Recommendations and Related Materials

from the

Long-Term and Behavioral Health Committee

for the

May 28, 2008

State Health Coordinating Council Meeting

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Recommendations to the N. C. State Health Coordinating Council

The Long-Term & Behavioral Health Committee met on May 16, 2008. The Committee considered policies and methodologies for nursing care, adult care homes, home health, hospice services, dialysis facilities, psychiatric inpatient services, substance abuse inpatient and residential services, and intermediate care facilities for the mentally retarded from the 2008 State Medical Facilities Plan; recommendations of the Home Health Task Force; recommendations regarding the in-patient hospice bed need methodology; a petition proposing changes to the home health policy; a petition proposing changes to the hospice home care methodology; and, a proposal regarding Policy PSY-2. From its deliberations, the Long-Term & Behavioral Health Committee makes the following recommendations for consideration by the North Carolina State Health Coordinating Council in preparation of the Proposed 2009 State Medical Facilities Plan.

Recommendations Related to the Nursing Care Facilities Chapter:

Policies related to nursing care facilities begin on page 18 of the 2008 State Medical Facilities Plan and the Nursing Care Facilities Chapter begins on page 155 of the Plan.

The Committee recommends that the current nursing facility policies, assumptions and methodology be accepted for the Proposed 2009 Plan. Also, for the Proposed 2009 Plan, references to dates would be advanced one year.

Combined data from freestanding and hospital-based nursing care facilities were used for development of "use rates per 1000 population." In keeping with the current methodology, use rates were trended forward for thirty months. The resulting "Use rates per 1000 Population" are noted at the bottom of Draft Table 10B (Attachment A). It is noted that the population projections and estimates used in the development of the rates and need projections are subject to change by the Office of State Budget and Management prior to publication of the Proposed 2009 Plan.

The inventory of nursing care beds has been updated to reflect changes in licensure status and exclusions. Application of the draft "Use Rates" to draft population projections for 2012 using the standard methodology would result in one need determination in the State for review during 2009. The need determination would be for 10 beds in Camden County. Refer to Draft Table 10B (Attachment A) for the bed need analysis by county.

Recommendations Related to the Adult Care Homes Chapter:

The policies related to adult care homes are on pages 24-25 of the 2008 State Medical Facilities Plan and the Adult Care Homes Chapter begins on page 179 of the Plan.

The Committee recommends that the current adult care home policies, assumptions and methodology be accepted for the Proposed 2009 Plan. Also, references to dates would be advanced one year, as appropriate.

Five year combined data from freestanding adult care homes and nursing home/hospital-based adult care homes were used for development of "use rates per 1000 population." The resulting draft "Use rates per 1000 Population" are noted at the bottom of Draft Table 11B (Attachment B). It is noted that utilization data and population projections and estimates used in the development of the use rates are subject to change prior to publication of the proposed 2009 Plan.

The inventory of adult care home beds has been updated based on available information to reflect changes in licensure status and exclusions. It is noted that the inventory is subject to further changes. Application of the draft "Use Rates" to draft population projections for 2012 would result in need determinations in four counties for a total of 200 adult care home beds for review during 2009. The counties are: Camden – 20 beds; Cherokee – 80 beds; Dare – 60 beds; and, Gates – 40 beds. Refer to Draft Table 11B (Attachment B) for a bed need analysis by county.

Recommendations Related to the Home Health Services Chapter:

The policy related to Home Health Services is on page 26 of the 2008 SMFP and the Home Health Services Chapter begins on page 213.

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.

A seven member Task Force was formed and met twice. The group included Council member Charles Hauser as Chairman, and Council members Senator Tony Foriest and Jerry Parks. Also represented was Medicare-Certified Home Health, Licensed Home Care (not Medicare-Certified), and the medical community. Timothy Rogers, Council member and Chief Executive Officer of the Association for Home and Hospice Care of North Carolina served as a home health industry expert resource. Resource people were also available representing the Division of Aging and Adult Services, Division of Medical Assistance, and the Division of Health Service Regulation Certificate of Need and Acute and Home Care Licensure and Certification Sections. The meetings were open to and attended by members of the public.

The Task Force presented three recommendations to the Long-Term and Behavioral Health Committee. The recommendations are detailed in the Task Force's report

(Attachment C). Changes to the plan based on the Task Force recommendations are as follows:

1. 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,
2. add an item "d" to item 8 of the Basic Assumptions of the Method to read, "address special needs populations." With the addition of item "d", item 8 would read as follows:

8. The North Carolina State Health Coordinating Council encourages home health applicants to:

   a. provide an expanded scope of services *(including nursing, physical therapy, speech therapy, and home health aide services);*
   b. provide the widest range of treatments within a given service;
   c. have the ability to offer services on a seven days per week basis as required to meet patient needs; and,
   d. address special needs populations.

The Committee recommends acceptance of these recommendations for inclusion in the Proposed 2009 Plan. The Task Force's third recommendation was that the need determination threshold be reviewed again in five years. The Committee recommends that the threshold be reviewed again in three years rather than five years.

The Committee considered a petition from the Granville-Vance District Home Health Agency to amend Home Health Policy HH-3 to allow District Health Department home health agencies to be considered located in each county served regardless of physical location. The Committee recommends that the petition be denied. Attachment D contains the Agency Report and Petition. As noted in the Agency Report on the petition, there would be a need determination in Granville County in the Proposed 2009 Plan based on Policy HH-3. The Committee recommends that the need determination for Granville County be removed from the Proposed 2009 Plan. A statement would be included in the Proposed 2009 Plan indicating that while there would have been a need determination for Granville County based on Policy HH-3, there was an adjusted determination of no new need for a Medicare-Certified Home Health Agency for the Proposed 2009 Plan. It is noted that the Granville-Vance District Home Health Agency office was moved a relatively short distance from its former location, the new site in Vance County is only 3.5 miles from the Granville County line according to the petitioner, 14 Home Health Agencies reported serving patients in Granville County based on 2008 License Renewal Applications and the number of patients reported as having been served increased from last year based on 2007 and 2008 License Renewals.

The Committee recommends that the home health services policy, assumptions and methodology be accepted for the Proposed 2009 Plan with changes as recommend. Also, references to dates would be advanced one year, as appropriate.

Population estimates and projections used in development of rates are subject to change prior to publication of the Proposed 2009 Plan. Application of the standard methodology, as revised, to draft

population projections for 2010 would indicate no need for new Medicare-Certified home health agencies or offices for review during calendar year 2009 anywhere in the State, as shown on draft Table 12C (Attachment E).

Recommendations Related to the Hospice Services Chapter:

The Hospice Services Chapter begins on page 253 of the 2008 Plan.

The Committee considered a petition from the Carolinas Center for Hospice and End of Life requesting a modification of the hospice home care methodology and that a task force be convened to fully evaluate the hospice home care and inpatient bed need methodologies for the 2010 Plan. Attachment F contains for the Agency Report, Petition and Comment. The Committee recommends that the petition be approved in part. It is recommended that a Hospice Methodology Task Force be convened to fully evaluate the hospice home care and hospice inpatient methodologies for the 2010 Plan and that the statewide median be used to project the number of hospice deaths for each county. It is recommended that the proposed modification of the home care methodology regarding application of a three-year compound growth rate to the number of deaths served by existing hospices be denied. Included as a part of the Agency Report (Attachment F) is a modified "Table 13B: Year 2010 Hospice Home Care Office Need Projections for Proposed 2009 Plan," reflecting use of the statewide median rather than the average. With the change and using draft population projections there would be need determinations in six counties for hospice home care offices; namely, Cherokee, Davidson, Johnston, Union, Vance and Wilkes. Without the change in the methodology, there would be need determinations in 16 counties as noted in Attachment G.

The Committee considered recommendations regarding changes in the hospice inpatient methodology for the Proposed 2009 Plan. The recommendations were made as follow-up to the recommendation that was made in 2007 that Agency staff work with the Carolinas Center for Hospice and End of Life Care and the Association for Home and Hospice Care to come up with recommendations for changes in the hospice inpatient methodology. Also, in 2005, the Hospice Methodology Task Force recommended that the use of 8% to estimate inpatient days of care be re-evaluated for the 2009 Plan. The Committee recommends adoption of the following: 1. Keep 8% of total estimated days of care to estimate inpatient days of care; and, 2. Adjust need determinations for counties that have high days of care per 1000 population as was done for the 2008 Plan. The adjustment would be made for counties that have 300% or greater days of care per 1000 population than the State average and also have an inpatient facility that has been licensed since January 1, 2006, or Certificate of Need approved beds, or need determinations in prior plans.

Application of the standard methodology to draft population projections for 2012 would indicate need determinations in eight counties (excluding Columbus County) as shown in the last column of Table 13C (Attachment H). The counties are: Cabarrus – 7 beds; Catawba – 6 beds; Craven – 6 beds; Lincoln – 6 beds; Polk – 6 beds; Randolph – 6 beds; Sampson – 10 beds; and, Stokes – 7 beds.

The Committee considered a comment (Attachment I) from Community Health, Inc. regarding Policy GEN-1 which is in Chapter 4 of the 2008 Plan. The Committee indicated the comment could be considered by the proposed Hospice Methodology Task Force.

The Committee recommends that the hospice services assumptions and methodologies be accepted for the Proposed 2009 Plan with the recommended change to the hospice home care methodology and the adjusted determination regarding hospice inpatient beds. Also, references to dates would be advanced by one year.

Recommendations Related to the End-Stage Renal Disease Dialysis Services Chapter:

The dialysis policy appears on page 26 of the 2008 SMFP. The narrative for the Dialysis Chapter begins on page 293 of that plan.

There were no "carry-over issues" regarding the Dialysis Chapter and no petitions or comments seeking revisions were received this spring. The Committee reviewed the current policy, basic principles, and methodology and recommends no substantive changes for the Proposed 2009 SMFP.

A proposed narrative for the Dialysis Chapter is included in this packet as ***Attachment J***. Data in the "Summary of Dialysis Station Supply and Utilization" have been updated and references to dates have been advanced by one year, as appropriate. As with the 2008 SMFP, the methodology requires Semiannual Dialysis Reports (SDRs) to be issued in January and July of 2009. Because the intent is to publish updated patient information twice each year, projected need determinations are not included in the "Proposed SMFP."

Recommendations Related to the Psychiatric Inpatient Services Chapter:

The methodology used to project need for psychiatric beds focuses on short-term psychiatric beds only, (i.e., those beds used primarily by patients with lengths of stay of 60 days or less). The methodology is based on utilization data obtained from Thomson, a collector of hospital patient discharge information. The data was gathered from all acute care hospitals and specialty psychiatric hospitals. State hospital data are excluded because these hospitals are not subject to the Certificate of Need Law.

The Department of Health and Human Services in January 2008 asked that the Agency to prepare a table (Table 15B, see ***Attachment K***) that would indicate the need for Psychiatric Inpatient Services by Local Management Entities (LME) areas. The methodology was applied individually to the 25 mental health planning area programs. The table produces need determinations by each Mental Health Planning Area, which is the same as the LME areas.

There were no petitions or comments. The Committee recommends that there is a determination of need in the following LME areas for child adolescent psychiatric inpatient beds: 1, 3, 7, 8, 14, 15, 16, 18, 20, and 24. The Committee recommends that there is a determination of need in the following LME areas for adult psychiatric inpatient beds: 1, 8, 14, 17, 19, 21, and 24.

The Committee recommends adoption of the proposed Chapter by the SHCC with any appropriate updates in the narrative and with continued updated inventory or other appropriate data in the Chapter's tables.

The Committee recommends that Policy PSY-2: Allocation of Psychiatric Beds be deleted. The policy currently reads as follows:

POLICY PSY-2: ALLOCATION OF PSYCHIATRIC BEDS
A hospital submitting a Certificate of Need application to add inpatient psychiatric beds shall convert excess licensed acute care beds to psychiatric beds. In determining excess licensed acute care beds, the hospital shall subtract the average occupancy rate for its licensed acute care beds (adjusted for any CON¬-approved deletions) over the previous 12-month period from the appropriate target occupancy rate of acute care beds listed in Policy AC-4 and multiply the percentage difference by the number of its existing licensed acute care beds, then subtract from the result the number of approved new acute care beds which are pending development.

Recommendations Related to the Substance Abuse Inpatient and Residential Services (Chemical Dependency) Chapter:

The methodology is based on hospital utilization data obtained from Thomson, a collector of hospital patient discharge information. Data utilization of chemical dependency (substance abuse) residential treatment facilities are obtained from the Substance Abuse Residential Facilities Data Collection Form as submitted to the North Carolina Division of Health Regulation Services. The methodology is applied individually to the 25 mental health planning area programs and then bed surpluses/deficits in the areas are combined to arrive at the total surpluses/deficits for the four designated mental health planning regions. Any bed need determination shall be designated as a residential treatment / detox bed need determination. Any residential treatment / detox bed need determination not applied for would be reallocated in accordance with Policy GEN-1 and designated for either a residential or a hospital-based treatment / detox bed need determination.

There were no petitions or comments. The Committee recommends that there is a determination of need for adult chemical dependency (substance abuse) treatment beds in LME Area 16 (seven beds; see Table 16B, *Attachment L*). In addition, there is a determination of no need for adolescent chemical dependency (substance abuse) treatment beds in the state. The Committee recommends adoption of the proposed Chapter by the SHCC with any appropriate updates in the narrative and with continued updated inventory or other appropriate data in the Chapter's tables.

Recommendations Related to the Intermediate Care Facilities for the Mentally Retarded Chapter:

Intermediate Care Facilities for persons who are Mentally Retarded or otherwise developmentally disabled (ICF/MR) is a category of group home care designated by the federal-state Medicaid program. A total of 5,252 certified ICF/MR beds are in operation. This total includes 2

demonstration projects and their 45 beds and 5 state facilities and their 2,570 beds. The beds located in state facilities are excluded from the regular bed inventory because such facilities are not subject to the state's certificate of need law.

The Committee recommends that there is a determination of no need for additional ICF/MR beds anywhere in the State based on the methodology in the chapter. The Committee recommends adoption of the proposed Chapter by the SHCC with any appropriate updates in the narrative and with continued updated inventory or other appropriate data in the Chapter's tables.

Other Action

The Committee authorized staff to update tables and need determinations for the Proposed 2009 Plan, as new and corrected data is received.