HOME HEALTH TASK FORCE
Report to Long-Term and Behavioral Health Committee of the North Carolina State Health Coordinating Council
May 16, 2008

On September 26, 2007, based on the recommendation of it's Long-Term and Behavioral Health Committee, the State Health Coordinating Council authorized the formation of a Home Health Task Force to make recommendations for the 2009 State Medical Facilities Plan.

A seven member Task Force was formed and met twice. The group included Council member Charles Hauser as Chairman, and Council members Senator Tony Foriest and Jerry Parks. Also represented was Medicare-Certified Home Health, Licensed Home Care (not Medicare-Certified), and the medical community. Timothy Rogers, Council member and Chief Executive Officer of the Association for Home and Hospice Care of North Carolina served as a home health industry expert resource. Resource people were also available representing the Division of Aging and Adult Services, Division of Medical Assistance, and the Division of Health Service Regulation Certificate of Need and Acute and Home Care Licensure and Certification Sections. The meetings were open to and attended by members of the public

At its first meeting, the Task Force considered a variety of information and topics. The Task Force wishes to thank, in particular, Mr. Rogers for arranging for presentation of an Overview of the Home Health Industry and Medicare Reimbursement by William Dombi, Vice-President for the National Association for Home Care and Hospice and Director of the Center for Health Care Law. Also provided for Task Force consideration was information on: the Basic Principles Governing Development of the State Medical Facilities Plan (SMFP), the current SMFP Home Health Service Policy and Methodology, utilization trends; methodologies from other states; recent petitions for changes in the methodology, policy or need adjustments; and, the Program for the All-Inclusive Care of the Elderly and Medicaid utilization. The Task Force heard from Mr. Ivans Belovs who had submitted three petitions over the past few years. Information needs were identified including: an analysis of the outcome if recommendations of the Council's 2004 Home Health Task Force had not been adopted; and, identification of counties served by each Home Health Agency based on data reported in the 2008 SMFP. Also, a sub-group was identified to look at a proposal that had been considered by the 2004 Task Force regarding need determinations, under defined conditions, in counties with large populations.

At its second meeting, the Task Force formulated the following recommendations. It is noted that the three basic principals governing development of the State Medical Facilities Plan were considered in the development of these recommendations. The principals concern promotion of cost effective approaches, expanding services to the medically underserved, and encouraging quality services. Further, development of the recommendations included discussion of county versus regional need determinations, need determinations focused on counties with the largest population size and special need populations. It is noted that the Task Force elected not to make any recommendations with regard to Policy.

Recommendation Regarding Methodology

The deficit threshold has been 400 patients since 2005. From 1996 to 2005, the deficit threshold had been 250. Viability of a Home Health agency was a factor considered in selecting 250 patients as the threshold for a need determination for the 1996 Plan as was 400 patients for the 2005 Plan. The Task Force considered changes in the reimbursement system and information related to viability. Viability of existing and new agencies can contribute to cost effective care to the under served in a quality manner.

Recommendation: The Task Force unanimously recommends: 1. the methodology be revised to lower the deficit threshold for a need determination and the "placeholder" adjustment for a new agency from 400 patients to 275; 2. the need determination threshold be reviewed again in five years; and, 3. an item "d" be added to item 8 of the Basic Assumptions of the Method to read, "address special needs populations."

The Task Force views 275 as a reasonable threshold for a need determination in a county based on the standard methodology. Regarding the recommendation, it is noted: if the deficit threshold had been 275 versus 400 since 2005, there would have been need determinations in Mecklenburg and Wake counties which are the same two counties that had need determinations at the 400 patient deficit threshold; 275 recognizes the need for consideration of financial feasibility; new home health agencies may increase their patient population over time; a 400 patient deficit may be viewed by some as a relatively high target that could affect the ability for need determinations to be identified; based on data reported in the 2008 SMFP, there are approximately 20 agencies that reported serving between 200 and 299 patients in the county in which their agency office is located and that the average number of patients for this group was 267; and, it may be possible for an agency to operate without being affiliated with or a part of a larger organization.

The Task Force considers it worthwhile to encourage home health applicants to address special needs populations. Factors that may be considered could include clinical, economic and societal factors within a particular proposed service area. Therefore, the Task Force recommends that an item "d" be added to item 8 of the Basic Assumptions of the Method to read, "address special needs populations.",

Item 8 of the Home Health Services Basic Assumptions of the Method currently reads as follows:

8. The North Carolina State Health Coordinating Council encourages home health applicants to:

   a. provide an expanded scope of services *(including nursing, physical therapy, speech therapy, and home health aide services);*
   b. provide the widest range of treatments within a given service; and
   c. have the ability to offer services on a seven days per week basis as required to meet patient needs.