MEMORANDUM

TO: HOSPICE METHODOLOGY TASK FORCE

THOMAS J. PULLIAM, MD, CHAIRMAN

FROM: JUDY BRUNGER; PETE BRUNNICK; DAWN CARTER; FLOYD COGLEY; SANDY ROBERSON; TIM ROGERS

SUBJECT: HOSPICE METHODOLOGY RECOMMENDATIONS

DATE: APRIL 24, 2009

DRAFT

At the last meeting of the Hospice Methodology Task Force, you asked our group to examine the major issues identified by the Task Force and develop draft material to reflect Task Force discussion. Our group has completed its task and has provided the attached draft methodology tables and narrative.

The following discussion reviews each of the major issues and outlines the results of our group's consideration.

SERVICE AREA ADJUSTMENT

Our group determined that the use of multi-county service areas, similar to the acute care bed methodology, would not resolve the current issues in the hospice methodologies, and instead might create new ones. The creation of multi-county service areas centered around an existing office in a manner analogous to acute care bed service areas does not align with the patient-based nature of hospice home care; the service can travel to the patient and is not facility-based. For hospice inpatient beds, our group determined that the aggregation of need for multiple counties may result in the disenfranchisement of counties whose need for services was seized by another county in their service area. The petition process is available to address multi-county considerations.

The use of multi-county service areas was determined not to be an effective solution to the current issues with the hospice methodologies.

HOME CARE METHODOLOGY

Our group examined several methodology changes individually and in concert including:

- Use of a deficit index similar to the adult care home methodology.
- Increase the need threshold and placeholder to 130 deaths.
- Add growth factor in number of deaths served and percent of deaths served.
- Add agency per capita limit.

The following table presents the result of each methodology change compared to the *2009 SMFP* methodology prior to adjustments made for special need petitions:

Methodology	***Resulting # of Home Care Office Need Determinations***
2009 SMFP	5
Need threshold and placeholder at 130 deaths	0
Growth in number of deaths served and percent of deaths served	4
Agency per capita limit	3

After a review of multiple combinations of the above methodology changes, our group agreed on a methodology which incorporates elements of each. Our proposed home care methodology adjusts the need threshold and placeholder to 90 deaths, assumes statewide growth in number and median percent of deaths served, and eliminates need determinations for counties above the statewide median agency per 100,000 population. Our group's reasoning for each element was as follows:

- The current need thresholds of 50 and 75 were considered to be lower than could financially sustain a new hospice office. The statewide average number of deaths served per hospice office of 130 was determined to be too high a threshold given the increase in comparison to the current threshold and that it may result in the elimination of need determinations even in counties where it would be appropriate. The group agreed on a need threshold and placeholder of 90 deaths which represents the approximate number of deaths served at the statewide median number of hospice offices per 100,000 and the statewide median penetration rate (8.5 deaths per 1,000 x 100 = 850 deaths per 100,000 x 29.5 percent of deaths served = 251 deaths served by hospice / 3 hospice agencies = approx. 90). The need threshold and placeholder were set equal in order to provide consistency.

- The inclusion of growth in the number and median percent of deaths served was determined to effectively address the potential for hospice offices to grow over time and for hospice penetration to increase as well. The two year trailing average growth rate was used in both instances which conforms with other need methodologies. In order to provide reasonable projections, the projected number of deaths served are held to a maximum level of 60 percent of total projected deaths which does not affect the methodology's results as only counties that would demonstrate a surplus of hospice patients are adjusted.

- An agency per capita limit for all need determinations was included to reflect the group's understanding that the addition of hospice offices in counties with low penetration rates despite adequate hospice services would not necessarily result in increased access or penetration. This element also aligns with the group's finding that counties with the highest hospice penetration rates in the State were often served by one or two hospice offices.

- The adoption of these changes supports the elimination of the use of a deficit index.

DRAFT

The application of the proposed home care methodology to the *2009 SMFP* data results in three hospice office need determinations in Johnston, Union, and Wilkes counties. Petitions were submitted and approved in both Johnston and Union counties to have their need removed in the *2009 SMFP.* Please see the attached draft hospice home care methodology table and narrative for greater detail.

INPATIENT BED METHODOLOGY

Our group examined several methodology changes individually and in concert including:

- Use of hospice admissions as basis for methodology.
- Add growth in number of admissions.
- Add growth in penetration rate.

The group determined that the addition of growth in the number of admissions would have the same effect as growth in the penetration rate, and thus, only evaluated the former as it was consistent with the use of admissions as the basis for the methodology. In addition, the group evaluated adjusting ALOS to be the lower of the statewide median ALOS or the ALOS for each county. The following table presents the result of each methodology change compared to the *2009 SMFP* methodology prior to adjustments made for special need petitions:

Methodology	***Resulting # of Counties with Need Determinations***	***Resulting # of Inpatient Beds Needed***
2009 SMFP	11	80
Base of hospice admissions	13	83
Growth in number of admissions	38	376
Minimum ALOS	4	24

After a review of the above methodology changes, our group agreed on a methodology which incorporates all of the above elements as well as a one additional change: reducing the percent of inpatient days as a percent of total days of care to six percent rather than eight percent. Our group's reasoning for each element was as follows:

- 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.

DRAFT

- 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. As such, the methodology uses the lower of the statewide median ALOS or the ALOS for each county.

- According to data compiled by The Carolinas Center for Hospice and End of Life Care, inpatient days constituted 5.7 percent of total days of care in 2007. Our group found that a flat rate of six percent of total estimated days of care in each county to be reasonable for estimating days of care in inpatient hospice facility beds.

The application of the proposed methodology to the 2009 SMFP data results in inpatient bed need determinations in 11 counties for a total of 74 beds. Please see the attached draft hospice inpatient methodology table and narrative for greater detail.

DRAFT