Long Term and Behavioral Health Committee
Agency Report
Petition to Modify the
Hospice Inpatient Bed Need Methodology
Proposed 2015 State Medical Facilities Plan

Petitioner:
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Contact:
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Request:
The petition, "requests that the Hospice Inpatient Bed methodology be changed such that the projected days of care for inpatient estimates are determined using the county *average length of stay*, (ALOS)," instead of the lower of the statewide median ALOS or the ALOS for each county *(Step 6c in the Hospice Inpatient Beds methodology).*

Background Information:
Chapter 2 of the State Medical Facilities Plan (SMFP) allows petitioners early each calendar year to recommend changes that may have a statewide effect. According to the Plan, "Changes with the potential for a statewide effect are the addition, deletion and revision of policies and revision of projection methodologies." The change recommended by the petitioner is a methodology revision that would have a statewide effect.

Historical documentation shows in 2009, a Hospice Methodology Task Force met several times to review, discuss and evaluate the effectiveness of the hospice inpatient bed need methodology.

A small sub-group explored several methodology changes including:

- Use of hospice admissions as basis for methodology;
- add growth in number of admissions; and
- add growth in penetration rate.

The group discovered that the addition of growth in the number of admissions would have the same effect as the growth in penetration rate, and therefore only evaluated the growth

in the number of admissions as it was consistent with the use of admissions as the basis for the methodology.

Also, the group looked at adjusting average length of stay, (ALOS), to be the lower of the statewide median ALOS or the ALOS for each county.

The group concluded that using hospice admissions as the basis for the inpatient methodology allows for adjustments to counties with higher ALOS, which may be significantly outside the norm and create need determinations where need does not actually exist, and is preferable to using hospice deaths as it includes non-death discharges and readmissions.

The inclusion of growth in number of admissions was determined to effectively address the potential for inpatient bed need to grow over time and maintains consistency with the proposed home care office methodology.

Also, the group determined that counties with higher ALOS should be adjusted to reflect the statewide median ALOS but that counties with lower ALOS should not be adjusted up to the statewide median. Therefore, the methodology uses the lower of the statewide median ALOS or the ALOS for each county.

The Task Force presented the Long-Term and Behavioral Health Committee with recommendations to modify the hospice inpatient bed methodology. The Committee accepted the recommendations which were subsequently approved by the State Health Coordinating Council (SHCC) for inclusion in the NC 2010 SMFP.

The hospice inpatient bed methodology was modified to utilize projected hospice days of care. This is calculated by multiplying projected hospice admissions by the lower of either the statewide median ALOS or the actual ALOS for each county. This assignment reduces the inclusion of days of care that may not be appropriate for an inpatient facility. Projected hospice admissions are determined by the application of the two-year trailing average growth rate in the number of admissions served to current admissions. According to a basic assumption, “six percent of total estimated days of care in each county is used as a basis for estimating days of care in licensed inpatient hospice facility beds”.

The hospice inpatient methodology projects inpatient beds based on 85% occupancy and, adjusts projected beds for occupancy rates of existing facilities that are not at 85% occupancy.

A hospice inpatient facility bed’s service area is the hospice inpatient facility bed planning area in which the bed is located. Each of the 100 counties in the state is a separate hospice inpatient facility bed planning area.

Analysis/Implications:
The petition provides a general rationale for this change inferring, "the current methodology is flawed in that step 6c…removes from the methodology calculation an actual county ALOS figure and replaces it with a lower statewide ALOS figure..." The petition further states that, "…there is no reason why the methodology should ignore the actual county experience and replace the actual data with a lower statewide number."

However, when the 2009 Hospice Methodology Task Force sub-group presented recommendations for changes to the Hospice Inpatient Bed methodology to the LTBH Committee and the SHCC for adoption in the 2010 Plan, the group specifically mentioned that they evaluated adjusting ALOS to be the lower of the statewide median ALOS or the ALOS for each county. "Our group determined that counties with higher ALOS should be adjusted to reflect the statewide median ALOS but that counties with lower ALOS should not be adjusted up to the statewide median."

Therefore, the current methodology uses the lower of the statewide median ALOS or the ALOS for each county.

The petition indicates when a county's actual ALOS is replaced by the statewide ALOS in the methodology, county need determinations are suppressed. This according to the petition, "leads to an artificially depressed need showing which hurts the providers and consumers who would otherwise be in a position to apply for, develop and utilize additional Hospice Inpatient beds."

Exhibit 1 shows the results of the proposed revision to the Hospice Inpatient Bed methodology, (Step 6c) as applied to hospice data from SMFP 2012 –SMFP 2014. As the petition stated, hospice inpatient bed need determinations, in general, did increase.

However, in looking at applying the basic principles of safety, access and value, this on average may increase access but it may not provide value to the citizens of North Carolina.

A review of hospice inpatient facility occupancy rates for the same time period (SMFP 2012-SMFP 2014) revealed a decreasing trend among hospice facilities that are operating at or above 85% occupancy in the state. (85% occupancy is the benchmark figure used to determine financial viability for operating a hospice inpatient facility.) In the 2012 Plan 20 of 34 hospice facilities (59%) in the state were operating at 85% or higher occupancy. In the 2013 Plan, 17 of 37 hospice facilities (46%) in the state were operating at 85% or higher occupancy. In the 2014 Plan, only 13 of 40 (33%) were operating at or above 85% occupancy (Exhibit 2).

Revising the current methodology such that would result in additional inpatient hospice beds at a time when the industry is concerned about the financial viability of existing providers and looking at ways to continue to support and maintain current inventory does not meet the SHCC's basic principle of value.

The petition has not provided sufficient data to document that the current methodology is ineffective. There is a lack of justification in the petition for the requested change.

Comments received from two state associations representing North Carolina hospice care providers, the Association for Home & Hospice Care of North Carolina and the Carolinas Center for Hospice and End of Life Care and a hospice provider, Hospice of Wake County indicate the groups are working collaboratively in 2014 to form an internal hospice workgroup to review the current hospice inpatient bed need methodology and therefore, they are opposed to the requested change to the hospice inpatient bed need methodology as proposed in this petition.

Agency Recommendation:

The Agency supports the current approach to calculating projected hospice inpatient bed need for the purposes of the Proposed 2015 Plan. Given available information and comments submitted by the March 21, 2014 deadline date for comments on petitions and comments, the Agency recommends that this petition be denied based on the data trends, increasing the hospice inpatient bed inventory may not be financially sustainable in the current and future marketplace.

EXHIBIT 1

2014 SMFP
Hospice Inpatient Beds Need Determination

County	Current Methodology	Proposed Revision to Step 6c in Methodology
Craven	8	8
Guilford	16	26
Lee	7	7
Nash	6	6
New Hanover	0	7
Onslow	7	6
	44	60

2013 SMFP
Hospice Inpatient Beds Need Determination

County	Current Methodology	Proposed Revision to Step 6c in Methodology
Beaufort	0	6
Brunswick	0	6
Chatham	6	7
Craven	8	11
Lenoir	0	7
Lincoln	6	8
McDowell	6	8
Mecklenburg	6	6
Nash	7	9
New Hanover	0	7
Onslow	7	7
	46	82

2012 SMFP
Hospice Inpatient Beds Need Determination

County	Current Methodology	Proposed Revision to Step 6c in Methodology
Beaufort	0	6
Chatham	0	7
Lenoir	0	6
Lincoln	0	7
Mecklenburg	7	7
Nash	6	6
Sampson	0	6
	13	45

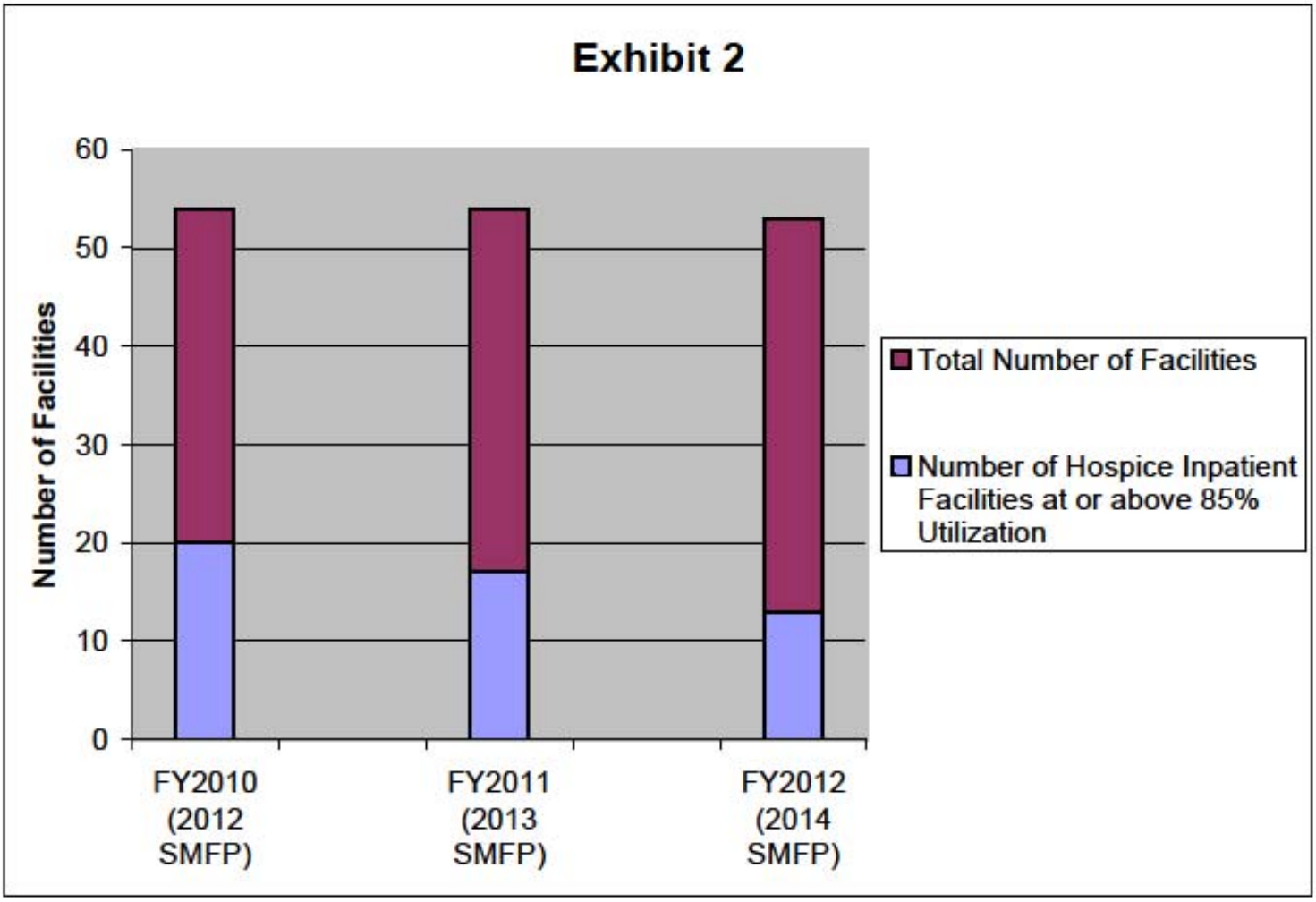
Exhibit 2
Number of Facilities
60
50
40
30
20
10
0
FY2010 (2012 SMFP)
FY2011 (2013 SMFP)
FY2012 (2014 SMFP)
Total Number of Facilities
Number of Hospice Inpatient Facilities at or above 85% Utilization