

**Healthcare Planning Response to Wake Forest Baptist Health
ESRD Facility Need Model
Prepared for February 13, 2019 ESRD Interested Parties Meeting**

In addition to the need to come into compliance with the law, Healthcare Planning presented the following goals at the November 14, 2018 Interested Parties meeting:

- Achieve parity, or better, with current ability to develop sufficient facilities and stations in a timely manner.
- Increase transparency and oversight by incorporating ESRD into the State Medical Facilities Plan (SMFP).

Planning also believes that the transition to the SMFP is not intended to

- negatively affect providers' ability to apply to develop needed facilities and/or stations;
- make data reporting more difficult for providers;
- make CON application and review process more difficult; or
- result in a comprehensive redesign of the methodology.

Staff also considered some general parameters that guided us in adjusting the SDR methodology for the SMFP.

- The Agency does not currently intend, or need, to undertake a complete redesign of the facility need methodology. Therefore, any proposed model should mirror the calculations in the current methodology, with adjustments for the annual reporting period. It is not necessary to create more elaborate steps beyond those in the current methodology, nor is it necessary that the adjustments require collection of additional data.
- The latest possible date for data reporting is 12 months before publication of the SMFP. For example, for the 2020 SMFP, the latest reporting date is December 31, 2018. This timeframe represents a 13-month lag between the data reporting date and the first CON application due date of the SMFP year (February). In other words, the "current patients" variable/field in the methodology comes from the December 31, 2018 data. The "previous patients" variable/field comes from the December 31, 2017 data. While it is useful to examine older data for testing the model, the actual revisions to the methodology should not need to use historical data earlier than the "previous" reporting period (just as in the current methodology).
- We propose an effective reporting date of December 31, with data due in approximately the first week in February. The providers currently submit data via Excel. Healthcare Planning does not currently anticipate a need to change this process.
- Any adjustments to the methodology must be feasible given available software and staff time, as well as the ability to integrate adjustments into the SMFP workflow.

Planning staff considered all of the above factors when creating our model and when examining the Wake Forest Baptist Health (WFBH) model.

Comments on WFBH Model

The WFBH model and Planning's model both propose to adjust the methodology to use data collected earlier than the data in the SDR. Specifically, both adjust the need utilization threshold to account for the lag time between data collection and publication of the SMFP.

An important difference is that one aim of the WFBH model is to find a facility need utilization threshold that does not create either excess capacity or overutilization. To do so, the model strives to find the "trigger" utilization at which the facility utilization stays below 4 patients per station (PPS) (or 100% utilization) versus above 4 PPS. In layperson's terms, the model looks for the "sweet spot" in utilization – low enough to trigger a need when warranted, but not so low that it creates the need for too many additional dialysis stations. This approach is generally mathematically reasonable, but is neither necessary nor advantageous to the current task.

The methodologies in the SMFP are mathematical projections. They always have included a "cushion" to ensure that the need determinations are sufficient and thus do not fail to address a need that actually exists. Historically, the ESRD facility need methodology has triggered need determinations for many more dialysis stations than facilities apply to develop. Facilities apply for the number of stations they can support. That is, the number of stations applied for is a business decision; it is not a Healthcare Planning function. Data presented at the January 16, 2019 ESRD Interested Parties meeting illustrated this practice. For example, the facility need based on the July 2017 SDR was for 384 stations, but facilities applied to develop only 86 (22%) of these. The three previous SDRs showed a similar pattern. If the methodology were to be completely redesigned, then this issue would warrant a detailed treatment. However, under the current methodology, creation of excess capacity does not cause harm. Therefore, we determined that the current adjustments to the methodology did not need to change this aspect.

A second difference is the collection of data at two time points for a single SMFP. It is Planning's position that this step is unnecessary. Originally, WFBH suggested collecting a second round of data in the middle of the planning year (e.g., collect data as of December 31, 2018 and June 30, 2019 for the 2020 SMFP). Planning explained that this was not possible given the timeline for development of the SMFP. WFBH's current approach is to collect data for June 30, 2018 instead (along with data for December 31, 2018). Providers have often expressed concern over the age of data used for dialysis need projections. However, data in the WFBH model will be between 18-23 months old at the time providers file CON applications, while data in Planning's model will be 13-23 months old. There is simply no advantage to collecting data at two time points as proposed by WFBH.

Part of this second difference is that the WFBH model appears to assume that providers will have more than one opportunity to submit a CON application in the same calendar year for the same facility. However, it is unclear whether multiple applications are a necessary part of the underlying mathematical operations of the WFBH model. From the beginning of the process of incorporating the SDR into the SMFP, Planning has held the position that adjustments to the methodology can render multiple applications unnecessary.

A third difference is that the WFBH model is not a model in the sense of a “model methodology,” but rather is the result of a statistical modeling process. Specifically, it is an analysis of utilization thresholds for individual facilities. While there is no single way to design a model methodology, entering data in a manner that requires a separate Excel file for every facility is simply not practical. It is not clear, however, whether WFBH is suggesting that their method of data entry and storage is necessary.

Finally, WFBH concludes that “74% utilization or 2.96 PPS appears to be (currently) a ‘good’ trigger utilization level to promote and support facility growth without creating too much excess capacity.” This conclusion is based on analysis of data that is 18 months old at the beginning of the SMFP publication year as well as in mid-year. Interestingly, the analysis in Planning’s model found that a 75% utilization threshold using annually reported data most closely resembled the needs projected using combined data from three SDRs. This observation is based on data that is 13 months old at the beginning of the SMFP publication year and assumes that facilities will have only one opportunity to apply to add stations during a calendar year. (Note that although the Planning model assumes that there will be one CON application opportunity annually, this does not mean that all CON applications will be due on a single date. There may be multiple CON application dates to add dialysis stations, but a facility can apply on only one of those dates during a single calendar year.)

In summary, both models strive to identify a reasonable utilization threshold for triggering facility need. Both models arrive at a similar threshold, while using different techniques to arrive at their conclusions. However, the WFBH model format and procedures do not offer a workable replacement for the current methodology.