



AFFINITY

HOSPICE & PALLIATIVE CARE

Delivered Via Email

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Cooper Linton, Chair
Hospice Workgroup

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Re: Comments on Hospice Home Care Methodology for Need Determinations

Dear Members of the Hospice Home Care Methodology Workgroup, the State Health Coordinating Council, and the Healthcare Planning Department:

Thank you for the opportunity to provide comments on the ongoing review of North Carolina's hospice home care methodology for need determinations. Affinity Health Management appreciates the thoughtful discussion reflected in the workgroup's recent meeting and commends the State Health Coordinating Council and Healthcare Planning staff for engaging providers in this important evaluation. We welcome the chance to share our perspective based on our experience developing, operating, and supporting hospice and home care agencies.

Affinity Health Management principles have been involved in hospices for more than 14 years. Today Affinity owns 28 hospice agencies in 15 states and the District of Columbia. We are an active member of the National Hospice and Palliative Care Organization and a member of North Carolina Home Care and Hospice Association. Affinity home care hospice offices serve people from most demographics, including in rural and underserved communities.

We understand the impact of methodologies on hospice access in CON states. Our comments are offered in the spirit of collaboration, with the goal of ensuring that the Work Group's proposed changes to North Carolina's need methodology accurately reflects real-world hospice operations and supports timely access to services. Our comments focus on three topics:

- minimum number of patients served for a successful hospice home care agency
- geographic organization of need
- CMS acceptance of 60 mile limits.

Patient Threshold for Need Determinations

North Carolina's current hospice home care methodology establishes a threshold of 90 patients to trigger a determination of need within a county. Our experience indicates this threshold is unnecessarily high and does not reflect operational realities. An efficient hospice can succeed with 40 patients. NC history demonstrates that few new hospices are reaching this threshold in the first two years.

Affinity experience with viable hospice home care agencies when the patient census is as low as 30. These agencies provide high-quality, compliant hospice services and the modest size meets the needs of small community niches in urban and rural areas. The current higher threshold effectively precludes new hospice development in many rural North Carolina counties. Small subgroups in urban areas may have similar challenges.

The combination of high threshold with county as the defined service area disproportionately limits access in rural counties and smaller population centers. The 2026 SMFP shows lower penetration rates in many small rural counties. Residents may experience limited provider choice or delayed access to hospice services simply because the methodology precludes a closer provider.

A lower need threshold would better align the methodology with actual hospice practice and would promote improved access to care across the state.

Service Area Definition

Affinity also encourages the Work Group to consider an alternative to single-county service areas for hospice home care need determinations. In practice, hospice agencies frequently serve patients across county lines. Restricting service area definition to individual counties does not reflect how care is delivered and may artificially mask need in a group of counties.

We support the concept of multi-county service areas as a more realistic and flexible approach. During the recent workgroup discussion, several alternatives were suggested, including the use of the six established North Carolina Health Service Areas. While these regions offer administrative simplicity, they may be too large and heterogeneous to accurately recognize localized need, utilization patterns, and population characteristics.

Single county may be adequate when the population is 200,000 or more. For the remaining 88 to 90 counties, defining the service area at the HSA level might offer better access. A more tailored approach to grouping counties could better address the access goals of the hospice need methodology. An evaluation that considers population size, population growth, geographic proximity, and existing provider distribution may result in service areas that more accurately reflect patient access and provider capacity. Such an approach would allow the methodology to be responsive to regional differences while avoiding the limitations of both single-county and overly large regional service areas.

Geographic Practicalities and Travel Considerations

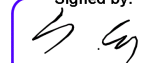
We encourage the Workgroup to acknowledge the geographic constraints under which hospice providers operate. While not explicitly stated in regulation, many agencies adhere to an informal “60-mile from the agency office” standard, influenced by Centers for Medicare and Medicaid Services Conditions of Participation and operational best practices. This expectation affects staffing, response times, and the ability to provide consistent, high-quality care.

Recognizing this practical travel limitation when grouping counties could further improve the realism and effectiveness of the methodology. Counties that fall within reasonable travel distances of one another may naturally form functional service areas, while those separated by greater distances may not, regardless of administrative boundaries.

Closing

Thank you again for the opportunity to comment and for your continued commitment to thoughtful health care planning in North Carolina. Affinity would welcome the opportunity to provide additional information or participate in further discussions as this process moves forward.

Respectfully submitted,

Signed by:

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