Healthcare Planning and Certificate of Need Section

DRAFT

Long-Term and Behavioral Health Committee Minutes
Friday, April 7, 2017
10:00 a.m. -12 Noon
Brown Bldg. Room 104, Raleigh, NC

Members Present: Ms. Denise Michaud – LTBH Committee Chair, Dr. Chris Ullrich – SHCC Chair, Mr. Peter Brunnick, Mr. Kurt Jakusz, Mr. Jim Martin, Dr. Jay Parikh
Members Absent: Mr. Keith Branch, Mr. Jim Burgin, Dr. TJ Pulliam
Healthcare Planning: Ms. Paige Bennett, Ms. Elizabeth Brown, Amy Craddock PhD, Mr. Patrick Curry, Tom Dickson PhD, Andrea Emanuel PhD
DHSR Staff: Mr. Mark Payne, Ms. Martha Frisone, Ms. Fatimah Wilson
AG's Office: Mr. Derrick Hunter

Agenda Items	Discussion/Action	Motion/ Seconded	Recommendations/ Actions
Welcome & Announcements	Ms. Michaud welcomed members, staff and guests to the first Long-Term and Behavioral Health (LTBH) Committee meeting. She stated that the purpose of this meeting was to review the polices and methodologies to determine if changes are needed for the Proposed 2018 State Medical Facilities Plan, to discuss the petitions received, and to vote on a recommendation for the State Health Coordinating Council (SHCC). Ms. Michaud stated the meeting was open to the public, but discussion would be limited to members of the Long-Term and Behavioral Health Committee and staff, unless questions are specifically directed to someone in the audience. Ms. Michaud noted that the next LTBH Committee meeting would be on May 5th at 10:00 a.m. in this location.		

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	Ms. Michaud asked the committee members and staff to introduce themselves.		
Review of Executive Order No. 122: Extending the State Health Coordinating Council & Executive Order No. 46: Ethical Standards for the State Health Coordinating Council	Ms. Michaud gave an overview of the procedures to observe before taking action at the meeting. Ms. Michaud inquired if anyone had a conflict, needed to declare that they would derive a benefit from any matter on the agenda, or intended to recuse themselves from voting on the matter. Ms. Michaud asked members to review the agenda and declare any conflicts on today's agenda. There were no recusals. Ms. Michaud stated that if a conflict of interest not on the agenda came up during the meeting, the member with the conflict of interest would make a declaration of the conflict.		.
Approval of September 9, 2016 Minutes	A motion made and second to accept the September 9, 2016, LTBH meeting minutes.	Mr. Brunnick Dr. Parikh	Motion approved
Nursing Care Facilities - Chapter 10	Dr. Andrea Emanuel provided the following report on policies and the methodology for Chapter 10 o There are four policies in Chapter 4 related to Nursing Homes. They can be found on pages 23-25 of the 2017 SMFP. • **NH-2: Plan Exemption for Continuing Care Retirement Communities** o This policy allows qualified continuing care retirement communities to include, from the outset, or add or convert bed capacity for nursing care without regard to the nursing care bed need shown in Chapter 10. o According to the current policy, all of these beds are excluded • **NH-5: Transfer of Nursing Facility Beds from State Psychiatric Hospital Nursing Facilities to Community Facilities**		

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	○ This policy sets criteria for the transfer of state psychiatric hospital nursing beds to community nursing facilities, provided that services are available in the communities receiving the beds. • **NH-6: Relocation of Nursing Facility Beds** ○ This policy sets conditions for relocating nursing facility beds in order to avoid creating a deficit or increasing a deficit in the county losing beds and to avoid creating a surplus or increasing a surplus in the county gaining beds. • **NH-8: Innovation in Nursing Facility Design** ○ This policy mandates that new nursing facilities applying for a CON pursue approaches, practices and designs that address quality of care and quality of life needs of the residents. • Description of the nursing home methodology is found on pages 189-191 of 2017 SMFP. • For this methodology, each of North Carolina's 100 counties is considered a separate service area when determining nursing home bed utilization. • The following is an overview of the steps for the methodology: ○ Need is determined by calculating the county bed use rate per 1000 population based on a five year average annual change. ○ These use rates, or "beds per 1,000 population," are applied to each service area's projected population going forward three years and a 95% vacancy factor, in order to calculate projected utilization. ○ The amount of need per service area is then established based on the size of the service area's projected surplus or deficit when the projected utilization is compared to the inventory of existing and approved beds.		

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	○ Page 191 details how deficit size is used to determine the county's bed need. Dr. Emanuel noted no petitions were received for Chapter 10.		
	Committee Recommendation A motion made and seconded to approve policies and the methodology for Chapter 10 to the SHCC.	Dr. Parikh Mr. Brunnick	Motion approved
Adult Care Homes – Chapter 11	Dr. Emanuel next provided the following report on policies and the methodology for Chapter 11: ○ There are two policies in Chapter 4 related to Adult Care Homes. These policies are found on pages 25-26 of the 2017 SMFP. • **LTC-1: Plan Exemption for Continuing Care Retirement Communities-Adult Care Home Beds** ○ This policy sets criteria for adding or converting adult care beds in CCRC's without regard for need determinations in Chapter 11. ○ The policy also provides an exclusion from the SMFP inventory for 50% of the adult care beds in CCRC's developed under this policy. • **LTC-2: Relocation of Adult Care Home Beds** ○ This policy sets conditions for relocating adult care home beds to contiguous counties served by the facility in order to avoid creating or increasing a deficit in the county losing beds and to avoid creating or increasing a surplus in the county gaining beds. • Description of the adult care home bed need methodology used is found on pages 217-219 of 2017 SMFP. • For this methodology, each of North Carolina's 100 counties is considered a separate service area when determining adult care home utilization. • The proximate determinant of adult care home utilization is the age of the population.		

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	• The steps for the methodology are as follows: o Need is determined by calculating the statewide five-year average use rate per 1,000 population for each of five age groups based on data from annual license renewal applications. o These use rates, or "beds per 1,000 population," are applied to the projected population going forward three years for each service area. o The amount of need per service area is then established based on the size of the service area's projected surplus or deficit when the projected utilization is compared to the inventory of existing and approved beds. o Page 219 details how deficit size is used to determine the county's bed need.		
	Committee Recommendation A motion made and seconded to approve policies and the methodology for Chapter 11 to the SHCC.	Mr. Brunnick Dr. Parikh	Motion approved
	Adult Care Home Petition submitted by Singh Development Ms. Michaud noted there was one petition received from Singh Development and also a comment by the petitioner in response to comments submitted by Ridge Care. The comments on the comments were received after the deadline. Regarding the comment on the comments, Ms. Michaud gave the committee background on how, during its first meeting of the 2018 SMFP Cycle, the Acute Care Committee responded to a comment that was also submitted late.		
	Committee Discussion Dr. Ullrich reiterated that the SHCC would return to its historic adherence of considering comments to the policy petition and of holding a strict deadline for submissions of comments.		
	Committee Recommendation A motion made and seconded to not consider the comments that were received after the deadline.	Dr. Parikh Mr. Brunnick	Motion approved

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	Committee Recommendation A motion made and seconded to reaffirm the SMFP deadlines for petitions and comments.	Mr. Brunnick Dr. Parikh	Motion approved
	Agency Report on Petition Dr. Emanuel noted that one petition from Singh Development was received for Chapter 11 and one comment from Ridge Care was submitted in opposition to the petition. The petition was submitted as a proposal to amendment to policy LTC-2 which pertains to relocation of adult care home beds. According to the current policy, adult care home beds can be relocated from one county to another provided three conditions exist: One is that the counties in question be contiguous to each other and that the county losing beds currently serves residents of the county receiving beds. The second condition requires that a deficit is not created or increased in the county losing beds. And the third condition is that a surplus is not created or increased in the county gaining beds The petitioner is proposing to replace the existing third criteria with language that would allow relocation of licensed adult care home beds from a county with a surplus of beds to a contiguous county also with a surplus of beds. According to the petitioner's proposed policy, counties that would qualify to lose beds, referred to as 'transfer out' counties, would have to have a bed surplus of at least 15% and be contiguous to a 'transfer-in' county. Transfer-in counties, or counties gaining beds, would have to have a bed surplus of less than 15%, have a five-year forward average population growth rate greater than the State's and be contiguous to a 'transfer-out' county. As part of our analysis, we followed the approach of the petitioner and used the most up-to-date population data from the NCOSBM. We found that a total of sixteen counties would potentially qualify as transfer-out counties and seven counties would potentially qualify as transfer-in counties. However, the Petitioner does not include zero-surplus or deficit counties in the model presented in the Petition. There are thirty-two such counties, and if the policy		

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	were expanded to include zero-surplus and deficit counties, but not have a population growth requirement, then an additional 22 deficit counties would qualify to receive beds. By not including these counties, the proposed policy does not increase patient access, which is a basic principle in the SMFP. In the petition, there is not an explanation for why zero-surplus or deficit counties would be excluded in the proposed policy. A second concern regarding amending the policy relates to the Adult Care Home need methodology. The need methodology and policies for Adult Care Home beds are very similar to that of the previous Nursing Home bed need methodology and policies. In recent history, a workgroup modified the projection calculation in the Nursing Home bed need methodology. Among other changes, utilization based on age groups no longer is considered, and county bed use rates, rather than State use rates, are now applied for more accurate projections of Nursing Home bed need. The current Adult Care Home bed need methodology uses some of the same elements that were removed from the former Nursing Home need methodology. Given the available information and comments submitted by the March 16th, 2017 deadline and in consideration of the factors discussed, the agency recommended denial of the Petitioner's request to amend Policy LTC-2. The Agency also proposed a review of the Adult Care Home methodology no earlier than the 2019 SMFP cycle, depending on the availability of staffing resources.		
	Committee Recommendation A motion was made and seconded to accept the Agency recommendation to deny the Petitioner's request to amend Policy LTC-2.	Mr. Brunnick Dr. Parikh	Motion approved
	Discussion Mr. Brunnick noted that he supports the recommendation of the Agency, and he fully supports the recommendation to review the ACH methodology as he is concerned about the points brought up by the petitioner regarding bed need in small-surplus, high growth service areas.		
Medicare Certified Home Health Services – Chapter 12	Ms. Michaud first noted that no petitions or comments were received for this chapter. Next, Ms. Elizabeth Brown provided the following report on policies and the methodology for Chapter 12:		

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	Polices Applicable to Home Health Services (p. 26): **Policy HH-3**: Need Determination for Medicare-Certified Home Health Agency in a County *Establishes a need for a new home health office when there is no existing office located in a county with a population of 20,000 people or more; or if the county population is less than 20,000 people and there is no home health office located in a North Carolina county within 20 miles.* *[Except Granville County that has been served by Granville Vance District Health Department and recognized by DHSR as a single geographic entity for purposes of location of a home health agency office.]* **Standard Methodology** [Steps 1-14] (p.255-256) used to project need for new home health offices: *Through the use of four different age groups, the utilization patterns of young and old patients are assessed. The standard methodology looks at growth in the number of patients and at growth in the existing agencies' ability to serve future patients. Historically, this is done county by county and averaged at the Council of Government region's level annual rate of change.*		
	Committee Recommendation A motion made and seconded to approve policies and the methodology for Chapter 12 to the SHCC.	Dr. Parikh Mr. Brunnick	Motion Approved
Hospice Services – Chapter 13	Next, Ms. Michaud noted that no petitions or comments were received for this chapter. Ms. Brown noted there are no policies applicable to Hospice Services. She then provided the following report on the methodology for Chapter 13: **Standard Methodology** [Steps 1-14] (p. 325-327) used to project need for new hospice home care offices…		

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	• The hospice home care standard methodology uses county mortality rates for the most recent five years as the basis for hospice patient need projection. A two-year trailing average growth rate in statewide number of deaths served is used over the previous three years. This projects changes in the capacity of existing agencies to serve deaths from each county by the target year. Median projected hospice deaths is done by applying the projected statewide median percent of deaths served by hospice to projected deaths in each county. An additional home care office is needed if the county's deficit is 90 or more and the number of licensed offices in the county per 100,000 is 3 or less. **Standard Methodology [Steps 1-12] (p. 327-328)** used to project need for new hospices inpatient beds… • The methodology uses total projected admissions, statewide median average length of stay per admission and each county's average length of stay per admission and each county's average length of stay per admission for projecting estimated inpatient days for each county. Similar to the hospice home care methodology, previous years' data is used, so a two-year trailing average growth rate in statewide hospice admissions is done over the previous three years. Total projected admissions and the lower of the statewide median average length of stay per admission and each county's average length of stay per admission are used as the basis for projecting estimated inpatient days for each county. A two-year trailing average statewide inpatient utilization rate of the total estimated days of care in each county is used as a basis for estimating days of care in licensed inpatient hospice facility beds. **Hospice Residential Beds (p. 324)** There is no need methodology for hospice residential beds		
	<u>Committee Recommendation</u> A motion made and seconded to approve policies and the methodology for Chapter 13 to the SHCC.	Mr. Brunnick Mr. Martin	Motion approved

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End-Stage Renal Disease Dialysis Facilities – Chapter 14	Ms. Michaud noted that no petitions or comments were received for this chapter. Next, Ms. Brown provided the following report on policies and the methodology for Chapter 14: **Policy ESRD-2: Relocation of Dialysis Stations (p.27)** *This policy notes that stations can be relocated only within the host county and to contiguous counties. Certificate of need applicants proposing to relocate stations to a contiguous county shall demonstrate that the facility currently serving patients of that contiguous county. Even then, the relocation must not create a "surplus" in the receiving county or a "deficit" in the donor county.* **Standard Methodology (p. 375-378)** used to project need for new dialysis stations… The need for new dialysis stations is determined two times each calendar year. Determinations are made available in the North Carolina Semiannual Dialysis Report (SDR). • **County Need:** Is based on all residents of North Carolina, regardless of where they are currently receiving services. Future patient counts are projected for 6 to 12 months into the future based on a five-year trend line. Need is based on 80 percent utilization of existing stations, at 3.2 patients per station. The threshold for need is a projected deficit of 10 stations. • **Facility Need:** Is a permissive methodology, which allows an existing provider located in a county where the projected County Need is zero, to apply for additional stations if that facility is operating at or above 80 percent utilization and feels it needs additional capacity. (Because patients can chose to cross county lines, this allows a facility in "high demand" to apply for expansion even if the host county has sufficient stations based on local county residents.)		
	<u>Committee Recommendation</u> A motion made and seconded to approve policies and the methodology for Chapter 14 to the SHCC.	Mr. Brunnick Dr. Parikh	Motion approved

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Psychiatric Inpatient Services - Chapter 15	Ms. Michaud noted there were no petitions received for this chapter. Regarding LME-MCOs, Dr. Amy Craddock noted that mergers are continuing. Nash County will leave the Eastpointe LME-MCO and become part of Trillium effective July 1. Eastpointe announced that it will merge with Cardinal Innovations Health Care on July 1, as well, but this has not been confirmed by DMH. Dr. Craddock next provided the following report on policies and the methodology for Chapter 15: **Policies** The first policy MH-1. Linkages between Treatment Settings. This policy pertains not only to Chapter 15, but also to chapters 16 & 17. According to this policy, the CON applicant shall document that the affected LME-MCO has been contacted and invited to comment on proposed services described in the CON application. A second policy PSY-1. Transfer of Beds from State Psychiatric Hospitals to Community Facilities applies specifically to Chapter 15. According to this policy, beds may be relocated from state facilities through the CON process, provided services and programs shall be available in the community. Beds transferred from state facilities shall be closed within 90 days after the date that the community beds become operational. CON applicants must commit to serve the type of short-term patients normally placed in the state facility beds. To help ensure that this occurs, there must be a written Memorandum of Agreement between LME-MCO, Secretary of DHHS, and the CON applicant. **Recommended Changes to Diagnosis Coding** Before discussing the methodology for Chapter 15, Dr. Craddock discussed an issue that pertains to both Chapter 15 and Chapter 16. She then reviewed data for psychiatric and substance use disorder days of care provided in acute care hospitals, which comes from the data that the hospitals submit to Truven. Truven submits this data to the Sheps Center at UNC, and Sheps provides it to Healthcare Planning. In the past, Sheps has used ICD-9 codes to select cases, based on the person's primary		

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	diagnosis at discharge. Beginning this year, the data uses ICD-10 codes. The process of mapping ICD-9 to ICD-10 codes is onerous and error-prone. A much simpler method is to use the Major Diagnosis Categories (MDC) created by the Centers for Medicare and Medicaid Services (CMS). These categories are created using ICD-9 codes. Beginning with the data provided to us this year; the MDC codes will reflect the use of ICD-10 codes. There is one code for psychiatric disorders and one for substance use disorders. Sheps provided Healthcare Planning with last year's data selected using the MDCs to see what, if any, differences exist between the two methods of selecting cases. Dr. Craddock pointed out that in the table projected on the screen shows that the differences are very slight. In the 2017 SMFP, using MDC versus ICD-9 codes would not have changed needs for adult psychiatric beds at the state level, but would have resulted in a small change in needs for child/adolescent psychiatric beds in two LME-MCOs. The 35-bed need for Eastpointe would have increased to 36 beds; the 2-bed need in Partners Behavioral Health Management would have decreased to 1 bed. The use of MDC codes would not have changed substance use disorder bed need in any region or for any other age groups. Therefore, the Agency recommends use of MDCs to select cases for Chapters 15 and Chapter 16. If approved, the language will be changed accordingly and presented for consideration by the committee at the next meeting. Dr. Craddock pointed out that voting on this recommendation will occur when the committee votes on each chapter's methodology. **Methodology** Basic assumptions of the methodology include identification of the bed service area as the LME-MCO in which the beds are located, note that treatment settings for adults should be separate from those for children and adolescents, and identify the optimum occupancy to be 75%. Days of care are projected two years beyond the		

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	SMFP publication year (2020). **Part 1: Determining Projected Patient Days of Care and Bed Need for Children and Adolescents** Step 1: The estimated Year 2020 days of care for children/adolescents are determined by taking the current (2016) days of care for patients up through 17 years of age, multiplying that number by the projected Year 2020 child/adolescent population and then dividing by the Year 2016 child/adolescent population. Step 2: The adjusted Year 2020 days of care is divided by 365 and then by 75 percent to arrive at the child/adolescent bed need for 75 percent occupancy. Step 3: The planning inventory is determined based on licensed beds, adjusted for CON-Approved/License Pending beds and beds available in prior Plans that have not been CON-approved. The number of existing child/adolescent beds in the planning inventory is then subtracted from the bed need (from Step 3) to arrive at the Year 2020 unmet bed need for children and adolescents. **Part 2: Determining Projected Patient Days of Care and Bed Need for Adults** The methodology is identical to the child/adolescent methodology, except that it is based on the child/adolescent population rather than the adult population. Step 1: The estimated Year 2020 days of care for adults is determined by taking the actual Year 2016 days of care for the age group 18 and over, multiplying that number by the projected Year 2020 adult population and then dividing by the Year 2016 adult population. Step 2: The projected Year 2020 days of care is divided by 365 and then divided by 75 percent to arrive at the adult bed need in Year 2020 for 75 percent occupancy. Step 3: The planning inventory is determined based on licensed beds, adjusted for CON-Approved/License Pending beds and beds		

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	available in prior Plans that have not been CON-approved. The number of existing adult beds in the planning inventory is then subtracted from the bed need (from Step 2) in order to arrive at the Year 2020 unmet bed need for adults. Dr. Craddock clarified that MDC codes were created by categorizing IDC-9 codes, and have been updated to correspond to ICD-10 codes.		
	Committee Recommendation A motion made and seconded to approve policies, the methodology, and use of MDC codes for Chapter 15.	Dr. Parikh Mr. Brunnick	Motion approved
Substance Abuse/Chemical Dependency - Chapter 16	Ms. Michaud noted there were no petitions received for this chapter. Dr. Craddock next noted there were no policies specific to Chapter 16 other than MH-1, which was discussed earlier. She then provided the following report on the methodology for Chapter 16: Basic assumptions of the methodology note that treatment units for the adult and the child/adolescent population should be physically and programmatically separate. Eighty-five percent has been determined to be the target occupancy rate for chemical dependency treatment beds in hospitals and residential treatment facilities. Days of care and bed need are projected two years beyond the current SMFP publication year (2020). **Part 1: Determining Projected Patient Days of Care and Total Bed Need** Step 1: The estimated Year 2020 days of care for all age groups is determined by taking the current reporting year (2016) days of care, multiplying that number by the projected Year 2020 population and then dividing by the Year 2016 population. Step 2: The Year 2020 days of care is divided by 365 and then by 85 percent to arrive at the total bed need in Year 2020, assuming an 85 percent occupancy. Eighty-five percent has been determined to be the target occupancy rate for chemical dependency (substance		

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	abuse) treatment beds in hospitals and residential treatment facilities. **Part 2: Determining Projected Unmet Bed Need for Children and Adolescents and for Adults** Step 1: The planning inventory is determined based on licensed beds, adjusted for CON-Approved/License Pending beds and beds available in prior Plans that have not been CON-approved. The number of existing beds in the planning inventory is then subtracted from the total bed need (from Part 1, Step 2) to arrive at the Year 2020 *unmet* bed need for all age groups ("total bed surplus/deficit"). Step 2: Nine percent of the total bed need is subtracted as the estimated Year 2020 bed need for children and adolescents, based on utilization patterns reflected in past data (nine percent of the days of stay were for children and adolescents). Step 3: The child/adolescent planning inventory is subtracted from the child/adolescent bed need (from Part 2, Step 2) to arrive at the Year 2020 child/adolescent unmet bed need. Step 4: The adult bed need is then calculated by subtracting the child/adolescent bed "surplus/deficit" from the total bed "surplus/deficit."		
	Committee Recommendation A motion made and seconded to approve policies, the methodology, and use of MDC codes for Chapter 16.	Mr. Brunnick Mr. Martin	Motion approved
Intermediate Care Facilities - Chapter 17	Ms. Michaud noted there were no petitions received for this chapter. Dr. Craddock then provided the following report on policies and the methodology for Chapter 17: Three polices address Chapter 17. **ICF/IID-1: Transfer of Beds from State Operated Developmental Centers to Community Facilities for Medically Fragile Children**		

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	Beds in state operated development centers may be relocated to community facilities via the CON process to serve children age birth through six years who have severe to profound developmental/intellectual disabilities and are medically fragile. Pertains to transfer of beds only, not patients. Once licensed in the community, the state operated beds shall be closed. **ICF/IID-2: Transfer of Beds from State Operated Developmental Centers to Community Facilities for Individuals Who Currently Occupy the Beds** Existing beds in state facilities may be transferred via the CON process to establish group homes in the community to serve people with complex behavioral challenges and/or medical conditions for whom such a community placement is appropriate. Once licensed in the community, the state operated beds shall be closed. Applicants must demonstrate their clinical experiences in serving the target population. To ensure that beds will be used to serve these individuals, a written agreement is required among the following: LME-MCO where group home is to be located, director of NC Division of State Operated Facilities, Secretary DHHS, and operator of group home. **ICF/IID-3: Transfer of Beds of State Operated Developmental Centers to Community Facilities for Adults with Severe to Profound Developmental Disabilities** Existing ICF/IID beds in state facilities may be transferred to the community via the CON process to replace Community Alternatives Program for Individuals with Intellectual and Developmental Disabilities (CAP I/DD) waiver slots lost as a result of the Centers for Medicaid and Medicare Services (CMS) policy designed to prohibit CAP I/DD waiver and ICF/IID beds from being located on the same campus. Applies to transfer of beds only, not patients. Once licensed in the community, the state operated beds shall be closed. Applies only to facilities that have lost waiver slots as a result of this CMS policy. CON applicants must demonstrate commitment to serve adults who have severe to profound intellectual/developmental disabilities.		

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	Methodology Beds are created in ICF/IID facilities by issuance of a CON to transfer beds from State Operated Developmental Centers. There is no calculation of bed need for ICF/IID facilities.		
	Committee Recommendation A motion made and seconded to approve policies and the methodology for Chapter 17.	Dr. Parikh Mr. Brunnick	Motion approved
Final Recommendation	A motion was made to authorize staff to make updates and corrections to all tables and narratives as needed, including updates to the preambles.	Dr. Parikh Mr. Brunnick	Motion approved
Other Business	Ms. Michaud noted the next LTBH committee meeting will be on Friday, May 5, 2017 at 10:00 a.m. at this location. Also, the next full SHCC meeting will be on June 7, 2017 at 10:00 a.m at this location.		
Adjournment	Ms. Michaud called for adjournment. A motion was made and seconded to adjourn the meeting.	Ms. Michaud Dr. Parikh	Motion approved