Basic Methodology Components

- Calculations are by age group
- County Population (and aggregated to COG)
- County
  - Number of patients served in reporting year
- COG
  - Average annual change rate (AACR) in ***number of patients*** over last 3 reporting years (2018-2019, 2019-2020, 2020-2021).
  - AACR in ***use rate*** per 1,000 population patients over last 3 reporting years (2018-2019, 2019-2020, 2020-2021).

Important Points about Home Health Methodology

- The methodology calculates the number of patients in the projection year for the county, based on use rates per 1,000 population and change over last 3 years for ***both*** the county and the COG.
  - If the COG-based projection is higher than the county projection → county surplus
  - If the county-based projection is higher than the COG projection → county deficit
  - If the county deficit is at least 325 → need determination
- Unlike all other methodologies, inventory of agencies/offices is irrelevant
  - Methodology assumes that additional resources are needed when the patient deficit reaches 325.
  - 325 patients = opportunity for a new office → Access Principle
    - New office doesn't necessarily expand access for patients because existing providers could "simply" hire more staff to accommodate the additional need
    - Rather, expands access in the market because it creates opportunities for new providers and competition

Why so many need determinations?

- Combination of factors
- Changes at the COG level have a large influence on projected number of patients for the projection year
  - AACR patients by age
  - AACR use rate by age
- AACR is not directly related to population
  - AACR can be positive even if population is stable or slightly decreases
    - 2021 estimates based on 2020 Census (used in 2023 SMFP) were overall slightly lower than 2021 estimates based on 2010 Census projections (used in 2022 SMFP)
    - This <u>may</u> have made use rates somewhat higher because of the smaller population denominator
  - County population has less influence than COG AACRs

Planning Data Collected through LRAs

- We are not likely to be able to obtain additional data from the LRAs in the foreseeable future

- Clients who received Part-time/Intermittent Home Health services

  - Number of clients by county of residence for each age group

0-17	60-64	85+
18-40	65-74	
41-59	75-84	

  - County of agency that provided services

  - Number of Part-time/Intermittent Home Health visits by county

Planning Data Collected through LRAs

- Reporting Dates
  - July 1, 202X through June 30, 202X
  - October 1, 202X through September 30, 202X
  - If the Agency or Office provided services less than 12 months, then the provider enters the dates of operation that fall within the reporting year.

ADDITIONAL ELEMENTS FOR CONSIDERATION

- Projection of Need
  - Three years beyond reporting year (one year beyond the publication year of current SMFP)
  - Four years beyond reporting year (two years beyond the publication year of current SMFP)
  - Five years beyond reporting year (three years beyond the publication year of current SMFP)

ADDITIONAL ELEMENTS FOR CONSIDERATION

- Active-duty Military Population
  - Excludes 18-64 age group
  - Exclude under 35 age group
  - No exclusion

- Age Groups
  - Four age groups (under 18, 18-64, 65-74, 75 and over)
  - Seven age groups (under 17, 18-40, 41-59, 60-64, 65-74, 75-84, 85 and over)
  - No age groups

ADDITIONAL ELEMENTS FOR CONSIDERATION

- **Threshold**
  - 325 Patients or more
  - Increase, Decrease or No threshold

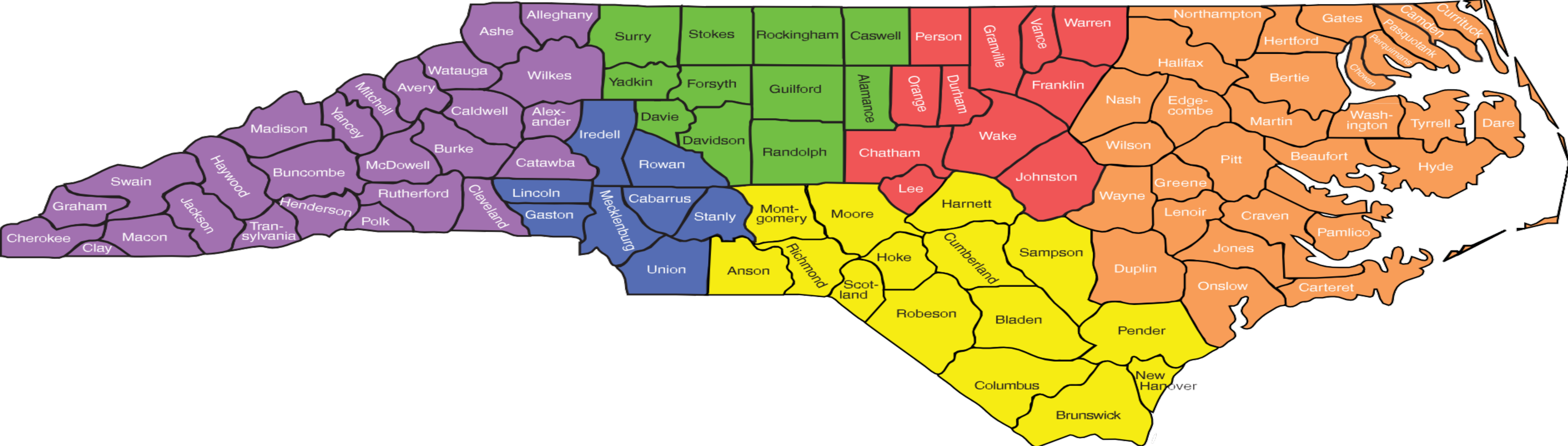
- **Service Area**
  - County
  - HSA

- **Conceptualization of “Agency or Office”**
  - CON Law requires a physical address for an office, but what does that really mean?

Staff Recommendations

- Continue to include age groups
- Continue to exclude military population
- Change service area
  - County is too small
    - BUT if county is chosen, the methodology must have a mechanism to determine a need for counties that do not currently have services.
    - About 45% of patients in 2021 were served in county of residence.
  - Consider larger and stable grouping of counties
    - All county groupings are arbitrary
    - COGS can be reconfigured by the Council of Governments
  - Health Service Areas?
    - Between 88% and 98% of patients in 2021 were served in HSA of residence.

Health Service Areas



Health Service Areas	Counties	Color Code
HSA I	Alexander, Alleghany, Ashe, Avery, Buncombe, Burke, Caldwell, Catawba, Cherokee, Clay, Cleveland, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Watauga, Wilkes, Yancey	
HSA II	Alamance, Caswell, Davidson, Davie, Forsyth, Guilford, Randolph, Rockingham, Stokes, Surry, Yadkin	
HSA III	Cabarrus, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly,Union	
HSA IV	Chatham, Durham, Franklin, Granville, Johnston, Lee, Orange, Person, Vance, Wake, Warren	
HSA V	Anson, Bladen, Brunswick, Columbus, Cumberland, Harnett, Hoke, Montgomery, Moore, New Hanover, Pender, Richmond, Robeson, Sampson, Scotland	
HSA VI	Beaufort, Bertie, Camden, Carteret, Chowan, Craven, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Jones, Lenoir, Martin, Nash, Northampton, Onslow, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington, Wayne, Wilson	

Staff Recommendations

- Consider pros and cons of large county groupings
  - Will offices be concentrated in urban areas?
  - Does this matter? If office is in urban area, can it supervise staff and services anywhere in the service area? Yes.
- Meaning of “agency” or “office”
  - 10A NCAC 13J .0903(c)
    - The license shall be posted in a prominent location accessible to public view within the premises. The agency shall also post a sign at the public access door with the agency name.
  - Must the agency/office be located in the service area with the need determination? Yes, under the current methodology.