PETITION

Petition for Changes to the Home Health Agency Need Methodology

Petitioner

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Summary

Hospice of Wake County, d.b.a. Horizons Home Care, respectfully petitions the State Health Coordinating Council to modify the home health agency need methodology by increasing the deficit threshold for a need determination, and corresponding placeholder, from 275 patients to 325 patients.

Background

2005 State Medical Facilities Plan

On September 23, 2003 based on the recommendation from its Long-Term and Behavioral Health Committee, the State Health Coordinating Council authorized the formation of a Home Health Methodology Task Force to make recommendations for the 2005 State Medical Facilities Plan. The Task Force presented 3 recommendations to the Long-Term and Behavioral Health Committee. The Committee accepted the recommendations which were subsequently approved by the Council. One of the three recommendations approved by the Council was stated as follows in the 2005 SMFP:

> **"The methodology has been revised to raise the deficit threshold for a need determination from 250 patients to 400 patients. This will be re-evaluated for the 2007 State Medical Facilities Plan."**

2009 State Medical Facilities Plan

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. The Task Force presented three recommendations to the Long-Term and Behavioral Health Committee. The Committee accepted the recommendations which were subsequently approved by the Council. for inclusion in the 2009 Plan. 2 of the 3 recommendations approved by the Council were stated as follows in the 2009 SMFP:

> **"Revise the methodology to lower the deficit threshold for a need determination and the "placeholder" adjustment for a new agency from 400 patients to 275; and**
> **The Task Force's third recommendation was that the need determination threshold be reviewed again in five years. The Committee recommended and the Council approved that the threshold be reviewed again in three years rather than five years."**

Given the history of revising the deficit threshold every 3 to 4 years, now is the time to re-evaluate the threshold for the 2013 Plan, particularly with changes in health care and increased financial pressures on home health agencies. A modest update to the deficit threshold is the only change to the methodology recommended in this petition.

Requested Change

Horizons Home Care requests that the State Health Coordinating Council raise the deficit threshold, and corresponding placeholder, for a new home health agency from 275 patients to 325 patients. We believe this a reasonable and necessary adjustment that protects the basic principals of safety and quality, access to health care services and value per health care dollar expended.

There are two compelling reasons for increasing the deficit threshold that take into account changes to the financial viability of new or existing home health providers and ensuring access to high quality home health providers that can meet the needs of a growing population.

Financial Viability

1) According to the National Association for Home Care and Hospice, 35.1% of all home health agencies in NC will have a negative profit margin in 2012. This is the result of Medicare and Medicaid reimbursement cuts coupled with increased costs associated with the administrative burden of complex regulations, quality reporting requirements and increased compliance audits.

The number of home health agencies at risk of annual deficits will continue to increase over the next 5 years. The Centers for Medicare and Medicaid Services (CMS) has issued rules that cut home health payment rates by over 16% from 2008 through 2013. In addition to these scheduled rate cuts, the Patient Protection and Affordable Care Act mandates additional "productivity cuts" to home health rates that will start in 2015. The National Association for Home Care and Hospice estimates that the productivity adjustment will be an additional 1% reduction to the home health market basket update each year.

2) The cost of operating a home health agency has increased due to face to face requirements, therapy functional reassessments, inclusion of all non-covered services and supplies on claims, physician signature and date requirements, revalidation, PECOS, and intensive oversight from MAC reviews and ZPIC, CERT, PERM, RAC and MIC audits.

3) The CMS capitalization requirement for a new home health agency before the new agency can bill Medicare has created a significant cash burden for start up home health offices. New home health facilities must maintain 3 months operating cash on hand throughout the first year of operation. Capitalization requirements are imposed in addition to start up costs and create pressure on start up facilities to achieve a profit sooner in order to recoup the higher capital investment.

Based on average home health revenue per patient and standard costs of operating a start-up home health office, 275 patients is not a viable number or critical mass to break even financially and will result in deficits year over year. 325 patients are required to fund the direct and indirect costs associated with operating a viable home health facility and provide a modest profit margin to recoup the capitalization and start up cash requirements over a 3 year period.

Access to High Quality Home Health Care

One of the reasons cited by the 2007 Home Health Task Force for reducing the deficit threshold from 400 patients to 275 patients was that the 400 patient deficit target set the bar too high for need determinations to be identified in the plan. That may have been true 5 years ago, however, in 2012, we believe the 275 patient deficit target sets the bar too low.

When an agency starts a new home health facility in a county they risk their financial viability and the financial viability of all the existing providers in the county when there is not adequate patient need to sustain the new and existing agencies.

When there is an insufficient unmet need, the entrance of a new home health facility within a county drives up the cost for all home health providers by pushing up wages and recruitment costs and the costs associated with competing for the same patients. As mentioned above, operating costs for home health providers is increasing due to new regulations and audits. **As costs increase and reimbursements decline, quality of care will suffer and the value of the healthcare expenditures is eroded. Smaller providers within a region are already in financial risk and will be forced to close if a new facility opens without an adequate level of new patient demand.**

For the past several years the Medicare Payment Advisory Commission (MedPAC) has stated in their annual reports to Congress that the supply of home health providers and access to home health services is high, and supply does not present a problem in any region of the country. In the 2012 SMFP, Table 12A: Home Health Data by County of Patient Origin, every county in North Carolina except three lists at least 1 home health agency based in the county. Within the three counties that do not have a home health facility listed in the county Graham lists 3 agencies from nearby counties, Granville lists 17 agencies from nearby counties and Swain lists 1 agency from a nearby county serving their population. On average, smaller population counties have 2 to 3 agencies based in the county and large population counties have 5 to 10 agencies based in the county.

Existing home health facilities in North Carolina consistently outperform growth projections in prior year SMFP's. The 2009 SMFP projected that existing agencies would serve 13,230 patients in 2010. Per the 2010 data in the 2012 SMFP existing agencies served 13,519 patients. This is a positive variance of 2.2%. According to the 2012 SMFP, 212 Medicare-certified home health agencies served 210,839 patients in 2010, an average of 995 patients per agency. The average number of patients served per agency increased 9.5% from 2009 (2011 SMFP).

It should be noted that if the 2012 SMFP had used a 325 patient deficit threshold the needs identified in the plan would have been the same – a need for 2 new agencies in Mecklenburg County and 1 new agency in Wake County.

It should also be noted that counties with smaller populations will never show a need for a new home health agency even at the lower 275 patient threshold, because they have an adequate supply of existing agencies based in the county or in neighboring counties. 2 of the 3 counties listed above that do not have a home health facility listed in their county had a surplus of patients served and the third had a deficit of only 3 patients. Only when agencies begin to close down because of financial difficulty will significant deficits be identified in the plan within smaller population counties.

Conclusion

Given the history of the Long-term and Behavioral Health Committee's precedent and preference for reviewing and adjusting the patient deficit threshold, and corresponding placeholder, every three years, I am requesting that the State Health Coordinating Council consider this petition to increase the patient deficit threshold for establishing a new home health office in a county from 275 patients to 325 patients in the 2013 Plan. The patient deficit threshold was last adjusted in the 2009 Plan, 4 years ago.

The driving factors behind this modest increase are the financial viability of new and existing home health facilities and the potential risk to the future supply, quality and value of home health services available to residents of North Carolina.

Thank you for your consideration.