STATE OF WASHINGTON
DEPARTMENT OF HEALTH
ADJUDICATIVE SERVICE UNIT

In the Matter of: CERTIFICATE OF NEED APPLICATION OF FAMILY HOME CARE TO ESTABLISH A MEDICARE CERTIFIED/MEDICAID ELIGLIBLE HOSPICE AGENCY TO SERVE THE RESIDENTS OF SPOKANE COUNTY, Petitioner.	Docket No. 07-10-C-2005CN Master Case No. M2008-117721 **AMENDED** FINDINGS OF FACT, CONCLUSIONS OF LAW, AND FINAL ORDER

APPEARANCES:

Petitioner, Family Home Care (FHC), by
Freimund Jackson Tardif & Benedict Garratt, PLLC, per
Kathleen D. Benedict and Jeff Freimund, Attorneys at Law

Department of Health Certificate of Need Program (Program), by
Office of the Attorney General, per
Richard McCartan, Assistant Attorney General

Intervenor, Hospice of Spokane (HOS), by
Workland & Witherspoon, PLLC, per
Peter A. Witherspoon, Attorney at Law

PRESIDING OFFICER: Christopher G. Swanson, Health Law Judge

A hearing occurred March 1-2, 2011, in Kent, Washington. FHC filed a certificate of need application for a hospice providing **hospice** services in the Medicaid or Medicare program in Spokane, Washington. The Program denied the application. Certificate of Need granted.

AMENDMENT OF FINAL ORDER

On July 7, 2011, the Program moved for technical corrections to the final order. The Program requested the following corrections: (1) clarification of the certificate of need at issue in the case: *a hospice serving terminally-ill patients in the Medicaid and Medicare program,* not a hospice providing home health services in the Medicaid and Medicare program as referenced in the Final Order; (2) the inclusion of an additional condition upon granting of the CN that was included in the Program's original review, but inadvertently omitted in the Final Order: that FHC provide the Program with all "ancillary agreements" related to meeting the criteria regarding structure and process (quality) of care criteria, ancillary and support services; and (3) the deletion of references to hospital beds in the Final Order. Neither FHC nor HOS opposed technical amendment of the final order as requested by the Program. *See* Family Home Care's Response to Department's Motion for Technical Corrections to Final Order and Intervenor Hospice of Spokane's Response to Department's Motion for Technical Corrections to Final Order.

Since the errors identified by the Program were the result of scrivener's errors and oversight by the Presiding Officer, under the rationale of CR 60(a), this Amended Order is entered and the corrections are in **bold** face.

ISSUE

Did FHC's application to establish a **hospice providing hospice services in the Medicare/Medicaid program** meet all of the applicable certificate of need criteria?

SUMMARY OF PROCEEDING

At the hearing, the Program presented the testimony of Karen Nidermayer, Department of Health (DOH) Analyst and Mark Thomas, DOH Analyst. The Petitioner, FHC, presented the testimony of: Mike Nowling, owner of FHC; Nancy Field, FHC consultant; and Dr. Nayak Polissar, FHC Expert. The Intervenor, HOS, presented the testimony of Jody Carona, HOS's consultant, and Gina Drummond, CEO, HOS.

The following Program exhibits were admitted:

Exhibit P-1: Certificate of Need Program Record (Application Record (AR) Pages 1–1247).

The following Petitioner exhibits were admitted:

Exhibit PT-1: Excerpts of the Deposition of Bart Eggen.[1]

Exhibit PT-2: Program's Answer to Odyssey's Complaint in a federal lawsuit against the Program;

Exhibit PT-3: Settlement agreement entered into by the Program and Odyssey, settling Odyssey's federal lawsuit against the Program.

Exhibit PT-4: Settlement Agreement entered into by the Program and Odyssey, settling Odyssey's adjudicative proceeding contesting the denial of Odyssey's hospice Certificate of Need applications.

[1] The following pages are admitted: 1-6, 14-15, 18-19, 23-30, 32-34, 36, 41-82, 89-90, 95-102, 106-109, 118-121, 128-130, 135-136, 144-145, 148-149, 155-156, and 158.

Exhibit PT-5: Worksheet of Nancy Field (Exhibit 1 to Second Declaration of Nancy Field).

Exhibit PT-6: Email and exhibits of Nancy Field (Exhibit 2 to Second Declaration of Nancy Field).

Exhibit PT-7: Appendices 1-18 attached to the Declaration of Karen Nidermayer (Program's memorandum supporting FHC's motion for summary judgment).

Exhibit PT-8: Appendices 1-6 (Program's second memorandum supporting FHC's motion for summary judgment).

Exhibit PT-9: Declaration of Bart Eggen, dated December 9, 2010 (contained in Program's second memorandum supporting FHC's motion for summary judgment).

Exhibit PT-10: Polissar data summary, dated March 2, 2011.

The following Intervenor exhibits were admitted:

Exhibit I-1: Email correspondence, dated November 1, 2010.

Exhibit I-2: Department's Evaluation of the Certificate of Need Application submitted by Odyssey Healthcare, Inc., regarding a proposed hospice agency to serve Snohomish County.

Exhibit I-3: DOH Notes for Rulemaking regarding WAC 260-310-290, issued on May 4, 2010.

Exhibit I-4: Declaration of Judy Carona and Exhibits A-G attached thereto.

Exhibit I-5: Excerpts of the Deposition of Bart Eggen.[2]

Exhibit I-6: Comparison of methodologies (admitted for illustrative purposes only).

[2] The following pages are admitted: 9-10, 13-15, 18, 37-38, 52-53, 96, 101-102, 109-112, 115, 119, 12- 127, 134-135, and 143

The Presiding Officer permitted the parties to file briefs in lieu of closing argument pursuant to RCW 34.05.461(7). The parties filed opening briefs on March 24, 2011, and responsive briefs on March 31, 2011. The Presiding Officer closed the hearing record effective April 1, 2011.

Based upon the evidence presented, the Presiding Officer makes the following:

I. FINDINGS OF FACT

Certificate of Need.

1.1 A Certificate of Need (CN) is a non-exclusive license to establish a new health care facility. *St. Joseph Hospital & Health Care Center v. Department of Health*, 125 Wn.2d 733, 736 (1995). The purpose of the CN process is to promote public health by providing accessible health services and facilities, while controlling costs. RCW 70.38.015. The applicant for a CN must show or establish that it can meet all of the applicable criteria. WAC 246-10-606.

1.2 Establishment of new health care facilities, including a hospice providing **hospice** services in the Medicaid or Medicare programs, requires a CN from the DOH. RCW 70.38.025(6), RCW 70.38.105(4)(a), and WAC 246-310-010(31).

Application Process.

1.3 The submission of an application initiates the CN review process. WAC 246-310-090. The Program reviews the information submitted and grants or denies the application. WAC 246-310-200, WAC 246-310-490, and WAC 246-310-500.

1.4 In reviewing the application, the Program applies the criteria in WAC 246-310-200 through WAC 246-390-240. The applicant must show the proposed project: is needed; will foster containment of costs of health care; is financially feasible; and will meet the structure and process of care. *See* WAC 246-310-200(1).

1.5 After reaching a decision, the Program issues written findings. WAC 246-310-490. The findings must include the basis for the decision. WAC 246-310-490(1)(a).

1.6 Following the denial of a CN application, the applicant may request an adjudicative proceeding. RCW 70.38.115(10)(a) and WAC 246-310-610. Prior to requesting an adjudicative proceeding, an applicant may also request reconsideration of the Program's decision. WAC 246-310-560.

Family Home Care's Application.

1.7 In October 2006, FHC submitted its application for a CN to establish a Medicare Certified/Medicaid eligible hospice agency to serve the residents of Spokane County. At the time of the application, Spokane County had two certificates of need-approved hospice agencies, Horizon Hospice and HOS. AR 942. FHC was operating a hospice in Spokane County, but it was exempt because it did not service Medicare/Medicaid patients. FHC submitted its application so that it could begin serving Medicare/Medicaid patients. AR 1-49.

1.8 In April 2007, the Program denied FHC's CN application for lack of need. In the simplest terms, FHC did not show the Spokane planning/service area required an

additional Medicare/Medicaid facility to provide hospice services to terminally ill individuals and support to the individual's family. *See* WAC 246-310-290(1)(d) and (e). To make its decision, the Program compared the projected amount of Medicare/Medicaid Hospice services that will be needed in Spokane County in the future to the amount that are presently being provided.

1.9 More specifically, the Program determined that the six-step methodology of WAC 246-310-290(7) used to calculate need for a Medicare certified Medicaid eligible hospice, resulted in a determination of an unmet need that was less than the amount required to support another facility. After reviewing the FHC's application, the Program projected an Average Daily Census of 20 for Spokane County. The Program concluded that this was below the Average Daily Census of 35 that is the minimum required before a new hospice will be approved.

1.10 In May 2007, FHC submitted a request for reconsideration of the Program's decision. A reconsideration hearing was held on July 12, 2007, resulting in the Program's decision on reconsideration maintaining its denial of FHC's application for a CN. In its decision, the Program identified an error in its application of the six-step methodology. After correcting for the error, the Program calculated an unmet net need of Average Daily Census of 25, below the required Average Daily Census of 35.

1.11 In October 2007, FHC requested an adjudicative proceeding on the Program's denial of its application for a CN. In November 2007, FHC and the Program submitted a joint petition to stay the adjudicative proceeding pending the outcome of the

Odyssey Healthcare appeal and related cases, which addressed issues in common with the current matter.[3] The joint petition for stay was granted, and this matter was stayed.

1.12 On November 6, 2009, following the request of the parties, this matter was remanded to the Program, so that it could use corrected survey data to evaluate FHC's application. The Program conducted a survey in 2008 of existing hospice providers for 2007 use data. In reviewing this data, the Program discovered inconsistencies in the data relevant to this case. The parties sought remand so that the FHC's application could be reviewed using the corrected data.

1.13 On February 11, 2010, the Program released its first remand decision, which granted FHC's CN application based upon the corrected survey data. The Program calculated an unmet net need of Average Daily Census of 36, above the required Average Daily Census of 35. As a result, the Program concluded that FHC demonstrated need.

1.14 HOS submitted comments in response to the remand decision asserting that the Program's remand decision contained errors. On May 5, 2010, the Program released its final remand decision denying FHC's application. After correcting for errors, the Program calculated an unmet net need of Average Daily Census of 24, below the required Average Daily Census of 35.

1.15 FHC timely filed its request for an adjudicative proceeding challenging the Program's final remand decision. The Program has abandoned its decision denying

[3] *See Odyssey Healthcare v. Department of Health*, 145 Wn. App. 131, 143 (2008). The cases are now concluded.

FHC's application.[4] The Program now agrees that FHC's application meets the applicable CN criteria. HOS contests that FHC shows need, but agrees that if FHC shows need, FHC meets all other CN criteria.

Need Criteria.

1.16 To demonstrate need, FHC must show that the population "has need for the project and other services of facilities of the type proposed are not or will not be sufficiently available or accessible to meet the need." WAC 246-310-210(1). Additionally, FHC must show that "All residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly are likely to have adequate access to the proposed health service or services." WAC 246-310-210(2).

Need Criteria: Six-Step Methodology.

1.17 To determine whether a hospice is needed in the planning area in this case (Spokane County), a six-step methodology contained in WAC 246-310-290(7) is used. The methodology takes statistical data from a period of time (here 2003-2005). *See* WAC 246-310-290(7)(a). Then, using the past statistical data, the methodology projects the need for the service into a future "planning horizon" (a period of time into the future, here the third year of operation for the applicant, counted from the first year of operation). *See* WAC 246-310-290(6).

[4] January 21, 2011, the Presiding Officer denied the cross motions for summary judgment filed by FHC and HOS because their remained genuine issues of fact. Prehearing Order No. 12. The Program first abandoned its denial decision in briefs filed in response to the cross motions.

Step 1.

1.18 Step 1 calculates a state-wide hospice use rate among four groups: (1) age 65 and over with cancer, (2) age 65 and over without cancer, (3) under age 65 with cancer and (4) under 65 without cancer, by predicting the percentage of cancer patients in each of the groups who will use hospice services. WAC 246-310-290(7)(a).

1.19 To accomplish this, data showing the average number of hospice admissions over the last three years for patients in each of the groups is divided by data showing the average number of past three years statewide total deaths. "CMS [Center for Medicare and Medicaid Services] and department of health data or other available data sources" may be used. WAC 246-310-290(7)(a).

1.20 The Program obtained 2006 hospice data through state-wide surveys of existing facilities to determine the use rates in this case. However, the Program did not obtain all of the required survey data because not all facilities responded or responded completely. In order to perform the calculations, it is necessary to supplement the submitted survey information using historical survey data (using information submitted by facilities prior to 2006) or CMS data.

1.21 The parties agree the missing survey data should be filled in to obtain an accurate result. Of the two sources of information (historical data and CMS data) only the historical data can be broken down by the age group as required by WAC 246-310-290(1). CMS data cannot be broken down. Therefore the only credible data available to supplement the 2006 hospice service need methodology calculations

is the 2003-2005 survey data obtained by the Program. After application of Step 1, the following hospice use rates apply:

65 and over with cancer: 72.19 %

65 and over without cancer: 30.81%

Less than 65 with cancer: 66.79%

Less than 65 without cancer: 8.50%

Step 2.

1.22 In Step 2 the average total resident deaths in the planning area over the last three years is calculated. Data from the DOH's Center for Health Statistics is used in this step. The average total resident death number is calculated for each of the four categories of patients.[5] Application of Step 2 results in an average of 2,773 patient deaths for the 65 and over group, and an average of 889 patient deaths for the less than 65 group.

Step 3.

1.23 In Step 3, each hospice use rate determined in Step 1 is multiplied by the planning areas total resident deaths determined in Step 2. The result is the number of hospice patients for each of the four categories of patients: (1) patients age 65 and older, with cancer; (2) patients age 65 and older, without cancer; (3) patients under 65, with cancer; and (4) patients under 65, without cancer. Step 3 carries data over from

[5] In applying Step 2, the Program reads "total" to mean the total number of deaths for each of the four categories of patients in Step 1. This approach to the rule was upheld in *Odyssey*, 145 Wn. App. at 142-45.

Step 1 and Step 2. The following data results from the application of Step 3:

65 and over with cancer: 459

65 and over without cancer: 658

Less than 65 with cancer: 165

Less than 65 without cancer: 55

Step 4.

1.24 In Step 4, "the four subtotals derived in Step 3 [are added] to project the potential volume of hospice services in each planning area."[6] When the four subtotals from Step 3 are added together, the total potential patient volume for Spokane County is 1,337 patients.

Step 5.

1.25 Step 5 inflates the potential volume of hospice service by the one-year estimated population growth using Office of Financial Management (OFM) data. When this step is completed using the data from Step 4, the following potential volumes are present:

2006: 1,367 patients

2007: 1,382 patients

2008: 1,398 patients

2009: 1,414 patients

[6] FHC asserts that the age groups should be added separately in this step to account for greater population growth in the over 65 group. The Program and HOS disagree with using the approach as inconsistent with the rule's requirements. The process set out in rule clearly requires adding the four groups together. The Presiding Officer declines to adopt FHC's approach.

2010: 1,429 patients

2011: 1,448 patients

Step 6: Preliminary Calculations.

1.26 Under this step, the current hospice capacity in each planning area is subtracted from the projected volumes in Step 5 to determine unmet need. WAC 246-310-290(1)(c)(i). Since there are two hospices providing **hospice** services in the Medicaid or Medicare program in Spokane County and both have operated in the planning area for three years or more, the definition of current hospice capacity that applies is "the average number of admissions for the last three years of operation." WAC 246-310-290(1)(a).

1.27 Based upon this definition, the current hospice capacity in Spokane County is 1,162 admissions.[7] When this number is subtracted from the numbers from Step 5 (potential volumes of patients), the following are calculated:

2006: 205 unmet need admissions

2007: 220 unmet need admissions

2008: 236 unmet need admissions

2009: 252 unmet need admissions

2010: 267 unmet need admissions

2011: 286 unmet need admissions.

[7] This is based upon survey data.

Step 6: Final Calculations.

1.28 Under WAC 246-310-290(6), a CN may be issued if an unmet need of an Average Daily Census of 35 hospice patients by the third year of operation is shown.

Average Daily Census (ADC).

1.29 ADC is calculated by multiplying the projected annual agency admissions by the most recent Average Length of Stay in Washington (based on CMS data) to derive the total annual days of care and dividing this total by 365 days. WAC 246-310-290(1)(a). Thus, to obtain ADC, Average Length of Stay must be calculated first.

How should Average Length of Stay (ALS) be calculated?

1.30 The Program used CMS data to calculate ALS and applied the CMS method of dividing total patient days provided in a given year by total number of patients receiving hospice care in that year to obtain an ALS for each provider.[8] The Program then combines the CMS totals for each provider and computes a statewide ALS.

1.31 FHC agrees that CMS data should be used, but proposes a different method to calculate ALS. FHC argues that instead of using the method used by CMS, the WAC 246-310-290(1)(a) definition of ADC should be converted using mathematical

[8] All parties used CMS data in Step 6 at the adjudicative proceeding. Prior to the adjudicative proceeding, survey data had been used by the Program.

principles to a calculation for ALS.[9] Under this proposal, the calculation for ALS is as follows:

(ADC x 365)/Annual Admissions = ALS.

1.32 The Program disagrees with FHC's proposal for calculating ALS. The Program points out that FHC's method overstates ALS because patients admitted in one year, for example 2004, would not be counted even when their care extended into the next year, 2005. Instead, the 2004 patients' care (that extended into 2005) would be attributed to the ALS of patients admitted in 2005.[10] The Program's approach to WAC 246-310-290(1)(a) does a better job of capturing data for a given year. Therefore, it is adopted.

Which data should be used to calculate ALS?

1.33 HOS advocates using a 2010 run of 2005 CMS data to calculate ALS, while the Program and FHC advocate using a 2006 run of the data. Both data runs purport to describe admissions for 2005. However, the 2010 run contains information that was not reported until after 2006, the year the application was filed.

1.34 The CN application process is intended to decide whether an application should be granted based upon the circumstances in existence during a particular period of time. *University of Washington v. Department of Health*, 164 Wn.2d 95, 103-104

[9] FHC performs this conversion by (1) converting the Average Daily Census into a formula: ADC = (annual Admissions x Average Length of Stay)/365. FHC converts the formula to an Average Length of Stay formula in two steps: (1) ADC x 365 = (Annual Admissions x Average Length of Stay); and (2) (ADC x 365)/Annual Admissions = Average Length of Stay.

[10] On cross examination, FHC's expert, Dr. Polissar admitted that FHC's proposed method overstates average length of stay.

(2008). This is accomplished by setting a deadline by which all evidence must be submitted for consideration. The *University of Washington* case identified the deadline as the close of the public comment period. Although the Presiding Officer is not bound to exclude evidence submitted after this deadline, such evidence may be denied admission as irrelevant.

1.35 The Presiding Officer chose to admit the 2010 run of the CMS data. However, admission of this evidence does not preclude the Presiding Officer from giving it less weight because it came into existence long after the application record closed. Likewise, since the 2006 run of the CMS data came into existence at the time of the application process, the Presiding Officer may consider it more useful in applying the methodology. After weighing the evidence, the Presiding Officer finds that use of 2006 CMS data should be used to determine ALS, because its use data is consistent with the policies expressed the *University of Washington* case and Chapter 70.38 RCW, as well as the language of WAC 246-310-290(1)(a) directing the Program to use "the most recent ALS" information. [11]

1.36 When ALS is calculated under the CMS method using the 2006 run of data, the result is an ALS of 50.6 days.

[11] *See University of Washington*, 164 Wn.2d at 104 (Since the request for an adjudicative proceeding does not begin the application process anew, requiring the Presiding Officer to admit evidence created long after this period of time would undermine the statutory objective of expeditious decision making and prevent meaningful public input on that evidence).

ADC/ALS Calculation.

1.37 Based upon the ALS of 50.6 days, the ADC is calculated as follows[12]:

2006: 205 x 50.6 / 365 = 28 ADC

2007: 220 x 50.6 / 365 = 31 ADC

2008: 236 x 50.6 / 365 = 33 ADC

2009: 252 x 50.6 / 365 = 35 ADC

2010: 267 x 50.6 / 365 = 37 ADC

2011: 286 x 50.6 / 365 = 40 ADC

By which year must FHC reach an ADC of 35?

1.38 To be granted a CN, FHC must show an ADC of 35. WAC 246-310-290. The year by which the ADC must be reached is the "planning horizon." HOS asserts that FHC must show that it will reach an ADC of 35 by 2006. The Program and FHC assert that FHC must show that it will reach an ADC of 35 by 2011. If HOS's argument is accepted, no need is present.

1.39 WAC 246-310-290(6) provides "Hospice agencies applying for a certificate of need must demonstrate that they can meet a minimum ADC of thirty-five patients by the third year of operation." HOS argues that in addition to this standard, the WAC 246-310-290(7) methodology sets independent requirement that 35 ADC shown be based solely on a run of the methodology (without reference to the WAC 246-310-290(6) three year standard).

[12] The results have been rounded.

1.40 Step 5 of the methodology provides: "Inflate the potential volume of hospice service by the one-year estimated population growth (using OFM data)." WAC 246-310-290(7)(e). HOS argues that Step 5 coupled with the other steps in the methodology mean that the 35 ADC must be shown within one year. FHC reasons that if this step was intended to set a three-year planning horizon, it would have contained language to that effect. FHC and the Program argue that the provisions of WAC 246-310-290 should be read together to conclude that the 35 ADC be reached within three years.

1.41 WAC 246-310-290(6) requires a three-year planning horizon. WAC 246-310-290 should be interpreted to harmonize and give effect to all provisions within the regulation, "a term in a regulation should not be read in isolation but rather within the context of the regulatory and statutory scheme as a whole." *Odyssey*, 145 Wn. App. at 142. A law should be read as a whole. *State v. Jacobs*, 154 Wn.2d 596 (2005). In construing a law, all parts of the law should be given effect, and no part should be rendered inoperative. *Cox v. Helenius*, 103 Wn.d 383 (1985). When the provisions are read as a whole, it is clear that WAC 246-310-290(7) provides the method used to project need, while WAC 246-310-290(6) provides the required planning horizon: three years. This is confirmed by the plain language of WAC 246-310-290(7) describing what is to be accomplished by the six steps: "Need Projection." To interpret the rule otherwise, renders the WAC 246-310-290(6) three year requirement meaningless.

1.42 Thus, an ADC of 35 hospice patients by the third year of operation is required. FHC proposed to start operation in 2008 making 2011 the third full year of operation. An ADC of 35 is reached in 2009. Application of the WAC 246-310-290(6) methodology shows need beginning in 2009 continuing through 2011.

General Need.

1.43 In addition to the WAC 246-310-290 six-step methodology showing need, general need under WAC 246-310-210(1) must also be shown. WAC 246-310-290(8). FHC must show that the population "has need for the project and other services of facilities of the type proposed are not or will not be sufficiently available or accessible to meet the need." WAC 246-310-210(1).

1.44 Spokane County has only two Medicaid Certified/Medicaid Eligible hospice agencies. AR 16-18. FHC has established that another agency will provide additional access and choices for patients in the community. AR 15-28, 165-68, 179-81, 1201, 1203-05, and 1212-18. The WAC 246-310-290 six-step methodology shows that the population could support another facility. Findings of Fact 1.16 through 1.42 and Conclusion of Law 2.7. FHC has established that it will improve hospice use by increasing use among underserved non-cancer populations, nursing home residents, and rural residents. AR 16, 18, 22, and 19. FHC has also shown that it will increase use by giving its existing patients the hospice option without forcing them to transfer to other facilities.[13] AR 25-26.

[13] HOS's argument that a new provider should not be approved unless the service of existing providers is shown to be lacking is rejected. Were this argument adopted, existing providers would enjoy a continued

Need: Service to all residents, including underserved groups.

1.45 FHC must also show that "[a]ll residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly are likely to have adequate access to the proposed health service or services." WAC 246-310-210(2). FHC has an admission policy and non discrimination policy. AR 753-54 and 1185. FHC also has a charity care policy. These policies support the goals of WAC 246-310-210(2) and would be available to be used if the proposed agency were approved. Additionally, the facility would be required to conform to Medicare certification and Medicaid eligibility requirements to serve the elderly and the poor.

Financial Feasibility: Immediate and long-range capital and operating costs.

1.46 Under WAC 246-310-220(1), FHC must show that "[t]he immediate and long-range capital and operating costs of the project can be met." FHC's proposal meets the need criteria. Findings of Fact and 1.16 through 1.42 and Conclusion of Law 2.7. The capitol cost for expanding FHC's existing home health agency to include a hospice agency is $32,089.00, which will be paid through FHC's existing operations and would not require incurring any debt. AR 753, 754, and 1185. FHC anticipated having the program fully operational by July 2008, approximately one year after approval of its CN application – its first full year of operation would be 2009 and its third full year of operation would be 2011. By that time it would be profitable. The evidence

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market monopoly no matter how much the market grows or services are needed. This result is inconsistent with the CN criteria and the purpose of health planning.

or record shows that the proposed agency's immediate and long-range capitol and operating costs of the project can be met as provided in WAC 246-310-220(1).

Financial Feasibility: Unreasonable impact for health services.

1.47 Under WAC 246-310-220(2), FHC must show that "[t]he costs of the project, including any construction costs, will probably not result in an unreasonable impact on the costs and charges for health services." FHC's proposal meets the need criteria. Findings of Fact 1.16 through 1.42 and Conclusion of Law 2.7. Additionally, there are no construction costs: the proposed agency would be co-located within FHC's existing home health agency, and the capital expenditure of $32,089 is solely related to equipment needed for the proposed agency. AR 754 and 1186. Medicare reimburses agencies on a fixed per diem rate, and the addition of FHC to the Spokane service area will not generally result in an unreasonable impact on the costs and charges for health services. There are no construction costs and no unreasonable impact on costs/charges. Granting FHC's application will not result in an unreasonable impact on the costs and charges for health services as provided in WAC 246-310-220(2).

Financial Feasibility: appropriately financed.

1.48 Under WAC 246-310-220(3), FHC must show that "[t]he project can be appropriately financed." As noted, the capitol cost for expanding FHC's existing home health agency to include a hospice agency is $32,089, which will be paid through FHC's existing operations. FHC will not incur any debt and the source of financing for the project will be from FHC reserves. AR 754 and 1186. A review of FHC's historical

financial statements shows the funds necessary to finance the project are available.

Structure and Process (Quality) of Care Criteria: Staff.

1.49 Under WAC 246-310-230(1) FHC must show "[a] sufficient supply of qualified staff for the project, including both health personnel and management personnel, are available or can be recruited." FHC intended to begin providing hospice services in Spokane County in mid-year 2008. AR 755, 756, and 1187. Once operational, FHC expected to increase hospice staff as its patient census increased. FHC has strategies intended to use recruit and retain key hospice staff without negatively affecting the existing providers. FHC has identified staff on its interdisciplinary team to provide services and care.

Structure and Process (Quality) of Care Criteria: Ancillary and Support Services.

1.50 Under WAC 246-310-230(2), FHC must show that "[t]he proposed service(s) will have an appropriate relationship, including organizational relationship, to ancillary and support services, and ancillary and support services will be sufficient to support any health services included in the proposed project."

1.51 FHC has established appropriate ancillary and support agreements in the past and has set an appropriate timeline for establishing such agreements in this case.[14] AR 756, 757, 1187, and 1188.

[14] **However, FHC should be required to provide copies of all "ancillary agreements" to the Program as required by the Program's original decision. AR 756-757.**

Structure and Process (Quality) of Care Criteria: State/Federal Requirements.

1.52 Under WAC 246-310-230(3), FHC must show that "[t]here is reasonable assurance that the project will be in conformance with applicable state licensing requirements and, if the applicant is or plans to be certified under the Medicaid or Medicare program, with the applicable conditions of participation related to those programs." FHC personnel and facilities have a good history of compliance with state and federal requirements, including Medicare and Medicaid requirements, based upon surveys, DOH records, and other information of record. AR 757, 758, 1188, and 1189. FHC holds necessary licenses required by state and federal laws.

Structure and Process (Quality) of Care Criteria: Continuity of Care.

1.53 Under WAC 246-310-230(4), FHC must show that "[t]he proposed project will promote continuity in the provision of health care, not result in an unwarranted fragmentation of services, and have an appropriate relationship to the service area's existing health care system." Evidence shows that the proposed project is needed. This evidence is equally credible to show that the proposed project meets the continuity of care requirement of WAC 246-310-230(4).

Structure and Process (Quality) of Care Criteria: Safe and Adequate care.

1.54 Under WAC 246-310-230(5), FHC must show that "[t]here is reasonable assurance that the services to be provided through the proposed project will be provided in a manner that ensures safe and adequate care to the public to be served and in accord with applicable federal and state laws, rules, and regulations." Evidence shows that FHC met the structure and process (quality) of care criteria, state/federal

requirements. This evidence is equally credible to show that the proposed project meets the safe and adequate care requirement of WAC 246-310-230(5).

Cost Containment.

1.55 Under WAC 246-310-240, cost containment shall be based on whether "[s]uperior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable." FHC considered several alternatives and determined its proposal was superior. AR 45 - 47. FHC's proposal is needed. Findings of Fact and 1.16 through 1.42 and Conclusion of Law 2.7. This evidence is equally credible to show that superior alternatives are not available or practicable as provided in WAC 246-310-240. The project does not require construction.

II. CONCLUSIONS OF LAW

2.1 The Department has jurisdiction over this proceeding under Chapter 70.38 RCW.

2.2 The applicant must establish that its application meets all the applicable CN criteria. *See* WAC 246-10-606. Admissible evidence in CN hearings is the kind of evidence on which reasonably prudent persons are accustomed to rely in the conduct of their affairs. RCW 34.05.452(1). The standard of proof is preponderance of the evidence. WAC 246-10-606.

2.3 The Presiding Officer (on delegated authority from the Secretary of Health) is the agency's fact-finder and final decision maker. *DaVita v. Department of Health*, 137 Wn. App. 174, 182 (2007) (*DaVita*). The Presiding Officer may consider the analysis in reaching his decision but is not required to defer to the Program's decision or

expertise. *DaVita*, 137 Wn. App. at 182-183. The appeal process does not begin the application process anew. *University of Washington v. Department of Health*, 164 Wn. at 104 (2008).

Certificate of Need Criteria.

2.4 Whether a CN should be issued to an applicant is based on a determination that the proposed project:

(a) Is needed;

(b) Will foster containment of costs of health care;

(c) Is financially feasible; and

(d) Will meet the criteria for structure and process of care identified in WAC 246-310-230.

WAC 246-310-200(1).

Need.

2.5 To prove that need exists, FHC must initially meet the criteria in WAC 246-310-210. The criteria are:

(1) The population served or to be served has need for the project and other services and facilities of the type proposed are not or will not be sufficiently available or accessible to meet that need.

(2) All residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly are likely to have adequate access to the proposed health service or services.

WAC 246-310-210.

2.6 Under WAC 246-310-290(7), the following steps are used to project the need for hospice services:

(a) Step 1. Calculate the following four statewide predicted hospice use rates using CMS and department of health data or other available data sources.

(i) The predicted percentage of cancer patients sixty-five and over who will use hospice services. This percentage is calculated by dividing the average number of hospice admissions over the last three years for patients the age of sixty-five and over with cancer by the average number of past three years statewide total deaths sixty-five and over from cancer.

(ii) The predicted percentage of cancer patients under sixty-five who will use hospice services. This percentage is calculated by dividing the average number of hospice admissions over the last three years for patients under the age of sixty-five with cancer by the current statewide total of deaths under sixty-five with cancer.

(iii) The predicted percentage of noncancer patients sixty-five and over who will use hospice services. This percentage is calculated by dividing the average number of hospice admissions over the last three years for patients age sixty-five and over with diagnoses other than cancer by the current statewide total of deaths over sixty-five with diagnoses other than cancer.

(iv) The predicted percentage of noncancer patients under sixty-five who will use hospice services. This percentage is calculated by dividing the average number of hospice admissions over the last three years for patients under the age of sixty-five with diagnoses other than cancer by the current statewide total of deaths under sixty-five with diagnoses other than cancer.

(b) Step 2. Calculate the average number of total resident deaths over the last three years for each planning area.

(c) Step 3. Multiply each hospice use rate determined in Step 1 by the planning areas average total resident deaths determined in Step 2.

(d) Step 4. Add the four subtotals derived in Step 3 to project the potential volume of hospice services in each planning area.

(e) Step 5. Inflate the potential volume of hospice service by the one-year estimated population growth (using OFM data).

(f) Step 6. Subtract the current hospice capacity in each planning area from the above projected volume of hospice services to determine unmet need.

(g) Determine the number of hospice agencies in the proposed planning area which could support the unmet need with an ADC of thirty-five.

2.7 Based on Findings of Fact 1.16 through 1.44, FHC proved by a preponderance of the evidence that the application met the WAC 246-310-210(1) criteria (incorporating the six-step methodology from WAC 246-310-290(7)).

2.8 Based on Finding of Fact 1.45, FHC proved by a preponderance of the evidence that its application met the WAC 246-310-210(2) criteria.

Financial Feasibility Criteria.

2.9 To obtain a CN, FHC must show that its project is financially feasible under WAC 246-310-220. That regulation requires a showing that:

(1) The immediate and long-range capital and operating costs of the project can be met.

(2) The costs of the project, including any construction costs, will probably not result in an unreasonable impact on the costs and charges for health services.

(3) The project is appropriately financed.

WAC 246-310-220.

2.10 Based on Finding of Fact 1.46, FHC proved by a preponderance of the evidence that the application met the criteria set forth in WAC 246-310-220(1).

2.11 Based on Finding of Fact 1.47, FHC proved by a preponderance of the evidence that the application met the criteria set forth in WAC 246-310-220(2).

2.12 Based on Finding of Fact 1.48, FHC proved by a preponderance of the evidence that its application met the criteria set forth in WAC 246-310-220(3).

Structure and Process (Quality) of Care.

2.13 FHC must show that its application meets the structure and process of care requirements as set forth in WAC 246-310-230. That regulation provides:

> A determination that a project fosters an acceptable or improved quality of health care shall be based on the following criteria.
>
> (1) A sufficient supply of qualified staff for the project, including both health personnel and management personnel, are available or can be recruited.
>
> (2) The proposed service(s) will have an appropriate relationship, including organizational relationship, to ancillary and support services, and ancillary and support services will be sufficient to support any health services including the proposed project.

(3) There is reasonable assurance that the project will be in conformance with applicable state licensing requirements and, if the applicant is or plans to be certified under the medicaid or medicare program, with the applicable conditions of participation of related to those programs.

(4) The proposed project will promote continuity in the provision of health care, not result in an unwarranted fragmentation of services, and have an appropriate relationship to the service area's existing health care system.

(5) There is reasonable assurance that the services to be provided through the proposed project will be provided in a manner that ensures safe and adequate care to the public to be served and in accordance with applicable federal and state laws, rules, and regulations. The assessment of the conformance of a project to this criterion shall include but not be limited to consideration whether:

(a) The applicant or licensee has no history, in this state or elsewhere, of a criminal conviction which is reasonably related to the applicant's competency to exercise responsibility for the ownership or operation of a health care facility, a denial or revocation of a license to operate a health care facility, a revocation of a license to practice a health care profession, or a decertification as a provider of services in the medicare or medicaid program because of a failure to comply with applicable federal conditions or participation; or

(b) If the applicant or licensee has such a history, whether the applicant has affirmatively established to the department's satisfaction by clear, cogent and convincing evidence that the applicant can and will operate the proposed project for which the certificate of need is sought in a manner that ensures safe and adequate care to the public to be served and conforms to applicable federal and state requirements.

2.14 Based on Finding of Fact 1.49, FHC proved by a preponderance of the evidence that its application met the WAC 246-310-230(1) criteria.

2.15 Based on Findings of Fact 1.50 and 1.51, FHC proved by a preponderance of the evidence that the application met the WAC 246-310-230(2) criteria.

2.16 Based on Finding of Fact 1.52, FHC proved by a preponderance of the evidence that the application met the WAC 246-310-230(3) criteria.[15]

2.17 Based on Finding of Fact 1.53, FHC proved by a preponderance of the evidence that its application met the WAC 246-310-230(4) criteria.

2.18 Based on Finding of Fact 1.54, FHC proved by a preponderance of the evidence that its application met the WAC 246-310-230(5) criteria.

Determination of Cost Containment.

2.19 FHC must also show that it meets the determination of cost containment set forth in WAC 246-310-240. That regulation provides:

> A determination that a proposed project will foster cost containment shall be based on the following criteria:
>
> (1) Superior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable.
>
> (2) In the case of a project involving construction:
>
> (a) The costs, scope, and methods of construction and energy conservation are reasonable; and

[15] FHC's compliance with WAC 246-310-230(3) should be conditioned upon FHC identifying a qualified director of clinic services and his or her alternate. AR 757, 1189.

(b) The project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.

(3) The project will involve appropriate improvements or innovations in the financing and delivery of health services which foster cost containment and which promote quality assurance and cost effectiveness.

WAC 246-310-240.

2.20 Based on Finding of Fact 1.55, FHC proved by a preponderance of the evidence that its application met the WAC 246-310-240(1) criteria. WAC 246-310-240(1) does not apply because the project does not require construction. Finding of Fact 1.55

III. ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, the Presiding Officer ORDERS:

3.1 Family Home Care's application for a CN to establish a hospice providing **hospice** services in the Medicaid or Medicare program is GRANTED, provided that FHC identifies a qualified director of clinic services and his or her alternate **and submits to the Program all "ancillary agreements" related to meeting the criteria in WAC 246-310-230(2).**

Dated this _____ day of July, 2011.

_____
CHRISTOPHER G. SWANSON, Health Law Judge
Presiding Officer

NOTICE TO PARTIES

This order is subject to the reporting requirements of RCW 18.130.110, Section 1128E of the Social Security Act, and any other applicable interstate or national reporting requirements. If discipline is taken, it must be reported to the Healthcare Integrity Protection Data Bank.

Either party may file a **petition for reconsideration**. RCW 34.05.461(3); 34.05.470. The petition must be filed within 10 days of service of this order with:

Adjudicative Service Unit
P.O. Box 47879
Olympia, WA 98504-7879

and a copy must be sent to:

Certificate of Need Program
P.O. Box 47852
Olympia, WA 98504-7852

The petition must state the specific grounds for reconsideration and what relief is requested. WAC 246-11-580. The petition is denied if the Presiding Officer does not respond in writing within 20 days of the filing of the petition.

A **petition for judicial review** must be filed and served within 30 days after service of this order. RCW 34.05.542. The procedures are identified in chapter 34.05 RCW, Part V, Judicial Review and Civil Enforcement. A petition for reconsideration is not required before seeking judicial review. If a petition for reconsideration is filed, the above 30-day period does not start until the petition is resolved. RCW 34.05.470(3).

The order is in effect while a petition for reconsideration or review is filed. "Filing" means actual receipt of the document by the Adjudicative Service Unit. RCW 34.05.010(6). This order is "served" the day it is deposited in the United States mail. RCW 34.05.010(19).

For more information, visit our website at http://www.doh.wa.gov/hearings.