HAWAI'I STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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ADMINISTRATIVE APPLICATION - CERTIFICATE OF NEED PROGRAM

Application Number: #21-25A
To be assigned by Agency

Date of Receipt:

APPLICANT PROFILE

Project Title: Acquisition of Hospice Services

Project Address: 30 Oki Street
Kaunakakai, HI 96748

Applicant Facility/Organization: Hospice Maui, Inc.

Name of CEO or equivalent: R. Gregory LaGoy

Title: Chief Executive Officer

Address: 400 Mahalani Street, Wailuku, HI 96793

Phone Number: 808-244-5555 Fax Number: 808-243-0002

Contact Person for this Application: R. Gregory LaGoy

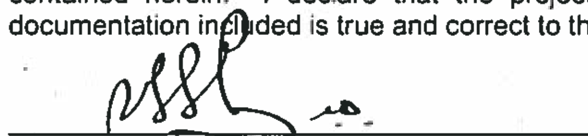
Title: CEO

Address: c/o Hospice Maui, Inc., 400 Mahalani Street, Wailuku, HI 96768

Phone Number: 808-244-5555 Fax Number: 808-243-0002

CERTIFICATION BY APPLICANT

I hereby attest that I reviewed the application and have knowledge of the content and the information contained herein. I declare that the project described and each statement amount and supporting documentation included is true and correct to the best of my knowledge and belief.



Signature

10/19/21
Date

R. Gregory LaGoy
Name (please type or print)

CEO
Title (please type or print)

1. **TYPE OF ORGANIZATION**: (Please check all applicable)

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Public	____
Private	x
Non-profit	x
For-profit	____
Individual	____
Corporation	x
Partnership	____
Limited Liability Corporation (LLC)	____
Limited Liability Partnership (LLP)	____
Other: ____________	____

2. **PROJECT LOCATION INFORMATION**

A. Primary Service Area(s) of Project: (please check all applicable)

Statewide:	____
O`ahu-wide:	____
Honolulu:	____
Windward O`ahu:	____
West O`ahu:	____
Maui County:	x
Kaua`i County:	____
Hawai`i County:	____

3. **DOCUMENTATION** (Please attach the following to your application form):

A. Site Control documentation (e.g. lease/purchase agreement, DROA agreement, letter of intent)

B. A listing of all other permits or approvals from other government bodies (federal, state, county) that will be required before this proposal can be implemented (such as building permit, land use permit, etc.)

C. Your governing body: list by names, titles and address/phone numbers

D. If you have filed a Certificate of Need Application this current calendar year, you may skip the four items listed below. All others, please provide the following:
   - Articles of Incorporation
   - By-Laws
   - Partnership Agreements
   - Tax Key Number (project's location)

4. **TYPE OF PROJECT.** This section helps our reviewers understand what type of project you are proposing. Please place an "x" in the appropriate box.

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	Used Medical Equipment (over $400,000)	New/Upgraded Medical Equip. (over $1 million)	Other Capital Project (over $4 million)	Change in Service	Change in Beds
Inpatient Facility					
Outpatient Facility					
Private Practice					

5. **BED CHANGES.** Please complete this chart only if your project deals with a change in your bed count and/or licensed types. Again, this chart is intended to help our reviewers understand at a glance what your project would like to accomplish. Under the heading "Type of Bed," please use only the categories listed in the certificate of need rules.

Type of Bed	Current Bed Total	Proposed Beds for your Project	Total Combined Beds if your Project is Approved
TOTAL			

6. PROJECT COSTS AND SOURCES OF FUNDS

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A. List All Project Costs:

		AMOUNT:
1.	Land Acquisition	N/A
2.	Construction Contract	N/A
3.	Fixed Equipment	N/A
4.	Movable Equipment	
5.	Financing Costs	N/A
6.	Fair Market Value of assets acquired by lease, rent, donation, etc.	N/A
7.	Other: Misc. supplies & equipment	< $1,000
	TOTAL PROJECT COST:	< $1,000

B. Source of Funds

1.	Cash	< $1,000
2.	State Appropriations	-0-
3.	Other Grants	-0-
4.	Fund Drive	-0-
5.	Debt	-0-
6.	Other: ____________	None
	TOTAL SOURCE OF FUNDS:	< $1,000

7. **CHANGE OF SERVICE:** If you are proposing a change in service, then please briefly list what services will be added/modified. Be sure to include the establishment of a new service or the addition of a new location of an existing service. Please reference the Certificate of Need Rules Section 11-186-5 for the categories of services. If you are unable to determine which category best describes your project, please consult with agency staff.

N/A

8. **IMPLEMENTATION SCHEDULE:** Please present a projected time schedule for the completion of this project from start to finish. Include all of the following items that are applicable to your project:

   a) Date of site control for the proposed project,
   b) Dates by which other government approvals/permits will be applied for and received,
   c) Dates by which financing is assured for the project,
   d) Date construction will commence,
   e) Length of construction period,
   f) Date of completion of the project,
   g) Date of commencement of operation

Please remember that the Agency does monitor the implementation of Certificates approved. Non-implementation of a project as described in your application may result in a fine and/or withdrawal of the certificate of need.

9. **EXECUTIVE SUMMARY:** Please present a brief summary of your project. In addition, provide a description of how your project meets each of the certificate of need criteria listed below. If a new location is proposed, please attach an easy to read map that shows your project site.

   a) Relationship to the State of Hawai`i Health Services and Facilities Plan.
   b) Need and Accessibility
   c) Quality of Service/Care
   d) Cost and Finances (include revenue/cost projections for the first and third year of operation)
   e) Relationship to the existing health care system
   f) Availability of Resources.

10. Eligibility to file for Administrative Review. This project is eligible to file for Administrative review because: (Check all applicable)

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_____ It involves bed changes, which will have a capital expense of $1,000,000 or less, and which will have an increased annual operating expense of less than $500,000.

_____ It involves service changes which will have a capital expense of $1,000,000 or less, and which will have an increased annual operating expense of less than $500,000.

_____ It is an acquisition of a health care facility or service, which will result in lower annual operating expenses for that facility, or service.

_____ It is a change of ownership, where the change is from one entity to another substantially related entity.

__X__ It is an additional location of an existing service or facility.

__X__ The applicant believes it will not have a significant impact on the health care system.

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Hospice Maui CON Application to acquire hospice services on Moloka'i from Navian Hawaii

Attachment A

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3. Documentation

A. See attached MOU.

B. Hospice Maui is already Medicare Certified to provide hospice services, and there are no other permits or approvals that are needed.

C. The current list of Hospice Maui's Directors and Officers is attached.

D. Copies of our Articles of Incorporation and By-Laws are attached. There are no partnership agreements nor a project location.

8. Implementation Schedule:

10/1/21	Hospice Maui initiated conversation with suppliers (pharmacy and medical equipment), contractors (physicians, inpatient facilities), and other members of the existing health care system on Moloka'i to establish relationships and assure the continuation of services currently being rendered to Navian Hawai'i and to the patients they serve.
10/19/21	Submission of CON application to SHPDA.
11/8/21	Hospice Maui and Navian Hawaii managers begin planning transition details.
11/15/21	Hospice Maui begins contract negotiations with suppliers/providers.
1/4/22	Hospice Maui begins HR processes and orientation of Navian employees.
2/1/22	Hospice Maui is prepared to start delivery of hospice services on Moloka'i when the CON transfer is approved.

9. Executive Summary:

Hospice Maui began the process of establishing hospice services on the island of Moloka'i in early 1995 with a training for volunteers and potential staff. At that time, Hospice Maui was thriving, and had the resources and capacity to cover the needed staffing, transportation, and other costs involved.

In the spring of 1995, before Hospice Maui submitted its CON application to formally provide those services, the radiation oncology center opened at Maui Memorial Medical Center, and our patient census dropped by about 1/3, introducing financial stresses that made our service expansion to Moloka'i no longer possible. Some time after that, we worked with Hospice Hawai'i (now Navian Hawai'i) to establish the service in our place, since they were in the position to do so.

Several months ago, Navian Hawai'i approached us to ask if we might be interested in taking back both the Moloka'i and Lana'i programs. They said that their first priority was that those communities receive the best care possible, and they felt Hospice Maui was now in a better position to provide hospice services on those neighbor islands because of transportation, proximity, and other considerations.

Because Hospice Maui now has the financial and managerial resources to take on those two programs, and because our Maui County-based volunteer board of directors is committed to serving Maui County to the best of our ability, we are submitting this application to acquire the hospice services on Moloka'i currently being provided by Navian Hawai'i.

How our proposed service transfer meets each of the CON criteria listed below:

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a) Relationship to the state's Health Services and Facilities Plan: The relationship is already established in application # 98-18a, and this acquisition won't affect the relationship to the State Plan.

b) Need and accessibility: The need and accessibility are already established in application # 98-18a, and our services under this acquisition will continue to serve the residents of Moloka'i.

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c) Quality of Service/Care: Medicare now collects and publishes data on the quality of hospice services. Hospice Maui's published Quality of Service data is at or above state and national averages for hospice care, and this is summarized on attachment B. The provision of our services in these locations will be according to those policies, procedures, and values that currently account for the high scores we are currently achieving for quality of service/care.

d) Cost and Finances: Attachment C shows the anticipated revenue and cost for the first and third years of operation. Because this is not a new service, but the continuation of a service, these numbers are not based on market research or projections, but on historical data.

e) Relationship to the existing health care system: Hospice has a well-established place in the health care continuum, and that is when the prognosis for a progressive incurable condition is less than six months and when the patient chooses comfort-oriented care over further disease-focused care. Hospice care is now well-understood by those managing the treatment of such patients, and appropriate referrals to hospice care by those in the existing health care system has become the norm. Navian Hawai'i has established close working relationships with the existing health care system on Moloka'i, and Hospice Maui has been working to establish those relationships beginning in mid-September, as shown on the implementation schedule.

f) Availability of Resources: For this existing service, the resources needed (management staff on Maui, operating policies, procedures, and systems, contract and employed staff, and relationships with other members of Moloka'i's healthcare system) are all in place and are part of the transfer of hospice services from Navian Hawai'i to Hospice Maui.