Healthcare Planning
and
Certificate of Need Section

Long-Term and Behavioral Health Committee Minutes - DRAFT

April 10, 2015
10:00 – 12:00 p.m.
Brown Bldg. Room 104

MEMBERS PRESENT: Dr. T.J. Pulliam, Chair;, Peter Brunnick, Stephen DeBiasi, Denise Michaud, Dr. Christopher Ullrich
MEMBERS ABSENT: Don Beaver, Dr. Jaylan Parikh
Medical Facilities Planning Staff Present: Elizabeth Brown, Paige Bennett, Amy Craddock, Tom Dickson
DHSR Staff Present: Drexdal Pratt, Shelley Carraway, Martha Frisone, Lisa Pittman, Celia Inman, Mike McKillip
AG's Office: Derrick Hunter, Jill Bryan

Agenda Items	Discussion/Action	Motion/ Seconded	Recommendations/ Actions
Welcome & Announcements	Dr. Pulliam welcomed members, staff and guests to the first Long-Term and Behavioral Health (LTBH) Committee meeting of 2015. He stated that the purpose of this meeting was to review the policies, methodologies and petitions requesting changes in basic policies and methodologies for the Proposed 2016 Plan (SMFP), review and vote on one petition. Dr. Pulliam stated the meeting was open to the public, but deliberations and recommendations were limited to the members of the LTBH Committee and staff, in order to respect the process of the State Health Coordinating Council (SHCC). Dr. Pulliam asked the committee members and staff seated at the table to introduce themselves.		
Review of Executive Order No. 46: Ethical Standards for the State Health Coordinating Council	Dr. Pulliam gave an overview of the procedures to observe before taking action at the meeting. Dr. Pulliam inquired if anyone had conflicts or if there items or matters on the agenda, they wished to declare that they would derive a benefit from or intended to recuse themselves from voting on the matter. Dr.		

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	Pulliam asked members to review the agenda and declare any conflicts. Mr. Brunnick recused from voting on The Association for Home & Hospice Care of North Carolina and The Carolinas Center for Hospice and End of Life Care petition. Dr. Pulliam stated that if a conflict of interest, not on the agenda, came up during the meeting that the member with the conflict would make a declaration of the conflict.		
Approval of September 16, 2014 Minutes	A motion was made and seconded to accept the September 16, 2014 LTBH Committee meeting minutes.	Ms. Michaud Mr. Burgin	Minutes approved
Hospice Services - Chapter 13	**Policies and Need Methodology Review** Ms. Brown stated there were no Polices Applicable to Hospice Services. Ms. Brown stated the data sources used with the hospice standard methodology for the Proposed 2016 State Medical Facilities Plan will be: • Total reported hospice patient deaths, admissions, days of care and licensed offices by county data are compiled from Hospice Agency 2015 Annual Data Supplement to Licensure Application; • Deaths and death rates are obtained from the State Center for Health Statistics ("Selected Vital statistic for 2013 and 2009-2013, Volume 1"); and • Estimates and projections of population are obtained from the North Carolina Office of State Budget and Management. • Estimated active duty military population numbers will be excluded from the 18-64 age group for any county with more than 500 active duty military personnel. We will obtain those estimates from the American Community Survey 2013 5-year Estimate. **Standard Methodology** **Hospice Home Care [Steps 1-14] (p. 317-318)** A brief summary of the standard methodology used to project need for new hospice home care offices…		

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	• The hospice home care standard methodology uses county mortality rates for the most recent five years as the basis for hospice patient need projection. A two-year trailing average growth rate in statewide number of deaths served is used over the previous three years. This projects changes in the capacity of existing agencies to serve deaths from each county by the target year. Median projected hospice deaths is done by applying the projected statewide median percent of deaths served by hospice to projected deaths in each county. An additional home care office is needed if the county's deficit is 90 or more and the number of licensed offices in the county per 100,000 is 3 or less. **Hospice Inpatient Beds [Steps 1-12] (p. 319-320)** To briefly summarize the standard methodology used to project need for new hospices inpatient beds: • The methodology uses total projected admissions, statewide median average length of stay per admission and each county's average length of stay per admission and each county's average length of stay per admission for projecting estimated inpatient days for each county. Similar to the hospice home care methodology, previous years' data is used, so a two-year trailing average growth rate in statewide hospice admissions is done over the previous three years. Six percent of the total estimated days of care in each county is used as a basis for estimating days of care in licensed inpatient hospice facility beds. **Hospice Residential Beds (p. 316)** There is no need methodology for hospice residential beds. ***Ms. Brown stated this concluded the review of the standard methodologies used in Chapter 13, Hospice Services.*** **<u>Petition 1: Request to Modify the Hospice Inpatient Bed Need Methodology</u>** ***<u>Request</u>:*** The Association for Home & Hospice Care of North Carolina and The Carolinas Center for Hospice and End of Life Care petitioned to modify the		

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	hospice inpatient bed need methodology by changing Step 7 of the hospice inpatient bed need methodology to reflect a two-year trailing average statewide inpatient utilization rate, rather than the static six percent in the current methodology. ***Analysis:*** The petition suggest modifying Step 7 of the hospice inpatient bed methodology to reflect a two-year trailing average statewide inpatient utilizing rate using statewide inpatient days of care. Step 7 of the current standard hospice inpatient bed methodology uses a static 6 percent to project hospice days of care and inpatient days of care for each county. The petition identifies national and statewide trends in hospice utilization as reasons for modifying the hospice inpatient bed need methodology. Data provided in the petition states, "inpatient days of care represented approximately 3.98 percent of total hospice days in North Carolina." While the Agency was not able to match the figures presented in the petition, we were able to verify a statewide hospice inpatient utilization rate lower than 6 percent consistently for the last five years. Table 2 in the agency report shows statewide inpatient percent of total days range from 3.44 percent in 2011 SMFP to 4.16 percent in 2015 SMFP. Furthermore, the petition states a two-year trailing average more accurately reflects industry trends as they happen. At the time, 6 percent was the most appropriate figure to use, but it is no longer supported by the data. By using the most current , updated data, the agency calculated a two-year trailing average rate of 4.023 percent as seen in Table 3 in the agency report. ***Recommendation:*** The Agency recommends the petition be approved given available information and comments submitted by the March 20, 2015 deadline date for comments on petitions and comments. However, this recommendation comes with the following caveats: 1) The Long-Term and Behavioral Health Committee will review the hospice methodology in 2 years (Proposed 2018 Plan) with input		

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	from all affected parties to determine if the recommended change to Step 7 of the hospice inpatient bed methodology is producing the intend effect; and 2) This suggested change in methodology requires different data to be pulled from other data fields then the current methodology on the license renewal data supplement. Therefore, in order to improve data integrity the Division of Health Service Regulation requests that The Association of Home Health and Hospice of North Carolina along with The Carolinas Center for Hospice and End of Life of Care work with the Healthcare Planning staff to educate hospice providers on accurately and fully completing Hospice Annual Data Supplements to Licensure Renewal Applications. **Committee Recommendations** A motion was made and seconded to approve the petition. Dr. Pulliam asked the petitioner if they had any comments regarding the petition and Tim Rogers and Carol Meyer spoke. Mr. Rogers stated a diverse group of large and small Hospice meet that had hospice inpatient units and some that did not have hospice inpatient units, but in the future might have inpatient units. Mr. Rogers stated the two Associations worked hand in hand together with petitioners present and reached a 100% unanimous decision on all parties after a 9-10 month process. A vote was taken to recommend acceptance of hospice services assumptions and methodologies and to advance years by one for inclusion in the Proposed 2016 SMFP.	Ms. Michaud Mr. Burgin	Motion approved Unanimous
Nursing Care Facilities - Chapter 10	**Policies and Need Methodology Review** Ms. Bennett provided the following report: **<u>Nursing Care Facilities, Relevant Policies- Chapter 4</u>** o There are eight policies in Chapter 4 related to Nursing Homes. They can be found on pages 25-30. • **NH-1: Provision of Hospital-Based Nursing Care** o This policy allows a hospital to convert up to 10 beds from its licensed acute care bed capacity for use as hospital-based nursing care beds without regard to need determinations in Chapter 10 of the SMFP.		

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	○ Conversion is contingent on two criteria: ▪ The hospital is in a rural area ▪ It is a small (<150 bed) facility • **NH-2: Plan Exemption for Continuing Care Retirement Communities** ○ This policy allows qualified continuing care retirement communities to include, from the outset, or add or convert bed capacity for nursing care without regard to the nursing care bed need shown in Chapter 10. ○ The purpose of this exemption is to meet the needs of residents who have signed continuing care contracts. • **NH-3: Determination of Need for Additional Nursing Care Beds in Single Provider Counties** ○ This policy allows a nursing care facility with fewer than 80 nursing care beds to apply for a CON for additional beds in order to bring the minimum number of beds in the county to no more than 80 without regard to need determinations in Chapter 10 when that facility is the on nursing care facility in the county. • **NH-4: Relocation of Certain Nursing Facility Beds** ○ This policy sets criteria for relocating existing licensed nursing facility beds to another county when the facility is supported by and directly affiliated with a particular religion. • **NH-5: Transfer of Nursing Facility Beds from State Psychiatric Hospital Nursing Facilities to Community Facilities** ○ This policy sets criteria for the transfer of state psychiatric hospital nursing beds to community nursing facilities, provided that services are available in the communities receiving the beds. • **NH-6: Relocation of Nursing Facility Beds** ○ This policy sets conditions for relocating nursing facility beds to contiguous counties served by the facility in order to avoid a deficit in the county losing beds and a surplus in the county gaining beds.		

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	○ However, there were some proposed wording edits to provide clarification to this and two other similar policies in two other chapters. Ms. Bennett presented the changes but Dr. Pulliam requested a vote on these changes after all three were presented. • **NH-7: Transfer of Continuing Care Retirement Community Beds** ○ This policy sets criteria for the transfer of CCRC beds without regard to nursing bed need determinations in Chapter 10. • **NH-8: Innovation in Nursing Facility Design** ○ This policy mandates that new nursing facilities applying for a CON, along with those facilities requesting expansion or renovation, pursue approaches, practices and designs that address quality of care and quality of life needs of the residents. A motion was made and seconded to recommend acceptance of new proposed language in NH-6. **<u>Adult Care Home Facilities, Relevant Policies- Chapter 4</u>** ○ There are two policies in Chapter 4 related to Adult Care Homes. These policies are found on pages 31-32. • **LTC-1: Plan Exemption for Continuing Care Retirement Communities- Adult Care Home Beds** ○ This policy sets criteria for adding or converting adult care beds in CCRC's without regard for need determinations in Chapter 11. ○ The policy also provides an exclusion from the SMFP inventory for 50% of the adult care beds in CCRC's developed under this policy. • **LTC-2: Relocation of Adult Care Home Beds** ○ This policy sets conditions for relocating adult care home beds to contiguous counties served by the facility in order to avoid a deficit in the county losing beds and a surplus in the county gaining beds.	Mr. Burgin Ms. Michaud	

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	◦ However, were some proposed wording edits to provide clarification to this and two other similar policies in two other chapters. Ms. Bennett presented these changes, but Dr. Pulliam requested a vote on the changes after all three have been presented. A motion was made and seconded to recommend acceptance of new proposed language in LTC-2.	Mr. Jakusz Mr. DeBiasi	
	• Description of methodology used is found on pages 189-191 of 2015 SMFP. • The proximate determinant of nursing home utilization is the age of the population. • Steps: ◦ Currently, each of North Carolina's 100 counties is considered a separate service area when determining NH utilization. ◦ Need is determined by calculating the statewide five-year average use rate per 1,000 population for each of four age groups based on data from annual license renewal applications. ◦ These use rates, or "beds per 1,000 population," are applied to the projected population going forward three years for each service area. ◦ The amount of need per service area is then established based on the size of the service area's projected surplus or deficit when the projected utilization is compared to the inventory of existing and approved beds. ◦ Page 191 details how deficit size is used to determine the county's bed need.		
	A motion was made and seconded to recommend acceptance of nursing care facilities policies, assumptions and methodology and advancing years by one for inclusion in the Proposed 2016 SMFP.	Mr. Burgin Ms. Michaud	Motion approved

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Adult Care Homes - Chapter 11	**Policies and Need Methodology Review** • Description of methodology used is found on pages 215-217 of 2015 SMFP. • The proximate determinant of adult care home utilization is the age of the population. • Steps: o Currently, each of North Carolina's 100 counties is considered a separate service area when determining ACH utilization. o Need is determined by calculating the statewide five-year average use rate per 1,000 population for each of five age groups based on data from annual license renewal applications. o These use rates, or "beds per 1,000 population," are applied to the projected population going forward three years for each service area. o The amount of need per service area is then established based on the size of the service area's projected surplus or deficit when the projected utilization is compared to the inventory of existing and approved beds. o Page 217 details how deficit size is used to determine the county's bed need. **Committee Recommendations** A motion was made and seconded to recommend acceptance of adult care homes policies, assumptions and methodology and to advance years by one for inclusion in the Proposed 2016 SMFP.	Mr. Jakusz Mr. DeBiasi	Motion approved
Medicare Certified Home Health Services - Chapter 12	**Policies and Need Methodology Review** Ms. Brown noted there was one policy related to Chapter 12; located in Chapter 4 of the 2015 SMFP. Policy HH-3: Need Determination for Medicare-Certified Home Health Agency in a County. Ms. Brown noted the data sources used with the home health standard methodology for the Proposed 2016 State Medical Facilities Plan will be:		

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	• patient origin data compiled from Home Health Agency 2014 Annual Data Supplement to Licensure Application; and • County population projections by age group (for 2016) obtained from the North Carolina Office of State Budget and Management. **Committee Recommendations** A motion was made and seconded to recommend acceptance of home health services policy, assumptions and methodology and to advance years by one for inclusion in the Proposed 2016 SMFP.	Ms. Michaud Mr. Jakusz	Motion approved
End-Stage Renal Disease Dialysis Facilities - Chapter 14	**Policies and Need Methodology Review** Ms. Brown noted there was one policy related to Chapter 14; located in Chapter 4 of the 2015 SMFP. **Policy ESRD-2: Relocation of Dialysis Stations** ** Proposed Revised Language – handouts were provided* *This policy notes that stations can be relocated within the host county, but adds that stations can only go across county lines to "contiguous" counties. Even then, the relocation must not create a "surplus" in the receiving county or a "deficit" in the donor county.* A motion was made and seconded to recommend acceptance of new proposed language in ESRD-2. **The data sources used with the home health standard methodology are…** • Data on the current number of dialysis facilities and stations is obtained from the Certificate of Need Section and from the Acute Care Licensure and Certification Section. • Data on the dialysis population by county and by facility is provided by End-Stage Renal Disease providers operating certified dialysis facilities to the Division of Health Services Regulation, Medical Facilities Planning Branch. **Standard Methodology (p. 363-366)**	Mr. Burgin Mr. Jakusz	

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	Provide a short summary of the standard methodology used to project need for new dialysis stations. The need for new dialysis stations is determined two times each calendar year. Determinations are made available in the North Carolina Semiannual Dialysis Report (SDR). • **County Need:** Is based on all residents of North Carolina, regardless of where they are currently receiving services. Future patient counts are projected for 6 to 12 months into the future based on a five-year trend line. Need is based on 80 percent utilization of existing stations, at 3.2 patients per station. The threshold for need is a projected deficit of 10 stations. • **Facility Need:** is a permissive methodology, which allows an existing provider located in a county where the projected County Need is zero, to apply for additional stations if that facility is operating at or above 80 percent utilization and feels it needs additional capacity. (Because patients can chose to cross county lines, this allows a facility in "high demand" to apply for expansion even if the host county has sufficient stations based on local county residents.) **Petitions and Comments** No petitions or comments were received regarding this chapter. **Committee Recommendations** A motion was made and seconded to recommend acceptance of End-Stage Renal Disease dialysis policies, assumptions and methodology and the suggested language to advance years by one for inclusion in the Proposed 2016 SMFP.	Mr. DeBiasi Mr. Jakusz	Motion approved
Psychiatric Inpatient Services - Chapter 15	**Policies and Need Methodology Review** **MH-1. Linkages between treatment Settings -- Applies to Chapters 15, 16, and 17** CON applicant shall document that the affected LME-MCO has been contacted and invited to comment on proposed services described in the CON application.		

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	<u>1 Policy applies specifically to Chapter 15</u> **PSY-1. Transfer of Beds from State Psychiatric Hospitals to Community Facilities** Beds may be relocated from state facilities through CON process, provided services and programs shall be available in the community. Beds transferred from state facilities shall be closed within 90 days after the date that the community beds become operational. CON applicants must commit to serve the type of short-term patients normally placed in the state facility beds. To help ensure that this occurs, there must be a written MOA between LME-MCO, Secretary of DHHS, and the CON applicant. **<u>Proposed Clarification of Methodology</u>** **Dr. Craddock provided a handout of the revised language.** This proposed clarification applies to both Chapters 15 and 16. It it proposed to clarify an anomaly in the methodologies in these 2 chapters. Under the current methodologies for Chapters 15 and 16, a bed need determination from the previous SMFP for which no CONs were issued will be included in the bed need for the current SMFP, even though it is not an additional need. This calculation makes it look like there is a new need that can be added to the prior year need when applying for a CON, and this is not the case. When a CON is issued based on the prior year's after the current SMFP has gone to the Governor, the Agency must issue a special memorandum explaining that the bed need in the current Plan has been reduced by the number of beds approved in the CON. This anomaly arises because the methodologies have no explicit definition of the "planning inventory" – although they use the word "planning inventory. A clarification to the text in Chapters 15 and 16 would eliminate the need for a special memorandum, thereby reducing potential confusion for people wishing to apply for a CON. In addition, the proposed clarification would make the application of the methodologies in Chapters 15 and 16 consistent with other chapters in how they account for prior year bed need determinations for which no CONs were issued. Proposed is a definition identical to those in Chapters 10 and 11, and consistent with other chapters:		

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	The planning inventory is determined based on licensed beds, adjusted for CON-Approved/License Pending beds and beds available in prior Plans that have not been CON-approved. If this clarification is approved, no change is necessary to any of the tables in Chapter 15. **Committee Recommendations** A motion was made and seconded to recommend acceptance of psychiatric inpatient services policies, assumptions and methodology to advance years by one for inclusion in the Proposed 2016 SMFP.	Mr. Burgin Ms. Michaud	Motion approved
Substance Abuse/Chemical Dependency - Chapter 16	**Policies and Need Methodology Review** Dr. Craddock provided the following report: **<u>Policies</u>** MH-1. Dr. Craddock noted that this policy, previously discussed, refers to Chapter 16. No policies specific to Chapter 16. **<u>Methodology</u>** Dr. Craddock provided a presentation regarding the methodology. **<u>Proposed Clarification of Methodology</u>** Virtually the same situation as described for Chapter 15 occurs in Chapter 16. It is proposed that a statement should be added to clearly define the planning inventory. ***The planning inventory is determined based on licensed beds, adjusted for CON-Approved/License Pending beds and beds available in prior Plans that have not been CON-approved.*** To implement this clarifiation, a column needs to be added to each section of Table 16A (for total beds, adult beds, and child/adolescent beds) to account for this new information. In addition, the recommendation was made to remove columns from the "Detox Only" bed inventory that referr to "Total Licensed + CON," "CON Not Yet Licensed," and "Beds under Review," and only report		

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	the number of "Total Licensed Beds." As of 2003, detox only beds do not require a CON. The last CON for a detox only bed was resolved in 2009, but these columns had never been removed from the table. **Committee Recommendations** A motion was made and seconded to recommend acceptance of substance abuse/ chemical dependency policy, assumptions and methodology to advance years by one for inclusion in the Proposed 2016 SMFP.	Mr. DiBiasi Ms. Michaud	Motion approved
Intermediate Care Facilities Chapter 17	**Policies and Need Methodology Review** Dr. Craddock provided the following report: **ICF/IID-1: Transfer of Beds of State Operated Developmental Centers to Community Facilities for Medically Fragile Children** Beds in state operated development centers may be relocated to community facilities via the CON process to serve children age birth through six years who have severe to profound developmental/intellectual disabilities and are medically fragile. Pertains to transfer of beds only, not patients. Once licensed in the community, the state operated beds shall be closed. **ICF/IID-2: Transfer of Beds of State Operated Developmental Centers to Community Facilities for Individuals Who Currently Occupy the Beds** Existing beds in state facilities may be transferred via the CON process to establish group homes in the community to serve people with complex behavioral challenges and/or medical conditions for whom such a community placement is appropriate. Once licensed in the community, the state operated beds shall be closed. Applicants must demonstrate their clinical experiences in serving the target population. To ensure that beds will be used to serve these individuals, a written agreement is required among the following: LME-MCO where group home is to be located, director of NC Division of State Operated Facilities, Secretary DHHS, and operator of group home.		

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	ICF/IID-3: Transfer of Beds of State Operated Developmental Centers to Community Facilities for Adults with Severe to Profound Developmental Disabilities Existing ICF/IID beds in state facilities may be transferred to the community via the CON process to replace Community Alternatives Program for Individuals with Intellectual and Developmental Disabilities (CAP I/DD) waiver slots lost as a result of the Centers for Medicaid and Medicare Services (CMS) policy designed to prohibit CAP I/DD waiver and ICF/IID beds from being located on the same campus. This policy applies to transfer of beds only, not patients. Once licensed in the community, the state operated beds shall be closed. Further, the policy applies only to facilities that have lost waiver slots as a result of this CMS policy. CON applicants must demonstrate commitment to serve adults who have severe to profound intellectual/developmental disabilities. **Methodology** Beds are created in ICF/IID facilities by issuance of a CON to transfer beds from State Operated developmental centers. There is no specific calculation of bed need for ICF/IID facilities (as is done in most other chapters). Information gathered from surrounding states (with CON process) indicates that NC has a more than adequate number of ICF/IID beds to meet the need. **Committee Recommendations** A motion was made and seconded to recommend acceptance of intermediate care facilities policies, assumptions and methodology to advance years by one for inclusion in the Proposed 2016 SMFP.	Ms. Michaud Mr. Burgin	Motion approved
Other Business	Dr. Pulliam noted the next Committee meeting is May 1st and the SHCC meeting is June 3rd. He then thanked the members and staff.		
Adjournment	Dr. Pulliam adjourned the meeting.		