ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

FINDINGS
C = Conforming
CA = Conditional
NC = Nonconforming
NA = Not Applicable

DECISION DATE: August 28, 2013
FINDINGS DATE: September 5, 2013
PROJECT ANALYST: Julie Halatek
TEAM LEADER: Lisa Pittman

PROJECT I.D. NUMBER: C-10112-13 / Hospice of McDowell County, Inc. / Develop a new inpatient hospice unit with six inpatient hospice beds / McDowell County

REVIEW CRITERIA FOR NEW INSTITUTIONAL HEALTH SERVICES

G.S. 131E-183(a) The Department shall review all applications utilizing the criteria outlined in this subsection and shall determine that an application is either consistent with or not in conflict with these criteria before a certificate of need for the proposed project shall be issued.

(1) The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.

NC

Hospice of McDowell County, Inc. (HoMC) proposes to develop a new inpatient hospice unit consisting of six inpatient hospice beds within the existing McDowell Hospital. The proposed project will be named Hospice of McDowell County Care Center (Care Center). HoMC has operated a licensed hospice home care agency in Marion, in McDowell County, since 1994. The 2013 State Medical Facilities Plan (SMFP) identifies a need determination for six new hospice inpatient beds in McDowell County. The applicant proposes to develop no more than six beds; thus, the application is conforming to the need determination in the 2013 SMFP.

Policy GEN-3 of the 2013 SMFP is applicable to this review. Policy GEN-3: Basic Principles states:

> "*A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will promote safety*

> *and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area.*"

Promote Safety and Quality

In Section III.3, page 30, the applicant discusses how the proposal will promote safety and quality. The applicant states that safety and quality are critical to delivery of end-of-life care.

On page 30, the applicant states:

> "*Evidence of safety and quality are consistent with license and certification expectations of NC DHSR, Certification for Medicare and Medicaid Services, and Workman's Compensation experience modification. Our track record for the provision of quality and safe exemplary hospice care has earned the confidence of physicians, hospitals, nursing homes, and other healthcare providers. Families demonstrate their trust in the quality of our services as evidenced by our consistent high ratings on the Family Evaluation of Hospice Care surveys distributed to families and caregivers after a death has occurred."*

The applicant also states on page 30 that it will commit to continuous attention to quality and safety standards. The applicant adequately demonstrates that the proposed project will promote safety and quality.

Promote Equitable Access

In Section III.3, pages 30-31, the applicant states how the proposal will promote equitable access:

> "*The proposed project will make hospice inpatient services more accessible to residents of McDowell County and surrounding county residents whose primary medical home is in McDowell County. HoMC's commitment to end-of-life care for all eligible persons irrespective of financial or insurance resources will extend to those individuals in need of short-term hospice inpatient care. Neither will HoMC discriminate based upon age, race, sex, religion, or handicap. No eligible hospice patient has ever been denied care. The increasing access to local general hospice inpatient will enable care provision in the most appropriate level without transfer to another hospice community which is onerous on family and caregivers requiring management of homes in McDowell County while tending to*

loved ones in hospice facilities as many as forty miles from the center of McDowell County."

The applicant adequately demonstrates that the proposed project will promote equitable access.

Maximize Healthcare Value

In Section III.3, page 31, the applicant states how the proposal promotes healthcare value:

"*HoMC proposes a cost-effective and coordinated approach to meeting the hospice inpatient needs of McDowell County and surrounding county hospice providers serving McDowell residents. The proposed project is designed to establish within a licensed facility enabling greater coordination between hospital and hospice, facilitating efficiencies that are difficult to gain in a small freestanding unit, and through cost-sharing opportunities with the hospital.*

HoMC has identified McDowell Hospital as a strategic partner to facilitate the development and integration of a comprehensive approach to meeting the end-of-life needs of our community. The opportunity to develop a hospice-specific unit within the hospital launches operational and financial performance opportunities…

This model enables teaching, discharge planning, and coordination of care prior to the patient transfer to another care setting following an inpatient stay. It also serves to assist in the decrease of the hospital readmission rate when those readmissions are hospice appropriate."

However, the applicant does not adequately demonstrate the need the population to be served has for the proposed services. See Criterion (3) for discussion regarding demonstration of need which is hereby incorporated by reference as if fully set forth herein. The applicant does not adequately demonstrate the financial feasibility of the proposed project is based on reasonable projections of costs and charges. See Criterion (5) for the discussion of financial feasibility which is hereby incorporated by reference as if fully set forth herein.

Projected Volumes Incorporate GEN-3 Concepts

The applicant fails to adequately demonstrate the need for the proposal. The applicant does not demonstrate that projected volumes for the proposed inpatient hospice beds incorporate the basic principles of Policy GEN-3 in meeting the needs of patients to be served. See Criterion (3) for additional discussion which is hereby incorporated by reference as if fully set forth herein.

Consequently, the applicant does not adequately demonstrate that the application, including the supplemental information, is consistent with Policy GEN-3 and therefore the application is nonconforming with this criterion.

(2) Repealed effective July 1, 1987.

(3) The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

NC

HoMC proposes to develop a new inpatient hospice unit with six inpatient hospice beds within the existing McDowell Hospital. The proposed inpatient hospice unit will be named Hospice of McDowell County Care Center (Care Center). HoMC has operated a licensed hospice home care agency in Marion, in McDowell County, since 1994.

Population to be Served

In Section III.4, page 31, the applicant states that the proposed service area is McDowell County. The applicant states that occasionally, the home care agency is asked to take patients who live outside of McDowell County, but who receive their primary medical care in McDowell County. The applicant states that the location chosen, McDowell Hospital, is the best location for the beds because the hospital is in the county seat of Marion, in the middle of the proposed service area. The applicant also states that it is possible that some patients living in the southernmost or easternmost parts of the community may utilize hospice providers in other counties that are geographically closer to the patients.

The applicant states in supplemental information that it expects its entire population to come from McDowell County:

> *"Hospice general inpatient planning area is defined as a county. HoMC expects 100% of the Care Center population to identify McDowell County as their primary place of residence. Internal patient statistics reflect that HoMC transfers,* [sic] *to area hospice facilities for pain and symptom management and end-of-life care. Transfer statistics are generated from internal reporting and anecdotal experience. HoMC offers patients and families options for general inpatient care based upon proximity to the closest facility with available options at the time of a request. By establishing a McDowell County option it is expected that other providers will utilize this service line."*

The applicant adequately identifies the population projected to be served by the proposed inpatient hospice unit.

Demonstration of Need

In Section III.1, page 25, the applicant states that the 2013 SMFP identifies a need for six inpatient hospice beds in McDowell County.

In Section III.1, pages 25-26, the applicant provides the following population data. Both McDowell County's total population and its population aged 65+ are projected to grow at slower rates than the state's rates, as shown below.

Tables III.1—III.2					
Area	**2012**	**2013**	**2014**	**2015**	**2012-2015 % Change (CAGR)**
McDowell County	45,692	45,921	46,111	46,265	0.31%
North Carolina	9,780,742	9,886,349	9,992,391	10,096,810	0.80%
McDowell County 65+	8,006	8,329	8,638	8,889	2.65%
North Carolina 65+	1,347,329	1,403,862	1,455,880	1,506,175	2.83%

Source: Office of State Budget and Management

The applicant states on page 26:

> *"McDowell County has recently received distinction as a 'Certified Retirement Community' by the NC Department of Commerce attracting seniors for:*
> - *Affordable housing*
> - *Moderate weather*
> - *Access to affordable healthcare*
> - *Access to cultural resources*
> - *Low crime rate*
> - *Easy accessibility to metropolitan areas of NC*
> - *Outdoor activities*
> - *Scenic attractions"*

Inpatient Utilization Projections

In supplemental information, the applicant provides the projected utilization for the first two years by level of care as shown in the table below.

	Inpatient				Residential (in GIP beds)	Total	
QTR	Patients	Patient Days	% Occupancy	# Beds	Patient Days	Patient Days	% Occupancy
1st	28	245	44.9%	6	71	316	57.9%
2nd	31	271	49.6%	6	53	324	59.3%
3rd	34	299	54.2%	6	45	344	63.0%
4th	39	340	62.3%	6	36	376	68.8%
Total FY2014	**132**	**1,155**	**52.7%**	**6**	**205**	**1,360**	**61.9%**
	Inpatient				**Residential (in GIP beds)**	**Total**	
QTR	**Patients**	**Patient Days**	**% Occupancy**	**# Beds**	**Patient Days**	**Patient Days**	**% Occupancy**
1st	42	357	65.4%	6	43	400	73.2%
2nd	43	363	66.5%	6	29	392	71.2%
3rd	45	382	69.2%	6	14	396	72.5%
4th	45	382	69.2%	6	8	390	71.4%
Total FY2015	**175**	**1,484**	**67.8%**	**6**	**94**	**1,578**	**72.1%**

Below Table IV.2 in supplemental information, the applicant describes the assumptions and methodology used to project the utilization data:

> *"General Inpatient occupancy inclusive of inpatient respite care is projected at 53% in year one (1) of operation. Projected inpatient occupancy in year two (2) is calculated at 67%. There is no request for residential beds in order to achieve greater flexibility of bed utilization. Patients should always expect the right care at the right time and within their optimal treatment preferences. General inpatient hospice services are offered to ensure that new or worsening symptoms are intensively addressed when those conditions are not successfully managed in any other setting.*
>
> *It is expected that many of the patients seeking general inpatient care during episodes of medical crisis will have periods of stability interrupted by anticipated worsening of symptoms. For those patients it is prudent to implement a plan of observation to ensure there is a reliable symptom management outcome in advance of disrupting the site of care with a premature discharge. Home care reimbursement is deemed appropriate when symptoms and pain no longer meet the threshold of inpatient care though the clinical picture suggests continued intensive hospice observation is in order. It is not uncommon for the end of the trajectory of the disease process to move in and out of control and for that reason we will utilize beds as residential from a billing and paperwork perspective. Discharge planning begins on admission and once a person's reason for an inpatient plan is complete there is likely a transitioning period to follow. Having the option of reducing the level of care to residential enables the IDT to more appropriately engage the patient and family as to continuing plans for care. Such "step down" to a less acute care service facilitates greater "just in time"*

teaching of new interventions and allows both the caregiver(s) and the patient adequate time to adjust to a new level of disease progression. Residential care in this context does not imply placement for continuing care within the Care Center and instead is transitional."

Nothing in the quoted discussion above relates to the utilization projections. The applicant continues its discussion:

"According to most recent Medicare Payment Claims Data, 2011, McDowell Hospital Recorded 28 deaths. We project conservatively that 14 of those patients would have benefitted from transfer to the HoMC Care Center. 11 of the recorded deaths were resulting from a respiratory illness and the other deaths had samples <11. Medicare requires blanking of data for purposes of confidentiality for sample sizes <11."

The applicant projects 14 potential hospital transfers to the Care Center. The applicant continues its discussion:

"HoMC has demonstrated responsiveness to our patient requests for services and the environment of care where services are delivered. The team is reliable to provide admissions to the program 24/7 x 365 and the expectation would transfer to the Care Center. <1% of aggregate days of care have been provided within an inpatient setting (65/9331 2009; 52/13,486 2010; 57/19,699 2011) Those patients eligible for more acute services have received them from McDowell Hospital or via transfer to a freestanding hospice facility. Patients transferring out of our care accounted for an additional 3% of care days that are calculated to a different hospice provider upon transfer based upon our continuing to track length of stay from point of transfer to notice of obituary. All measurement of transferred patients is crude secondary to there being no public Forum to date that captures transfer to death/discharge from a receiving program of Hospice care."

It is not clear how the quoted discussion above relates to utilization projections. The applicant continues its discussion:

"We know from the LRA that 3.9% (107,468 days) of all NC Hospice Days of Care (2,915,093) in 2011 were provided within a setting defined as general inpatient. A subset of this data is adjusted for programs with a freestanding hospice general inpatient facility or dedicated hospice unit. Conservatively, 5% of aggregate days of care are delivered in a hospice dedicated facility or unit.

Employing a conservative 5% to aggregate days for HoMC based on 2011 published data indicates 986 days of care. Add to this number the expected utilization of McDowell residents in care with other providers, and transfers from the McDowell Hospital to Care Center we have a high degree of confidence that

our lack of historical data accurately projects future need and utilization meeting threshold of 50% in year one (1) and 65% in year (2)."

The applicant does not adequately explain why it should use 5% instead of 3.9% to estimate the number of annual inpatient days as a percentage of total hospice days. Furthermore, the applicant incorrectly references *"the LRA"* as the source for the incorrect number and percentage of all NC hospice days that are inpatient hospice days. The correct number of days is found in the 2011 NC Hospice Data & Trends: 102,824 inpatient days out of 2,915,093 total hospice days in 2011, or 3.53% of all hospice days in North Carolina in 2011, were inpatient days of care. The applicant does not explain the source of *"986 days of care."* The applicant wraps up its discussion of the assumptions and methodology used to project utilization with the following:

*"**Sources of need projections***
www.HospiceAnalytics.com InfoMax compilation of McDowell County Medicare Claims 2011

Data Supplement to the Annual License Renewal application presented by the Carolinas Center for Hospice and End-of-Life NC Data and Trends

Anecdotal reports from area hospice executives regarding service to McDowell residents

Historical data generated internally representing transfer and current utilization yet published

Anecdotal information from site visits to hospital based hospice units in the Hospice of the Covenant system West Florida Hospital in Pensacola, and Florida & Bay Medical in Panama City, Florida."

The applicant references *"anecdotal information"* but does not provide any specifics, and thus, does not adequately document that this "anecdotal information" supports its projections. Furthermore, the historical data for the hospice home care program does not support the projected hospice inpatient utilization.

The applicant's home care agency admissions for the last five years are shown below.

HoMC Agency Admissions		
Fiscal Year	**Admissions**	**Change**

2007	125	
2008	130	4%
2009	134	3%
2010	140	4%
2011	171	22%
2012	137	-20%

Source: License Renewal Applications

HoMC's admissions spiked in 2011, as shown above, but then fell in 2012 to a number more consistent with growth in previous years.

The applicant does not adequately explain how it projects to generate 132 hospice inpatient admissions in CY 2014 when it admitted only 137 home care patients in FY 2012.

Actual and Projected Patients Served for Home Hospice Care and the Care Center					
	2011	**2012**	**2014**	**2015**	**2016**
Home Care Admissions	171	137	N/A *	N/A *	N/A *
Home Care Patients Served	227	202	255	265	275
Care Center Inpatients	N/A	N/A	132	175	232
Percentage of Inpatients to Home Care Patients	N/A	N/A	52%	66%	84%

*Applicant did not project home care admissions; just patients served which includes re-admissions

Furthermore, the applicant does not provide assumptions for its agency growth projections, which are shown below:

HoMC Agency Growth Projections					
	2011	**2012**	**2014**	**2015**	**2016**
Home Care Admissions	171	137	*	*	*
Home Care Patients Served	227	202	255	265	275

*Applicant does not project home care admissions; just patients served

The following table illustrates the number of inpatient admissions the applicant might project based on its historical home care admissions and the 6% inpatient admission rate (the rate utilized in the 2013 SMFP methodology):

HoMC Agency Admissions / Potential Inpatient Projections

Fiscal Year	Admissions	Projected inpatient admissions*
2007	125	7.5
2008	130	7.8
2009	134	8.0
2010	140	8.4
2011	171	10.3
2012	137	8.2

Source: License Renewal Applications
*At 6% inpatient admission rate

The applicant does not adequately demonstrate that the projected utilization is reasonable given that the methodology in the SMFP would project 8.2 inpatients in 2012.

Furthermore, the applicant provides conflicting information about projected Average Length of Stay (ALOS), and is not consistent in the use of the terminology "patients served" and "admissions," as shown in the two tables below.

Table IV.3 Supplemental Information			
Projected Care Center Inpatient Utilization			
	2014	**2015**	**2016**
Days of Care	1380	1578	1977
Patients Served	132	175	232
Admissions	139	188	244
Deaths	103	130	181
Discharges	51	30	39
ALOS per Patient Served	10.45	9.01	8.52
ALOS per Admission	9.78	8.38	8.10

Tables I1.1—II.3 Supplemental Information									
Care Center Projected ALOS per admission by type of admission									
	Inpatient			**Residential**			**Respite**		
	2014	**2015**	**2016**	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**
Admission	132	175	240	23	13	9	12	12	12
Days of Care	1155	1484	1922	205	94	55	5*	5*	5*
ALOS per admission	8.8	8.5	8.0	8.9	7.2	6.1	5.0	5.0	5.0

*Assumes the applicant means that respite care will be 5 days per admission, as it states in the "ALOS per admission" line, which equals 60 days of care for 12 projected patients per year.

Based on the two tables above, for CY 2014, the applicant projects 139 admissions and 132 admissions, and an ALOS of 9.78 days and 8.8 days per inpatient admission.

The applicant provides letters of support which document referrals from previous years in supplemental information. During the past year, letters from McDowell Hospital and six other providers indicate that 109 patients were referred to HoMC. Obviously, none of the past referrals were for inpatient hospice treatment. The letters do not provide future projections regarding number of referrals, either for hospice home care or for inpatient hospice care. Therefore, the letters provide no support for the applicant's projections.

Access to Services

The applicant projects 94% of its patients will be covered by Medicare (92%) and Medicaid (2%). The applicant demonstrates adequate access for medically underserved groups to the proposed services.

In summary, the applicant does not adequately demonstrate that its projected utilization is based on reasonable, supported, and credible assumptions of hospice patients served, total agency projections, or average length of stay. Thus, the applicant does not adequately demonstrate the need to develop the proposed inpatient hospice unit. Therefore, the application is nonconforming to this criterion.

(3a) In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly to obtain needed health care.

NA

(4) Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.

NC

In Section III.14, pages 34-36, the applicant discusses the following alternatives considered prior to the submission of this application:

1. Reconstruct Administrative Offices to Enable a Freestanding Inpatient Facility: The applicant decided against this alternative due to the cost-prohibitive construction of bringing the building up to code and being the sole provider for ancillary services.

2. Lease Space on Highway 221 South in Glenwood: The applicant decided against this alternative due to the cost of constructing the building to meet fire and safety codes. Additionally, the applicant states that the facility would be far from town and the applicant would again be the sole provider of ancillary services.

3. Renovate-to-Suit Leased Space within McDowell County as Freestanding Inpatient Facility: The applicant decided against this alternative due to the distance from town, cost, and being the sole provider for ancillary services.

4. Develop the Project as Proposed: The applicant chose this alternative because of the existing facilities and services in place as well as the location near the county seat, where it is equally accessible to all points in the county.

However, the applicant did not adequately demonstrate the need for the proposed project. Furthermore, the application is not conforming to all other statutory and regulatory review criteria and thus is not approvable. See Criteria (1), (3), (5), (6), (18a), and 10A NCAC 14C .4000—Criteria and Standards for Hospice Inpatient Facilities and Hospice Residential Facilities. An application that cannot be approved is not an effective alternative.

In summary, the applicant does not adequately demonstrate that its proposal to develop a new inpatient hospice unit with six inpatient hospice beds in McDowell Hospital is the least costly or most effective alternative to meet the need. Consequently, the application is disapproved.

(5) Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

NC

In Section VIII.1, pages 53-54, the applicant projects that the total capital cost of the project will be $492,400, including $364,000 for the construction contract. In Section VIII.5 and 6, pages 54-55, the applicant states that the capital cost will be funded with accumulated reserves, a land sale, and a public campaign. Supplemental information contains a letter from the Treasurer of Hospice of McDowell County, stating in part:

> *"…Hospice of McDowell County is committing to expending the required amount of $492,410 identified in the Certificate of Need application to re-purpose 3,922 square feet of space as a 6 bed Care Center for hospice patients within McDowell Hospital."*

The applicant also states in Section VIII.6, page 55:

> *"HoMC documents a successful public campaign in 2005-2006 to build an administrative building that was fully capitalized by public campaign pledges. … HoMC demonstrates working capital to complete this project without a public campaign. This is ill-advised as public campaigns raise as much awareness and friendship loyalty as they do project funding. HoMC expects to engage in a public campaign to generate greater public support for the proposed facility. Six acres of land are currently under option which will generate another $120,000 if the sale proceeds as expected."*

Exhibit U contains the audited financial statements of HoMC as of December 30, 2011 and 2010. As of December 30, 2011, HoMC had total assets of $2,859,376 in cash and $1,019,910 in cash equivalents. The applicant provides a pro forma balance sheet in Form A of supplemental information, but fails to indicate whether the data is for HoMC or the Care Center. Furthermore, no methodology or assumptions are provided.

The applicant's income and expense projections (Forms B and C from supplemental information) are not reasonable, credible, or supported, as described below:

1. The applicant projects a loss in the first three project years.

   In Form B in supplemental information, the applicant projects that expenses will exceed revenues in the first, second and third years of operation following completion of the project, as shown in the table below:

	Year 1	Year 2	Year 3
Revenue	$846,527	$1,043,962	$1,329,930
Expenses	$1,235,388	$1,274,077	$1,330,217
Profit	($388,862)	($230,115)	($287)

2. The budgeted amount for nursing, physician, and social services is less than the amount reflected in Section VII; consequently, the expenses are underbudgeted and unreliable.

   For the second operating year, in Form C of supplemental information, the applicant budgets $443,817 for routine nursing services, physician services, and social work services. No administrative services are budgeted.

   In Table VII.2 of supplemental information, for the second operating year, the applicant's projections for routine nursing services, physician services, social work services, and administrative services equal $600,121. The LPN listed in Table VII.2 is not included in the budgeted amounts in Form C. See tables below.

Form C, Supplemental Information	
Second Operating Year	
Nursing Services	**Salary**
RN	$219,671
LPN	$0
CNA	$119,695

Contract Work	$61,570
Medical Director/MD	$33,024
Total	**$433,960**
Social Services	
Personnel	$9,857
Administrative	
	$0
Total	**$443,817**

Table VII.2 Supplemental Information Second Operating Year

	Annual Salary	FTEs	Total Annual Salary
Routine Services			
Medical Director	$150,000	0.14*	$20,913
Clinical Manager	$39,480	0.50	$19,740
Registered Nurses	$60,320	5.57	$335,982
LPN	$17,680	1.00	$17,680
CNA	$22,880	5.57	$127,442
Social Work Services			
Social Worker	$44,038	0.10	$4,404
Bereavement/Chaplain	$43,222	0.10	$4,322
Administrative			
Ward Clerk	$24,960	2.79	$69,638
Total Positions/Hours/FTEs		**15.77**	**$600,121**

*Applicant lists Medical Director as working 290 hours per year. 290 hours / 2080 hours = 0.14 FTEs

Budgeted amounts for staffing are inconsistent and unreliable.

3. Reimbursement rates are unreliable because they are inconsistent with the applicant's stated methodology and because the applicant failed to provide reimbursement rates or charges for private pay or indigent patients.

   In Section X.3, page 61, the applicant projects the following reimbursement rates and charges for the first three years of operation of the proposed project.

Projected Per Diem Reimbursement Rates/Charges for Care Center			
Source of Payment by Type of Care	**10/1/2013-9/30/2014**	**10/1/2014-9/30/2015**	**10/1/2015-9/30/2016**
Hospice Inpatient			

Commercial	$695	$695	$706
Medicare	$632	$632	$642
Medicaid	$632	$632	$642
Private Pay	No data	No data	No data
Indigent/Other	No data	No data	No data
Hospice Respite Care			
Commercial	$165	$165	$167
Medicare/ Medicaid	$149	$149	$151
Hospice Residential Care			
Commercial	$75	$62	$63
Private Pay	$75	$62	$63
Routine Home Care Rate	$140	$141	$151
Hospice Home Care Rate	$140	$141	$143

In Section X.4, page 62, regarding reimbursement rate assumptions, the applicant states:

> "*Refer to Section II,* ***Exhibit J,*** *for the 2012* [2013] *reimbursement schedule The rate increase is estimated on a 1.50% per year rate of inflation. A conservative approach is employed secondary to reimbursement predictability being skewed by Affordable Care Act, 2% sequestration, and other budget uncertainties.*" [emphasis in original]

The applicant does not provide reimbursement rates or charges for private pay or indigent patients even though it projects both as part of its payor mix.

According to Exhibit J, the FFY 2013 Medicare/Medicaid inpatient hospice reimbursement rate per day for McDowell County is $617.62; the inpatient respite care rate is $145.94. However, the applicant does not apply a 1.5% increase per year to the rates.

If the applicant applied the stated 1.5% yearly increase, the inpatient hospice Medicare and Medicaid reimbursement rates would be as follows:

Projected Per Diem Reimbursement Rates/Charges for Care Center Increased By 1.5%/year				
	10/1/2012-9/30/2013	**10/1/2013-9/30/2014**	**10/1/2014-9/30/2015**	**10/1/2015-9/30/2016**
Inpatient Medicare/Medicaid	$617.62	$626.88	$636.28	$645.82

Respite Medicare/Medicaid	$145.94	$148.13	$150.35	$152.61

Furthermore, the applicant did not increase the commercial and routine home care rates by 1.5% per year as stated. Therefore, the applicant does not adequately demonstrate that projected charges are based on reasonable, credible, and supported assumptions.

4. Respite days of care are not included in the budgeted income and expense statements (Forms B and C in supplemental information).

5. Utilization projections are not reasonable. Consequently, to the extent that projections of revenues and expenses are based on utilization projections, projected revenues and expenses are also not reliable.

   In supplemental information, Tables II.1—II.3, the applicant projects annual number of patient care days for each level of care to be provided in each of the first three years of operation, as shown below. The methodology and assumptions used to develop the projections are provided in Section IV, pages 37-39. However, the applicant provides inconsistent data in different parts of supplemental information regarding projected patient care days. See Tables IV.3—IV.4 and Forms B and C below. See Criterion (3) for a discussion of the reasonableness and credibility of projections, which is hereby incorporated by reference as if fully set forth herein.

Tables II.1—II.3			
Care Center Projected Patient Care Days			
Care Level	**Year 1 FY2014**	**Year 2 FY2015**	**Year 3 FY2016**
Inpatient	1,155	1,484	1,922
Residential	205	94	55
Respite	60	60	60

Table IV.3—IV.4			
Care Center Projected Utilization			
	CY 2014	**CY 2015**	**CY 2016**
Inpatient	1380	1578	1977
Respite	60	60	60

*No mention of residential days of care

Forms B and C			
Care Center Patient Days of Care			
	CY 2014	**CY 2015**	**CY 2016**
Inpatient	1360	1578	1977

*No other days of care are included in budgeted projections in Forms B and C

In summary, the applicant adequately demonstrates the availability of sufficient funds for the development of the proposed inpatient hospice beds; however, the applicant does not adequately demonstrate the financial feasibility of the proposal is based upon reasonable projections of costs and charges for providing hospice inpatient, residential, and respite care services. Therefore, the application is nonconforming to this criterion.

(6) The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.

NC

The applicant proposes to develop and operate a six bed hospice inpatient unit in existing space in McDowell Hospital, pursuant to a need determination for six hospice inpatient beds for McDowell County in the 2013 SMFP. There are no hospice inpatient beds located in McDowell County. However, the applicant did not adequately demonstrate the need the population projected to be served has for the proposed services. Specifically, projected utilization is not based on reasonable, credible, and supported assumptions. See Criterion (3) for discussion regarding projected utilization which is hereby incorporated by reference as if fully set forth herein. Therefore, the applicant did not adequately demonstrate that the proposal would not result in the unnecessary duplication of existing or approved health service capabilities or facilities. Consequently, the application is nonconforming to this criterion.

(7) The applicant shall show evidence of the availability of resources, including health manpower and management personnel, for the provision of the services proposed to be provided.

C

Exhibit P contains letters from the Chief Medical Officer, as well as the Medical Director, stating their willingness to serve in their current roles for the new inpatient hospice unit.

In supplemental information, the applicant provides the projected staffing for the proposed hospice inpatient facility in the second operating year, as shown in the table below.

	Annual Salary	FTEs	Hourly/consultant fee	Annual hours
Routine Services				
Medical Director			$150,000	290
Clinical Manager	$39,480	0.50		

Registered Nurses	$60,320	5.57		
LPN	$17,680	1.00		
CNA	$22,880	5.57		
Social Work Services				
Social Worker	$44,038	0.10		
Bereavement/Chaplain	$43,222	0.10		
Ancillary Services				
Physical Therapist			$200 eval/$125 visit	
Occupational Therapist			$200 eval/$125 visit	
Speech Therapist			$200 eval/$125 visit	
Administrative				
Ward Clerk	$24,960	2.79		
Total Positions/Hours/FTEs		**15.63**		**290**

In the pro forma financial statements, the applicant did not budget for the LPN and ward clerk positions shown above. However, the applicant did budget adequate costs for the RN and CNA positions shown in the table. Moreover, the RN and CNA positions budgeted are sufficient for the level of services proposed.

On page 52 of the application, the applicant projects that two direct care staff will be on duty at all times. This includes one RN and one CNA scheduled for each 12 hour shift. In the second year of operation, the applicant projects to provide 11.10 nursing hours per patient day (NHPPD) [17,520 nursing hours per year / 1,578 days of care = 11.10 NHPPD].

The applicant adequately demonstrates the availability of sufficient resources, including health manpower and management personnel for the provision of the proposed hospice services. Therefore, the application is conforming with this criterion.

(8) The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system.

C

In Section II.3, pages 22-23, the applicant states that HoMC will provide all necessary ancillary services, and provides a table documenting the provider for each ancillary service to be provided. Exhibit E contains a letter from the Vice President of Finance/Business Operations for McDowell Hospital, stating that the hospital will provide dietary counseling, maintenance, and laboratory services to HoMC. Exhibit F contains letters from two pharmacies; a durable medical equipment company; and a surgical supply company, urging the acceptance of the application and stating their intention of providing services to the Care Center. On pages 40-41 of the application, the applicant discusses its current formal and informal referral and training networks.

Exhibit A contains a letter of intent for lease of space signed by the President and CEO of McDowell Hospital. Exhibit N contains a list of clinical and facility programs that are under contract with HoMC. Exhibit O contains letters of support from the community, and Exhibit Q contains letters of support from area physicians.

The applicant adequately demonstrates that necessary ancillary and support services will be available and that the proposed services will be coordinated with the existing health care system. Therefore, the application is conforming with this criterion.

(9) An applicant proposing to provide a substantial portion of the project's services to individuals not residing in the health service area in which the project is located, or in adjacent health service areas, shall document the special needs and circumstances that warrant service to these individuals.

NA

(10) When applicable, the applicant shall show that the special needs of health maintenance organizations will be fulfilled by the project. Specifically, the applicant shall show that the project accommodates: (a) The needs of enrolled members and reasonably anticipated new members of the HMO for the health service to be provided by the organization; and (b) The availability of new health services from non-HMO providers or other HMOs in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO. In assessing the availability of these health services from these providers, the applicant shall consider only whether the services from these providers:

(i) would be available under a contract of at least 5 years duration;
(ii) would be available and conveniently accessible through physicians and other health professionals associated with the HMO;
(iii) would cost no more than if the services were provided by the HMO; and
(iv) would be available in a manner which is administratively feasible to the HMO.

NA

(11) Repealed effective July 1, 1987.

(12) Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the public of providing health services by other persons, and that applicable energy saving features have been incorporated into the construction plans.

NA

(13) The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups,

such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:

(a) The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically underserved;

C

The Division of Medical Assistance (DMA) maintains a website which offers information regarding the number of persons eligible for Medicaid assistance and estimates of the percentage of uninsured for each county in North Carolina. The following table illustrates those percentages for McDowell County and statewide.

	2010 Total # of Medicaid Eligibles as % of Total Population *	**2010 Total # of Medicaid Eligibles Age 21 and older as % of Total Population ***	**2008-2009 % Uninsured (Estimate by Cecil G. Sheps Center) ***
McDowell County	20%	9.5%	18.3%
Statewide	17%	6.7%	19.7%

* More current data, particularly with regard to the estimated uninsured percentages, was not available.

The majority of Medicaid eligibles are children under the age of 21. This age group would not typically utilize the health services proposed in this application.

Moreover, the number of persons eligible for Medicaid assistance may be greater than the number of Medicaid eligibles who actually utilize health services. The DMA website includes information regarding dental services which illustrates this point. For dental services only, DMA provides a comparison of the number of persons eligible for dental services with the number actually receiving services. The statewide percentage of persons eligible to receive dental services who actually received dental services was 48.6% for those age 20 and younger and 31.6% for those age 21 and older. Similar information is not provided on the website for other types of services covered by Medicaid. However, it is reasonable to assume that the percentage of those actually receiving other types of health services covered by Medicaid is less than the percentage that is eligible for those services.

The Office of State Budget & Management (OSBM) maintains a website which provides historical and projected population data for each county in North Carolina. In addition, data is available by age, race or gender. However, a direct comparison to the applicant's current payor mix would be of little value. The

population data by age, race or gender does not include information on the number of elderly, minorities or women utilizing health services. Furthermore, OSBM's website does not include information on the number of handicapped persons.

Annual data provided by the Carolinas Center for Hospice and End of Life Care reports that hospice patients in North Carolina had the following payor mix during FFY2011.

NC Hospice Patients by Payor Mix		
Payor	**Patient Days**	**Number of Patients**
Hospice Medicare	91.6%	86.3%
Hospice Private Insurance	3.4%	5.9%
Hospice Medicaid	3.4%	4.9%
Self Pay / Other	1.6%	2.8%
Total	100.0%	100.0%

The following table shows North Carolina and national hospice patients by race and ethnicity for FFY2010.

Hospice Patients by Race and Ethnicity		
	% of Hospice Patients NC Data	**% of Hospice Patients National Data**
Race:		
White/ Caucasian	80.5%	77.3%
Black/ African American	15.4%	8.9%
Other Race	2.7%	11.0%
American Indian or Alaskan Native	1.0%	0.3%
Asian, Hawaiian, Other Pacific Islander	0.4%	2.5%
	100.0%	**100.0%**
Ethnicity		
Hispanic or Latino Origin	0.7%	5.7%
Non-Hispanic or Latino Origin	99.3%	94.3%
	100.0%	**100.0%**

Source: Carolinas Center for Hospice and End of Life Care 2011

The following table shows North Carolina and national hospice patients by age groups for FFY2010, which indicates more than 80% are age 65+ and would be Medicare eligible.

Hospice Patients by Age Categories		
Age Category	**% of Hospice Patients NC Data**	**% of Hospice Patients National Data**
0-34	0.8%	1.3%

35-64	17.4%	16.1%
65-74	18.4%	15.9%
75+	63.4%	66.8%
Total	**100.0%**	**100.0%**

Source: Carolinas Center for Hospice and End of Life Care 2011

In Section VI.1, page 43, the applicant provides the payor mix for HoMC hospice patients and days of care provided by its certified hospice home care agency during the 2012 licensure year, as shown in the table below.

HoMC Hospice Home Care Agency		
Payor	**Hospice Patients**	**Hospice Days of Care**
Medicare	88%	88%
Medicaid	4%	4%
Commercial	4%	4%
Indigent	2%	2%
Other	2%	2%
Total	100%	100%

In Section VI.5, page 45, the applicant states:

> *"Care is based upon medical eligibility without respect to age, sex, financial, insurance, or religious affiliation. As such it is the practice of HoMC to admit all medically eligible individuals who are informed and choose to participate with HoMC. Policies and Procedures support equal access to the full range of hospice services without discrimination."*

Exhibit D contains a copy of the Admission Criteria Policy.

The applicant adequately demonstrates that medically underserved populations currently have adequate access to existing services; therefore, the application is conforming with this criterion.

(b) Its past performance in meeting its obligation, if any, under any applicable regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal assistance, including the existence of any civil rights access complaints against the applicant;

C

In Section VI.10, page 47, the applicant states that there have been no such complaints filed against HoMC. Therefore, the application is conforming with this criterion.

(c) That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services; and

C

In supplemental information, the applicant provides the projected payor mix for inpatient services for the second year of operation at the proposed new facility, as shown in the table below.

Care Center Projected Payor Mix Year 2		
Payor	**Hospice Inpatients**	**Hospice Inpatient Days of Care**
Medicare	92%	92%
Medicaid	2%	2%
Commercial	2%	2%
Private Pay	2%	2%
Indigent	2%	2%
Total	**100%**	**100%**

The projected payor mix above shows 94% of days of care are expected to be paid by Medicare or Medicaid. This is consistent with the statewide hospice payor mix of combined Medicare/Medicaid of 95% provided in the FY2011 annual report from The Carolinas Center for Hospice and End of Life Care.

The applicant adequately demonstrates that medically underserved groups will be adequately served by the proposed hospice facility. Therefore, the application is conforming with this criterion**.**

(d) That the applicant offers a range of means by which a person will have access to its services. Examples of a range of means are outpatient services, admission by house staff, and admission by personal physicians.

C

In Section VI.9, pages 46-47, the applicant states:

> *"Accessing the services of the HoMC and the proposed Care Center is available through a variety of sources. Referrals for services are made from physicians offices, hospital discharge planners, skilled nursing and assisted living facilities, home health agencies, and community agencies. HoMC maintains ongoing communication through our community outreach program. HoMC practices just-in-time communication with anyone making an inquiry recognizing that reaching out to a hospice program with questions is a bold step that requires immediate connection.*

HoMC provides information, assessment, and admission services 24 hours a day, 7 days per week."

Exhibit D contains a copy of the Admission Criteria Policy.

The applicant adequately demonstrates the range of means by which a person will have access to the proposed hospice facility; therefore, the application is conforming with this criterion.

(14) The applicant shall demonstrate that the proposed health services accommodate the clinical needs of health professional training programs in the area, as applicable.

C

In Section V.1, page 40, the applicant states:

"HoMC documents contracts with McDowell Technical Community College and Isothermal Community College to provide nursing education on a routine basis. Social Work Interns from Appalachian University complete an internship with HoMC MSW's who serve as preceptors for the students during their field placement in hospice and end-of-life care."

Exhibit M contains a letter from the Dean of Sciences at McDowell Technical Community College confirming the affiliation between the college and HoMC. Exhibit M also contains an agreement in process between HoMC and the University of Southern California for their online MSW program.

The applicant adequately demonstrates that the facility will accommodate the clinical needs of health professional training programs in the area. Therefore, the application is conforming with this criterion.

(15) Repealed effective July 1, 1987.
(16) Repealed effective July 1, 1987.
(17) Repealed effective July 1, 1987.
(18) Repealed effective July 1, 1987.

(18a) The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

NC

The applicant, HoMC, proposes to develop a new inpatient hospice unit with six inpatient hospice beds within the existing McDowell Hospital. The proposed inpatient hospice unit will be named Hospice of McDowell County Care Center (Care Center).

HoMC has operated a licensed hospice home care agency in Marion, in McDowell County, since 1994. There are no inpatient hospice facilities in McDowell County at this time, so McDowell County residents have traveled out of county to utilize inpatient hospice services. Currently three hospice agencies in contiguous counties operate inpatient hospice facilities: Burke Palliative Care Center in Burke County; Hospice House of Rutherford County in Rutherford County; and CarePartners Hospice and Palliative Care Services in Buncombe County. Admissions and days of care to those three inpatient hospice facilities by McDowell County residents are illustrated in the table below.

McDowell County Residents Served in Inpatient Hospice Facilities			
Admission Facility	**McDowell County Residents Served**	**Inpatient Days of Care**	**ALOS**
FY 2011			
Burke Hospice and Palliative Care, Inc.	0	0	0
CarePartners Hospice and Palliative Care Services	14	52	4
Hospice of Rutherford County	27	224	8
Total	**41**	**276**	**7**
FY 2012			
Burke Hospice and Palliative Care, Inc.	N/A*	N/A*	N/A*
CarePartners Hospice and Palliative Care Services	14	109	8
Hospice of Rutherford County	30	296	10
Total*	**44**	**405**	**9**

Source: LRAs
*Data unavailable for Burke Hospice and Palliative Care, Inc. for FY 2012; not included in calculations

In Section V.7, pages 42-43, the applicant discusses the project as it relates to promoting cost-effectiveness, quality and access; however, it does not discuss how any enhanced competition will have a positive impact on cost effectiveness, quality, or access. The applicant does state that it expects that McDowell County residents will utilize the Care Center instead of using the three inpatient hospice facilities that are currently used most frequently by McDowell County residents. See also Sections II, III, V, VI, VII, and supplemental information where the applicant also discusses the impact of the project on cost-effectiveness, quality and access.

However, the applicant does not adequately demonstrate that any enhanced competition includes a positive impact on the cost-effectiveness of the proposed services for the following reasons:

1. Utilization projections are unsupported and unreliable.
2. Projections of ALOS and admissions are inconsistent.
3. Income and expense statements are not reasonable or reliable.

See Criterion (3) for discussion of utilization projections which is hereby incorporated by reference as if fully set forth herein. See Criterion (5) for discussion regarding income and expense projections which is hereby incorporated by reference as if fully set forth herein. Therefore, the application is nonconforming with this criterion.

(19) Repealed effective July 1, 1987.

(20) An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.

C

HoMC is an existing licensed hospice agency. In Section II.1, page 11, the applicant states that it is certified for participation in Medicare and Medicaid. According to the Acute and Home Care Licensure and Certification Section, DHSR, no incidents occurred within the eighteen months immediately preceding the date of this decision for which any sanctions or penalties related to quality of care were imposed by the State. Therefore, the application is conforming with this criterion.

(21) Repealed effective July 1, 1987.

(b) The Department is authorized to adopt rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. No such rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service.

NC

The application does not conform to all applicable Criteria and Standards for Hospice Inpatient Facilities and Hospice Residential Care Facilities 10A NCAC 14C .4000. The specific criteria are discussed below.

10A NCAC 14C .4002 INFORMATION REQUIRED OF APPLICANT

(a) An applicant proposing to develop hospice inpatient facility beds or hospice residential care facility beds shall complete the application form for Hospice Inpatient and Hospice Residential Care Services.

-C- The applicant used the correct application form.

(b) An applicant proposing to develop hospice inpatient facility beds or hospice residential care facility beds shall provide the following information:

(1) the projected annual number of hospice patients, admissions, deaths, and other discharges, for each level of care (i.e., respite care, hospice residential care and hospice inpatient care), to be served in the facility in each of the first three years following completion of the project and the methodology and assumptions used to make the projections;

-NC- In supplemental information, the applicant provides the projected number of hospice patients, admissions, deaths, and other discharges for inpatient and respite care to be served at the Care Center in each of the first three years following completion of the project as shown in the tables below. However, the applicant did not provide the projected number of hospice admissions, deaths, and other discharges for residential care. See Criterion (3) for a discussion of the reasonableness of projections, which is hereby incorporated by reference as if fully set forth herein.

Projected Care Center Utilization			
Inpatient	**2014**	**2015**	**2016**
Patients Served	132	175	232
Admissions	139	188	244
Deaths	103	130	181
Discharges	51	30	39
Residential	**2014**	**2015**	**2016**
Patients Served	23	13	9
Admissions	*	*	*
Deaths	*	*	*
Discharges	*	*	*
Respite	**2014**	**2015**	**2016**
Patients Served	5	5	5
Admissions	5	5	5
Deaths	0	0	0
Discharges	5	5	5

Source: Tables IV.3 and IV.4 in supplemental information
*This information was not provided by the applicant

(2) the projected annual number of hospice patients, admissions, deaths, and other discharges for each level of care to be served by the applicant's licensed hospice agency in each of the first three years following completion of the project and the methodology and assumptions used to make the projections;

-NC- In Section IV.3, page 39, the applicant provides the following information:

Care Center Total Hospice Operations			
	Year 1 FY2014	**Year 2 FY2015**	**Year 3 FY2016**
Patients	255	265	275
Admissions	25,198	26,205	27,253
Deaths	204	212	220
Discharges	19	20	21
ALOS	87	88	88

The applicant did not break out the data for each level of care.

(3) the projected annual number of patient care days, for each level of care (i.e., respite care, hospice residential care and hospice inpatient care), to be provided in each of the first three years of operation following completion of the project and the methodology and assumptions used to make the projections;

-NC- In supplemental information, Tables II.1—II.3, the applicant shows projected annual number of patient care days for each level of care to be provided in each of the first three years of operation, as shown in the table below. The methodology and assumptions used to develop the projections are provided in Section IV, pages 37-39. However, the applicant provides inconsistent data in different parts of supplemental information regarding projected patient care days. See also Table IV.3—IV.4 and Forms B and C below. See Criterion (3) for a discussion of the reasonableness and credibility of projections, which is hereby incorporated by reference as if fully set forth herein.

Tables II.1—II.3			
Care Center Projected Patient Care Days			
Care Level	**Year 1 FY2014**	**Year 2 FY2015**	**Year 3 FY2016**
Inpatient	1,155	1,484	1,922
Residential	205	94	55
Respite	60	60	60

Tables IV.3—IV.4			
Care Center Projected Utilization			
	CY 2014	**CY 2015**	**CY 2016**
Inpatient	1380	1578	1977
Respite	60	60	60

*No mention of residential days of care

Forms B and C			
Care Center Patient Days of Care			
	CY 2014	**CY 2015**	**CY 2016**
Inpatient	1360	1578	1977

*No other days of care are included in budgeted projections in Forms B and C

(4) the projected average length of stay (ALOS) based on admissions to the applicant's facility, for each level of care, (i.e., respite care, hospice residential care and hospice inpatient care) and the methodology and assumptions used to make the projections;

-NC- In supplemental information, Tables II.1—II.3, the applicant shows projected average length of stay (ALOS) for the Inpatient, Residential, and Respite levels of care, as shown in the table below. The methodology and assumptions used to develop the projections are provided in Section IV, pages 37-39.

Care Center Average Length of Stay			
Care Level	**Year 1 FY2014**	**Year 2 FY2015**	**Year 3 FY2016**
Inpatient	8.75	8.50	8.50
Residential	8.90	7.20	6.10
Respite	5.00	5.00	5.00

However, a different set of inpatient ALOS projections is provided in Table IV.3 in supplemental information.

Care Center Average Length of Stay			
Care Level	**Year 1 FY2014**	**Year 2 FY2015**	**Year 3 FY2016**
Inpatient	9.78	8.38	8.10

See Criterion (3) for a discussion of the reasonableness of projections, which is hereby incorporated by reference as if fully set forth herein.

(5) the projected readmission rate, for each level of care, (i.e., respite care, hospice residential care and hospice inpatient care) and the methodology and assumptions used to make the projections;

-C- In supplemental information, the applicant projects a 5% readmission rate for hospice inpatient care; a 0% readmission rate for hospice residential care, and a 0% readmission rate for respite care.

The applicant states that due to limited experience with hospice inpatient care, it is projecting a conservative readmission rate. The applicant states that currently, it does not experience a strong readmission rate, though it does not document what its current readmission rate is.

(6) the projected average annual cost per patient care day, by level of care (i.e., respite care, hospice residential care and hospice inpatient care) for each of the first three operating years following completion of the project and the methodology and assumptions used to project the average annual cost;

-NC- In Form C, in supplemental information, the applicant provides the projected average annual cost per patient care day, for the inpatient level of care for each of the first three operating years following completion of the project, as shown below. Few assumptions are provided. The applicant does not project average annual cost per patient day for residential or respite care.

Average Cost per Patient Day Hospice Inpatient Care		
Year 1 FY2014	**Year 2 FY2015**	**Year 3 FY2016**
$908.37	$807.66	$673.02

(7) documentation of attempts made to establish working relationships with sources of referrals to the hospice facility including copies of proposed agreements for the provision of inpatient care and residential care;

-C- In Section II, page 14, the applicant states:

> *"Hospice of McDowell County has established a strong relationship with our healthcare community. The program receives excellent referral patterns that are expected to continue following the completion of this project. Currently surrounding hospitals do not have an option to make general inpatient hospice referrals to Hospice of McDowell County secondary to the absence of such a facility. …*
>
> *Please refer to Exhibit B…for letters of support and referrals from area healthcare providers."*

The applicant provides letters of support and for referrals to the proposed project from area providers in supplemental information.

(8) documentation of the projected number of referrals to be made by each referral source;

-NC- In Section II, page 14, the applicant states:

> *"Those patients* [McDowell County residents served outside McDowell County] *are expected to be referred back to their county of residence."*

In supplemental information, local providers state they have referred 109 patients to Hospice of McDowell County within the last year. The local providers state that they anticipate further referrals, but do not specify how many to home care or to the proposed Care Center. In supplemental information, the applicant states: *"We approximate from the data provided through other hospices a potential referral base of 30% over our general home care population."*

(9) copies of the proposed contractual agreements, if the applicant is not a licensed hospice, with a licensed hospice or a licensed home care agency with a hospice designation on its license, for the provision of hospice services;

-NA- HoMC is a licensed hospice.

(10) documentation of the projected number of patients to be referred for each payor type from the referring hospices, if the applicant is not a licensed hospice or if the applicant proposes to admit patients on a contractual basis; and

-NA- HoMC is a licensed hospice.

(11) a copy of the admission policies, including the criteria that shall be used to select persons for admission to the hospice inpatient and residential care beds.

-C- Exhibit D contains a copy of the Admissions policy.

10A NCAC 14C .4003 PERFORMANCE STANDARDS

(a) An applicant proposing to develop hospice inpatient facility beds or hospice residential care facility beds shall demonstrate that:

(1) the average occupancy rate of the licensed hospice beds, for each level of care, in the facility is projected to be at least 50 percent for the last six months of the first operating year following completion of the project;

-NC- In supplemental information, the applicant shows that in the last six months of the first operating year, the average occupancy rate for inpatient care, including respite care, is projected to be at least 50 percent, as shown in the following table. However, the projections are based on unreasonable and unsupported assumptions. See Criterion (3) for discussion of methodology and assumptions. Therefore, the applicant is nonconforming to this rule.

Care Center Inpatient Care						
Project Year 1 FY2014	**Inpatient Days***	**Residential Days**	**Days Per 6 Mo. Period**	**# Beds**	**Inpatient Days Occupancy Rate**	**Combined Occupancy Rate**
Quarters 1 & 2	516	124	182	6	47.3%	58.6%
Quarters 3 & 4	639	81	183	6	58.2%	65.6%
Total Year 1	1,155	205	365	6	52.7%	62.1%

*Inpatient days include respite days

(2) the average occupancy rate for the licensed hospice beds, for each level of care, in the facility is projected to be at least 65 percent for the second operating year following completion of the project; and

-NC- In supplemental information, the applicant shows that in the last six months of the second operating year, the average occupancy rate for inpatient care, including respite care, is projected to be at least 65 percent, as shown in the following table. However, the projections are based on unreasonable and unsupported assumptions. See Criterion (3) for discussion of methodology and assumptions. Therefore, the applicant is nonconforming to this rule.

Care Center Inpatient Care						
Project Year 2 FY2015	**Inpatient Days***	**Residential Days**	**Days Per 6 Mo. Period**	**# Beds**	**Inpatient Days Occupancy Rate**	**Combined Occupancy Rate**
Quarters 5 & 6	720	72	182	6	65.9%	72.5%
Quarters 7 & 8	764	22	183	6	69.6%	71.6%
Total Year 2	1,484	94	365	6	67.8%	72.1%

*Inpatient days include respite days

(3) if the application is submitted to address the need for hospice residential care beds, each existing hospice residential care facility which is located

in the hospice service area operated at an occupancy rate of at least 65 percent for the 12 month period reported on that facility's most recent Licensure Renewal Application Form.

-NA- The applicant does not propose to add hospice residential care beds.

(b) An applicant proposing to add hospice inpatient facility beds to an existing hospice inpatient facility shall document that the average occupancy of the licensed hospice inpatient facility beds in its existing facility was at least 65 percent for the nine months immediately preceding the submittal of the proposal.

-NA- The applicant is not proposing to add hospice inpatient beds to an existing hospice facility.

(c) An applicant proposing to add residential care beds to an existing hospice residential care facility shall document that the average occupancy of the licensed hospice residential care beds in its existing facility was at least 65 percent for the nine months immediately preceding the submittal of the proposal.

-NA- The applicant does not propose to add residential care beds to an existing hospice facility.

10A NCAC 14C .4004 SUPPORT SERVICES

(a) An applicant proposing to develop a hospice inpatient facility beds or hospice residential care facility beds shall demonstrate that the following services will be provided directly by the applicant or by a contracted hospice to the patient and the patient's family or significant others:

(1) nursing services;
(2) social work services;
(3) counseling services including dietary, spiritual, and family counseling;
(4) bereavement counseling services;
(5) volunteer services;
(6) physician services; and
(7) medical supplies.

-C- Section II, Table II.7, pages 22-23 documents who will provide each of the services listed above.

(b) An applicant shall demonstrate that the nursing services listed in Paragraph (a) of this Rule will be available 24 hours a day, seven days a week.

-C- In Section VII, page 52, the applicant shows that four direct care staff will work each 24 hour period, divided into two 12-hour shifts. In Section II.2, page 18, the

applicant states that nursing services will be available 24 hours a day, seven days a week for the provision of direct patient care, and that the staffing pattern will be consistent with licensure requirements specified in 10A NCAC 13K.

(c) An applicant proposing to develop a hospice inpatient facility or a hospice residential care facility shall provide documentation that pharmaceutical services will be provided directly by the facility or by contract.

-C- In Section II.2, page 18, the applicant states that Marion Pharmacy will supply medications to HoMC patients as is currently contracted. Exhibit F contains a copy of the agreement between HoMC and Marion Pharmacy.

(d) For each of the services listed in Paragraphs (a) and (c) of this Rule which are proposed to be provided by contract, the applicant shall provide a copy of a letter from the proposed provider which expresses its interest in working with the proposed facility.

-C- In Section II.2, pages 17-18, the applicant states that all services listed above are provided through HoMC, McDowell Hospital, Holladay Medical Group, and Marion Pharmacy. Exhibits E and F contain copies of the agreements between HoMC and the providers.

10A NCAC 14C .4005 STAFFING AND STAFF TRAINING

(a) An applicant proposing to develop a hospice inpatient facility beds or hospice residential care facility beds shall document that staffing will be provided in a manner consistent with G.S. 131E, Article 10.

-C- In Section II.2, page 18, the applicant states that the staffing will be provided in a manner consistent with G.S. 131E, Article 10. In Section VII, the applicant provides staffing information.

(b) The applicant shall demonstrate that:

(1) the staffing pattern will be consistent with licensure requirements as specified in 10A NCAC 13K, Hospice Licensing Rules;

-C- In Section II.2, page 18, the applicant states that "*The staffing pattern will be consistent with licensure requirements as specified in 10A NCAC 13K…*"

In addition, the proposed staffing shown in Table VII.2, page 51, reflects that the above services will be provided.

(2) training for all staff will meet the requirements as specified in 10A NCAC 13K .0400, Hospice Licensing Rules.

-C- In Section II.2, page 18, the applicant states that all training will meet the requirements of 10 NCAC 13K .0400. Exhibit G contains training policies and procedures.

10A NCAC 14C .4006 FACILITY

An applicant proposing to develop new hospice inpatient facility beds or new hospice residential care facility beds shall document:

(1) that a home-like setting shall be provided in the facility;

-C- In Section II.2, page 19, the applicant states:

> *"Hospice of McDowell Care Center will up-fit an existing hospital designated area to form a suite offering a home-like atmosphere for patients and their families/loved ones, caregivers and friends."*

(2) that the services will be provided in conformity with applicable state and local laws and regulations pertaining to zoning, physical environment, water supply, waste disposal and other relevant health and safety requirements; and

-C- In Section II.2, page 19, the applicant states that it is locating the Care Center within an existing licensed/certified healthcare facility that complies with all applicable state and local laws and regulations.

(3) for new facilities, the location of the site on which the services are to be operated. If the site is neither owned by nor under option to the applicant, the applicant must provide a written commitment to pursue acquiring the site if and when the approval is granted, must specify a secondary site on which the services could be operated if acquisition efforts relative to the primary site ultimately fail, and must demonstrate that the primary and secondary sites are available for acquisition.

-C- In Section II.2, page 19, the applicant states:

> *"The Hospice of McDowell Care Center proposes installation within McDowell Hospital. Should this option fail we propose up-fitting our existing 15,000 square foot building to meet fire safety standards separating multi-use space to accommodate sharing of occupancy with the Hospice of McDowell Administrative and Home Care activities. Additions of fire separation, sprinkler system, and other relevant health and safety requirements will serve to expand the building to accommodate a six-bed unit. The*

neighborhood is currently serving both a nursing and rehabilitation center and an assisted living facility."