood	106	661	767	160	55	552	767	484	1,137
Wyoming	26	117	143	3	0	140	143	107	319
Totals	**1,886**	**10,378**	**12,264**	**1,694**	**538**	**10,032**	**12,264**	**8,878**	**23,450**

*As reported by the hospice agencies in the 2018 hospice survey

**Source: WV Health Statistics Center, Vital Statistics System, June 2019

Attachment D

Synopsis of Hospice Need Methodologies from Other States

West Virginia Health Care Authority

Hospice Workgroup

Review of Hospice Need Methodologies of Other Certificate of Need States

Seventeen states review Hospice services within their perspective Certificate of Need Departments. We reviewed ten of the states to compare their need methodologies. The following is a synopsis of these need methodologies:

(1) North Carolina: North Carolina classifies Hospice services into three groups: Hospice Home Care Offices, Hospice Inpatient Beds, and Hospice Residential Beds. With the exception of Hospice Residential Beds, the state uses the county mortality rates for the previous five years as an indicator of deaths from all sites in each county and is not affected by changes in actual deaths from year to year. The next step is to develop the two-year trailing average growth rate in statewide number of deaths utilizing the previous three years and applied to the current number of deaths served to project changes to the capacity of existing agencies. Hospice deaths served will not be projected to exceed 60% of total deaths. This is followed by applying a projected statewide median percent of deaths served by hospice to projected deaths in each county. To develop the median percent of deaths, they utilize the two-year trailing average growth in the statewide percent of deaths served over the previous three years to the current statewide percent of deaths served. Need is established if the county's deficit is 90 or more and the number of providers located in the county per 100,000 is three or less.

(2) Oregon: Currently going through revision. Licensure is the lead agency.

(3) Washington: Utilizes an age cohort (0-64 and 65+) methodology by diagnosis (cancer and non-cancer patients) for the most recent three-year average. Using the averages, they project the need for services. If there is a deficit of 35 the county is considered open for additional providers.

(4) South Carolina: Inpatient Hospice services are required to go through review. Home Based Hospice Services do not require any review. The facility must be within a sixty-minute drive time of the service area.

(5) Tennessee: Tennessee reviews both Hospice services and Residential Hospice services. Tennessee uses a numerical need formula to develop the Hospice penetration rate. The penetration rate must be less than 80% and there is a need shown for at least 100 total additional hospice services. For Residential Hospice services the same need methodology is utilized.

(6) Alabama: Numerical formula where the total number of Hospice deaths is divided by total number of county deaths to get the Hospice penetration rate. The penetration rate per county is less than 40%, and each approved hospice agency in the proposed county has been operational for at least 36 months. Only one application may be approved in each county during any approval cycle. Needs will be based on a three-year planning horizon.

(7) Arkansas: The projected number of hospice patients will be 25% of the average of the total deaths that occurred in the county for the four most recent years available. The number of hospice deaths by county of residence from the previous reporting year will be subtracted from the number of projected Hospice patients. Need is demonstrated if the projected number of hospice per calendar is 25 or greater in the proposed service area.

(8) Connecticut: Exempt from CON review for hospice services.

(9) Florida: Numerical need methodology utilizing the number of deaths by age cohort and age cohort with diagnosis compared with the number of Hospice deaths. Once the ratio is developed then there must be a deficit of 350 per county for a new provider to be approved.

(10) Kentucky: Reviews both general Hospice and Residential Hospice. Need Methodology is similar to other states using three-year county deaths and Hospice admissions. Kentucky's formula is somewhat different in that Kentucky takes into consideration large urban populations. Also, a new provider cannot be provided unless the existing providers have been operational for three years.

Attachment E

Comparison of Total Deaths and Total Deaths Excluding External Causes

2017 & 2018

2017 West Virginia Resident Deaths by County
Place Where Death Occurred
All Causes of Death

County	Total Deaths
Barbour	182
Berkeley	1,051
Boone	338
Braxton	178
Brooke	291
Cabell	1,360
Calhoun	98
Clay	118
Doddridge	83
Fayette	650
Gilmer	81
Grant	120
Greenbrier	500
Hampshire	289
Hancock	466
Hardy	137
Harrison	882
Jackson	393
Jefferson	540
Kanawha	2,599
Lewis	247
Lincoln	277
Logan	572
McDowell	294
Marion	705
Marshall	411
Mason	346
Mercer	950
Mineral	332
Mingo	371
Monongalia	723
Monroe	169
Morgan	238
Nicholas	358
Ohio	557
Pendleton	96
Pleasants	101
Pocahontas	103
Preston	395
Putnam	631
Raleigh	1,029
Randolph	355
Ritchie	133
Roane	208
Summers	232
Taylor	191
Tucker	76
Tyler	105
Upshur	293
Wayne	554
Webster	129
Wetzel	251
Wirt	67
Wood	1,094
Wyoming	344
WV Total	23,293

Source: West Virginia Health Statistics Center, Vital Statistics System, August 2019

2017 West Virginia Resident Deaths by County
Place Where Death Occurred
Chronic Causes of Death Only (Excluding External Causes)

County	Total Deaths
Barbour	161
Berkeley	863
Boone	300
Braxton	166
Brooke	266
Cabell	1,109
Calhoun	88
Clay	106
Doddridge	75
Fayette	583
Gilmer	77
Grant	113
Greenbrier	451
Hampshire	258
Hancock	426
Hardy	127
Harrison	806
Jackson	363
Jefferson	477
Kanawha	2,312
Lewis	221
Lincoln	240
Logan	511
McDowell	265
Marion	664
Marshall	381
Mason	312
Mercer	844
Mineral	312
Mingo	331
Monongalia	652
Monroe	147
Morgan	203
Nicholas	321
Ohio	511
Pendleton	84
Pleasants	97
Pocahontas	92
Preston	360
Putnam	555
Raleigh	919
Randolph	332
Ritchie	125
Roane	184
Summers	210
Taylor	176
Tucker	72
Tyler	96
Upshur	270
Wayne	464
Webster	120
Wetzel	235
Wirt	63
Wood	1,005
Wyoming	311
WV Total	20,812

Source: West Virginia Health Statistics Center, Vital Statistics System, August 2019

2018 (Preliminary) West Virginia Resident Deaths by County
Place Where Death Occurred
All Causes of Death

County	Total Deaths
Barbour	199
Berkeley	1,103
Boone	326
Braxton	198
Brooke	307
Cabel	1,337
Calhoun	110
Clay	136
Doddridge	78
Fayette	627
Gilmer	92
Grant	146
Greenbrier	505
Hampshire	246
Hancock	443
Hardy	170
Harrison	867
Jackson	385
Jefferson	500
Kanawha	2,680
Lewis	250
Lincoln	311
Logan	555
McDowell	372
Marion	744
Marshall	398
Mason	373
Mercer	893
Mineral	340
Mingo	346
Monongalia	732
Monroe	194
Morgan	231
Nicholas	316
Ohio	571
Pendleton	97
Pleasants	97
Pocahontas	107
Preston	387
Putnam	603
Raleigh	1,098
Randolph	353
Ritchie	135
Roane	236
Summers	183
Taylor	208
Tucker	98
Tyler	117
Upshur	254
Wayne	533
Webster	126
Wetzel	235
Wirt	65
Wood	1,137
Wyoming	317
WV Total	23,467

2018 (Preliminary) West Virginia Resident Deaths by County
Place Where Death Occurred
Chronic Causes of Death Only (Excluding External Casues)

County	Total Deaths
Barbour	180
Berkeley	843
Boone	278
Braxton	166
Brooke	286
Cabell	1,142
Calhoun	103
Clay	118
Doddridge	70
Fayette	555
Gilmer	87
Grant	102
Greenbrier	425
Hampshire	163
Hancock	409
Hardy	113
Harrison	791
Jackson	354
Jefferson	353
Kanawha	2,350
Lewis	230
Lincoln	276
Logan	474
McDowell	289
Marion	677
Marshall	368
Mason	333
Mercer	742
Mineral	214
Mingo	233
Monongalia	662
Monroe	139
Morgan	164
Nicholas	290
Ohio	526
Pendleton	66
Pleasants	90
Pocahontas	92
Preston	343
Putnam	542
Raleigh	966
Randolph	321
Ritchie	125
Roane	214
Summers	157
Taylor	193
Tucker	90
Tyler	108
Upshur	236
Wayne	429
Webster	115
Wetzel	212
Wirt	62
Wood	1,052
Wyoming	286
WV Total	20,204

Attachment F

List of West Virginia Hospice Agencies and Counties Served

West Virginia Hospice Agencies

Hospice Agency	Counties Served
Amedisys Hospice Bluefield	McDowell, Mercer and Wyoming
Amedisys Hospice Vienna	Wood
Morgantown Hospice-an Amedisys partner	Monongalia
Amedisys Hospice Care	Brooke, Harrison, Marion, Marshall, Monongalia, Ohio, Preston, Taylor and Wetzel
Dignity Hospice and Home Health	Boone, Lincoln, Logan, Mingo and Wayne
Grant Memorial Hospice	Grant, Hampshire, Hardy, and Pendleton
Hospice Compassus	McDowell and Mercer
Hospice of Huntington	Cabell, Lincoln, Mason and Wayne
Hospice of the Panhandle	Berkeley, Hampshire, Jefferson and Morgan
Hospice of Potomac Valley Hospital	Mineral
Hospice of Southern WV	Fayette, Raleigh, Summers and Wyoming
HospiceCare	Boone, Braxton, Clay, Fayette, Greenbrier, Jackson, Kanawha, Lincoln, Mason, Monroe, Nicholas, Pocahontas, Putnam, Roane, Summers and Webster
Housecalls Hospice of Camden Clark Memorial I	Calhoun, Pleasants, Ritchie, Roane, Wirt and Wood
Journey Hospice	Pleasants, Tyler and Wetzel
Mountain Hospice	Barbour, Grant, Mineral, Pendleton, Pocahontas, Randolph and Tucker
People's Hospice, Inc	Barbour, Doddridge, Harrison, Lewis, Marion, Monongalia, Taylor, Upshur and Wetzel
Pleasant Valley Home Health and Hospice	Mason
Valley Hospice, Inc	Brooke, Hancock, Marshall and Ohio
West Virginia Hospice	Barbour, Braxton, Harrison, Lewis, Randolph, Upshur and Webster
WV Caring	Barbour, Braxton, Calhoun, Gilmer, Marion, Monongalia, Pocahontas, Preston, Randolph, Taylor, Tucker and Wetzel