Issues and Questions Identified for Further Consideration
Hospice Home Care and Hospice Inpatient Need Determination Methodologies
North Carolina State Health Coordinating Council - Hospice Methodologies Task Force – 2009
(Discussion notes based on discussion at February 20, 2009 Task Force meeting.)

Home Care and Inpatient

1. License data – tighten up. (Discussion notes: Clarify what needs to be reported and correct way to report – enhance what the State is asking agencies to do. Effect of data on need determinations. Validate data – standardized approach. Data is self-reported. Adding data to be collected can add an administrative burden on agencies. Small group to look at license renewal form and reformat the way information is asked for and collected.)

2. Over age 65 population. Greater use of services. For home care methodology, currently use statewide median percent of deaths served by hospice. (Discussion notes: Are there other age stratifications? Do death rates used help compensate for age? Lower death rates in some counties may reflect younger population in County.)

3. Need determinations using contiguous counties in rural areas. Consideration of list of special circumstances. (Discussion notes: Question how to reflect in methodology? Is the county the appropriate service area for need determinations? Petition process is available.)

Home Care

1. Use of 50 for rural counties and 75 for metropolitan as deficits for need determinations. Use of standard for State. Relationship to use of 110 as placeholder. (Discussion notes: What do 50 and 75 represent – why used – are they applicable? Consider use of median number of deaths per hospice program.)

2. Apply a three-year compound annual growth rate to the number of deaths served by existing hospices to then be subtracted from projected hospice deaths to determine unmet need. (Discussion notes: Are there consistencies/inconsistencies in the Medicare-Certified Home Health and Hospice Home Care methodologies? Can the methodologies be standardized? If not, rational for difference in the Home Health methodology and Hospice Home Care methodology. Apply some type of cap on compounded growth – cap could be a percent. May have skewed numbers. Growth rates based on Councils of Governments can vary. How to compensate for provider growth?)

3. Consider chronically underutilized hospice service areas. (e.g. Unwillingness of physicians to refer patients to hospice, cultural barriers). (Discussion notes: Recognize that chronically underutilized areas may exist. How to address? Can be addressed in petition process. In rural areas, there are not as many specialties.)

4. Consideration of number of existing providers in county and serving county. (Discussion notes: How can this be addressed? Is there a need in a rural county for another provider if the county is already served by several providers? The methodology does not allow for consideration of the number of providers. Costs associated with providing services - duplication of administrative costs. Consider capacity of providers. What is the capacity of existing providers? Many small counties are served by multiple agencies. There are some counties where this is not the case. May be addressed via petitions. How to consider relationship of penetration rates, acuity of patients, access to services and number and size of providers. What is needed for a viable entity that meets needs?)

Inpatient

1. Question use of Days of Care – acuity as factor. Relationship of hospice deaths versus days of care. Use hospice admissions versus days of care. Question if eight percent of total days are too high? 5.7 percent in State and three to four percent in nation. Look at the current use of 300% or greater days of care per 1000 population than the State average as a basis for adjusting need determinations. (Discussion notes: The above issues were generally viewed as being related. Which approach to use? Are deaths the more appropriate driver of inpatient hospice days and usage? What are the more appropriate drivers and what has a higher correlation? If admissions are used, how to adjust for those that are admitted to inpatient without having been first admitted to home care? Should days of care be used? Do days of care speak to acuity? If days of care are used, what is the percentage? Use patients served. What is the statewide average length of stay (ALS)? Question use of statewide ALS? Some counties have higher ALS. Keep adjustment for outliers if days of care used. Continue to encourage inpatient beds to improve geographic access while recognizing need to staff and be financially viable.)

2. Use of six bed minimum for need determination? Barrier for smaller counties. Adding beds to facility. (Discussion notes: Petition process can be used for smaller number of beds. Is there a possibility of a population adjustment for smaller counties for need determinations? A change in service area definition may address smaller counties.)

3. Residential/inpatient license barrier and other licensure/regulatory issues. South Carolina does not distinguish between beds.

General Note

Need rational for assumptions used in the methodologies. Consider variable correlations/relationships. Consider availability of data.