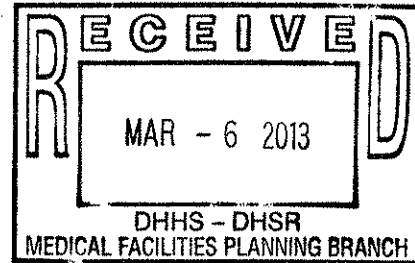


PETITION
March 6, 2013
Petition for Change to the Hospice Inpatient Bed Need Methodology

Petitioner

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Summary

Hospice of Wake County respectfully petitions the State Health Coordinating Council to modify the hospice inpatient bed need methodology by decreasing the inpatient day percent calculation (Step 7 in the Hospice Inpatient Beds methodology) from 6.0% to 3.5%. This update to the percent used for need calculation will bring the percent of hospice inpatient days in alignment with the state and national averages for hospice inpatient days as a percent of total hospice days of care.

Background

2010 State Medical Facilities Plan

In 2008, based on the recommendation of its Long-Term and Behavioral Health Committee, the State Health Coordinating Council authorized the formation of a Hospice Methodologies Task Force to make recommendations for the 2010 State Medical Facilities Plan. The Task Force presented its 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 2010 Plan.

One of the changes approved by the Committee was to reduce the inpatient day percent from 8% to 6%. In 2008 the Hospice Methodologies Task Force analyzed hospice inpatient data from 2007 reports. In 2007 the statewide inpatient days as a percent of total days was 5.7%.

The Task Force also recommended reviewing the hospice methodologies for the 2012 SMFP in order to determine the effect of all of these changes. The Association for Home Health and Hospice Care, the Carolina Center for Hospice and End of Life Care, and hospice provider representatives, including some members from the 2008 methodology task force, have met to review the hospice inpatient bed methodology and are recommending this one change to the methodology calculation in Step 7.

Requested Change:

Hospice of Wake County requests that the State Health Coordinating Council **lower the inpatient day percent used in Step 7 of the Hospice Inpatient Beds methodology from 6% to 3.5%**. We believe this a reasonable and necessary adjustment that protects the basic principles of safety and quality, access to health care services and value per health care dollar expended.

There are three compelling reasons for decreasing the inpatient day percent:

1. trends in state and national utilization of hospice inpatient days
2. changes in the regulations for hospice inpatient care and increased oversight
3. preventing unnecessary duplication of hospice inpatient beds.

Other alternatives, such as maintaining the status quo, were considered. However, this decrease in percentage to account for the changes in hospice inpatient utilization is the most direct and straightforward way of solving the problem in the application of the current methodology addressed below.

1. State and National Trends

Hospice care utilization and payment is measured in patient care days and is broken down by levels of care. Total hospice care days include routine home care days, general inpatient care days (GIP), respite days and continuous care days. For the hospice inpatient bed need methodology, the projected total hospice days of care is multiplied by 6% to project the number of expected inpatient days. The percent used in Step 7 of the methodology calculation is intended to reflect the statewide hospice inpatient utilization. In 2008 the Hospice Methodology Task Force used the most recent hospice utilization data from 2007 to revise the percent from 8% to 6%. In 2007 hospice inpatient days were 5.7% of total hospice days.

According to the table below the most current percent of North Carolina hospice inpatient days is 3.53%. The national inpatient day percent is 2.2%. The North Carolina data are extracted from the respective Division of Health Services Regulation hospice data supplements; the national data is from the National Data Set via The National Hospice and Palliative Care Organization.

Year	Total NC Hospice Days	NC Hospice Inpatient Days	NC GIP % of Total Days	National GIP % of Total Days
2007	2,691,555	152,703	5.67%	3.3%
2008	2,679,298	83,728	3.12%	2.9%
2009	2,657,371	91,646	3.45%	2.9%
2010	2,873,424	99,178	3.45%	2.9%
2011	2,915,218	102,824	3.53%	2.2%

2. Changes to Regulations and Increased Oversight

In 2008 the Centers for Medicare and Medicaid (CMS) published new conditions of participation (COP) for hospice programs. At that time new interpretive guidelines for eligibility for the inpatient level of care (GIP) were published. CMS significantly tightened the GIP eligibility requirements in two ways (42 CFR Part 418, published in the Federal Register June 5, 2008):

- Clarifying in their interpretive guidelines and final rules that caregiver breakdown did not qualify a patient for inpatient care (See FY 2008 hospice wage index 72 FR 50214).
- In its guidance to hospice providers CMS has stated that a hospice patient's imminent death does not automatically mean they meet the clinical guidelines for GIP care. The fact that the patient is actively dying does not necessarily qualify for GIP level of care.

These two clarifications in the rule contributed to the significant decline in GIP days in the table above.

Each year the Office of the Inspector General (OIG) publishes its work plan for health care oversight. In 2012 the OIG identified hospice inpatient utilization as an area of concern.

The combined effect of CMS clarification of the rules for eligibility for hospice inpatient care and increased oversight by CMS and the OIG have caused the utilization of hospice inpatient care to drop from 5.7% to 3.5% in the state and from 3.3% to 2.2% nationally.

By keeping the inpatient level percent of total days at 6% the state medical facilities plan would be encouraging over utilization of the GIP level of care, and could put hospice providers at risk of non-compliance with CMS or disregard for OIG risk factors.

3. Unnecessary Duplication of Hospice Inpatient Beds

Downward trends in hospice inpatient utilization have caused the current methodology assumptions to be obsolete and stimulate unnecessary duplication of hospice inpatient beds in the community. An oversupply of inpatient beds threatens the financial viability of new and existing hospice facilities. Revenue projections for new or existing hospice facilities are based on the projected number of inpatient days. If the inpatient percent factor is inflated the revenue projections will be inflated as well.

6% inpatient utilization projections are not sustainable in the current market and create unrealistic financial expectations for new facilities. In addition, even though the hospice inpatient facility is the preferred setting of care, not all inpatient care can be provided in a

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hospice inpatient facility. A portion of the inpatient days are provided in a hospital or in a nursing home, depending on the preference of the patient and family or the medical judgment of the physician.

An inflated inpatient percent in the current methodology adds unnecessary inpatient beds to the market. This causes lower occupancy rates and financial hardship on the hospice facilities that cannot sustain occupancy rates less than 85%. As facilities face financial pressures they will close down or restrict staffing and restrict admissions. Both scenarios jeopardize patient access to quality hospice inpatient care.

Conclusion

The current hospice inpatient percent of total hospice days, 6 percent, was adjusted in the 2010 SMFP hospice inpatient bed methodology from 8 percent to 6 percent, based on the statewide average inpatient days as a percent of total days at that time (2007 data).

Today the statewide average percent has dropped to 3.5%.

The current inpatient bed methodology does not conform to current inpatient utilization or eligibility standards and will create an unnecessary duplication of inpatient beds that are approved in the plan. This in turn creates financial pressures and non-compliance pressures for hospice facilities to fill the inpatient beds. Hospice facilities that cannot maintain inflated occupancy projections will be forced to close down or reduce staff in the facility, negatively impacting patient access and quality.

Thank you for your consideration.