Medical Facilities Planning

Hospice Methodologies Task Force
Draft Report
Friday, January 23, 2009

10:00am – 12:30 pm
Council Building

MEMBERS PRESENT: Dr. T.J. Pulliam, Chair, Peter Brunnick, Rita Burch, Lynn Hardy, David Lee, Stephen Nuckolls, Jerry Parks, Sandy Roberson, Timothy Rogers (via phone), John Thoma, and David Work RESOURCE PEOPLE PRESENT: Helen Alexander, Judy Brunger and Azzie Conley
MEMBERS AND RESOURCE PEOPLE ABSENT: Dawn Carter and Teresa Piezzo
STAFF PRESENT: Floyd Cogley, Elizabeth Brown and Kelli Fisk

Standing Agenda	Discussion
Welcome & Announcements	Dr. Pulliam, Task Force Chair, welcomed members and guests.
Introduction of Members	At Dr. Pulliam's request, Task Force members, resource people, Division staff and guests introduced themselves. Dr. Pulliam noted that Dr. Myers, Chairman of the State Health Coordinating Council, indicated he appreciated the commitment of time and that he hoped that the Task Force would come up with a product that will carry us well into the future.
Discussion of Goals, Process and Time Frame for Completion of Recommendations	Dr. Pulliam indicated that the goal was to review the current methodologies in light of areas of any perceived deficiencies or future needs, work through the methodologies, and develop recommendations. He reviewed the agenda. He noted that two additional meetings were scheduled and that the Task Force's recommendations will be presented to the Council's Long-Term and Behavioral Health Committee for consideration at the Committee's May 15 meeting. The Committee's recommendations would be considered at the May 27 Council meeting.
Review of Principles Governing Development of State Medical Facilities Plan	Dr. Pulliam spoke to the Principles governing development of the State Medical Facilities Plan, which were mailed with the meeting material. The Principles address Safety and Quality, Access and Value. He asked that an eye be kept on equity and fairness and that the group look to the future.
Overview of Hospice Industry/Trends/ Demographics	Dr. Pulliam called upon Judy Brunger, President and CEO of the Carolinas Center for Hospice and End of Life Care. Ms. Brunger introduced Judi Lund Person, Vice President, Regulatory & State Leadership of the National Hospice and Palliative Care Organization. Ms. Brunger indicated that Ms. Person had worked in North Carolina and was familiar with Certificate of Need in North Carolina. During her presentation Ms. Person noted: -Nationally, about 1.4 million patients were served in 2007 versus 950,000 in 2003. -There is growth of about nine to 15 percent per year.

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	-Regarding length of stay, 31 percent of patients served last year were served for seven days or less. A question is how to get patients into hospice sooner? In 2007, 13.1 percent had stays greater than 180 days. Question is what are the characteristics of long stay patients. -There are about 3400 providers with most growth being in the number of for-profit providers, which serve about 4700 locations. There is some discussion among policy makers in Washington about profit and reimbursement. -83 percent are Medicare, five percent Medicaid and about eight percent private insurance. -There are four levels of care - home care, inpatient, continuous and inpatient respite. 95 percent is routine home care, 3.3 percent is general inpatient care even with growth in the number of inpatient facilities. -There are regulations regarding level of care – at least 80 percent of days of care must be at the home care or continuous care rate and up to 20 percent can be at the inpatient rate. -A most dramatic change has been in the patient diagnosis with a decrease in the percent with cancer. The patient population mirrors the types of diseases of the Medicare population. -A premise is that if a person needs hospice and they qualify for the service, they should receive the service regardless of disease. In 2000, five of the top ten diagnoses were cancers. In 2005, two of the top five were cancers. There has been a large increase in Alzheimer's and Dementia and multi-systems failure and there is a debate about whether these patients should receive hospice services. Other top ten diagnoses are Chronic Obstructive Pulmonary Disease and Congestive Heart Failure. The change in population served can contribute to length of stay. -Data for 2000 to 2005 for hospice users by State shows Alaska with ten percent of Medicare persons served (Alaska providers indicated that the Medicare hospice benefit does not work because they cannot afford it), Maine with 17 percent, South Dakota with 17 percent, Wyoming with 18 percent, and North Dakota with 20 percent. The national average is 31.25 percent. The states with the highest percent are Colorado with 42.7 percent, Florida with 43.5 percent, Utah with 45.5 percent and Arizona with 50.1 percent. North Carolina was at 33 percent. -Individual providers, depending on the community and services provided, range from four percent to 70 percent of deaths served by hospice. Many communities in the country are in the 40 to 50 percent range. -The Medicare Payment Advisory Commission has been looking at hospice and a presentation will be given to Congress in March. The Medicare benefit structure has not changed in 25 years and it is being looked at by the Commission. There is concern about the number of providers with a high percentage of patients going over 180 days. -The National Quality Forum is looking at priorities for the country and a focus is end of life care. There is discussion about hospice integration with other aspects of the health care system. -Her organization is involved in how to determine hospice quality. A family evaluation process has been operating for five years. In response to questions, Ms. Person indicated: -She predicted an area for scrutiny is patients who reside in nursing homes. -The experience has been that there are cost savings for hospice inside hospice. -North Carolina is ahead of other states in the growth of inpatient hospice and this is contributed too by the Council's foresight in making the option available. -She did not know if penetration rates would be much affected by changes in reimbursement. The goal is to get patients in at the appropriate time and to shorten the length of stay for some patients. Advocates at the Alzheimer's Association and others

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	would not want their constituents' admission limited. -She did not think there would be a focus on specific diseases but on length of stay. -The focus is that the people who are with hospice a long time are appropriate and eligible. The higher expense to the hospice is in the earlier and latter periods of patient care. -Observation about rural versus urban providers. She observed that the average length of stay for one provider in rural Mississippi was over 330 days compared to 60 to 70 days in other parts of the country. The explanation was that there was no other health care in the community. In addition, rural providers have a smaller patient population and fewer patients and days of care to spread their resources over. She has not observed a tremendous difference in length of stay. A question may be if they can afford to take care of a particular patient. There is a little more scrutiny of who the patient population is. -There has been discussion about the six-month rule but it probably will not change. Mr. Rogers noted that MedPAC has looked at any area of growth within the Medicare program and home health and hospice have received scrutiny even though it is less than 10 percent of the Medicare total budget. These are faster growing programs that the public are asking for. He also indicated that in North Carolina, the growth in inpatient beds has been within the last few years. In response to a question, Rita Burch indicated about 50 percent of her admissions to the hospice inpatient facility are from the hospital. There was discussion of cancer treatment modalities. It was noted that it is difficult to predict outcome. Dr. Work indicated that issues associated with drug therapy could be issues of price versus cost. Dr. Pulliam indicated his belief is that prevention and palliative care need to be at the forefront.
Overview of Current SMFP Methodologies and Background Information	Dr. Pulliam referred to Floyd Cogley. Mr. Cogley briefly reviewed the material that had been mailed. Namely; the current Hospice services chapter of the 2009 State Medical Facilities Plan including a review of the home care and inpatient need determination methodologies, background information which addressed the evolution of the current methodologies since 2002, historical information on home care and inpatient need determinations, information regarding residential beds, recent petitions and comments, and other distributed information. Stephen Nuckolls spoke to the focus by the prior Hospice Task Force on inpatient bed development in the state. In response to an inquiry about what may effect inpatient bed development, Helen Alexander, resource person from the Certificate of Need (CON) Section, spoke to the review of CON applications for inpatient hospice beds and the need for applicants to demonstrate the need for the beds being requested even if there is a need determination in the State Medical Facilities Plan. She also noted that there have been some delays related to the need to raise capital for project development as well as delays related to the appeal of CON decisions. It was also noted that there have been need determinations for which no CON applications were received. Tim Rogers spoke in support of inpatient bed development in the state and indicated that his Association has encouraged applicants to have pre-application conferences with the CON Section. Mr. Brunnick indicated that the number of beds identified as needed may be marginal and it may be a viability question. Ms. Alexander noted the use of eight percent days of care for inpatient need determinations compared to 3.3 percent as noted by Ms. Person. She also noted that some inpatient CON reviews have been competitive. Lynn Hardy noted that she felt that

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	inpatient bed availability provides access to hospice care that people would not otherwise have had and that it is reaching another population that may not have accessed hospice.
Identification/Discussion of Issues	Dr. Pulliam asked members, resource people and guests to identify issues. A brainstorming session ensued for approximately 40 minutes. Issues and questions were identified and recorded. It was noted that the items would be included in a list compiled by Mr. Cogley and the list would be mailed with the next meeting's materials.
Initiation of Outlined for Development of Recommendations	Dr. Pulliam asked the members to think about the issues and how to prioritize them. He also indicated that he thought a fourth meeting should be scheduled and, if it were not needed, it could be cancelled. Mr. Cogley will survey members regarding available dates. Mr. Cogley asked members to think about the data source and the calculation that would need to occur with regard to priority issues.
Adjournment	Dr. Pulliam thanked everyone present and adjourned the meeting.