



LEADERSHIP
VOICE
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IMPACT

HPCON - received - 8/09/2017

August 9, 2017

Denise Michaud
Chair, Long-Term and Behavioral Health Committee
State Health Coordinating Council
c/o North Carolina Division of Health Service Regulation
Healthcare Planning and Certificate of Need Section
2704 Mail Service Center
Raleigh, NC 27699-2704

Dear Ms. Michaud:

The Carolinas Center for Hospice and End of Life Care (The Carolinas Center) is the only North Carolina organization exclusively representing hospice and palliative care providers. We have worked on behalf of hospices in the Carolinas for more than 40 years and we are proud to represent the many exceptional hospice programs that work in our state.

Hospice is an interdisciplinary team-based approach to care that offers whole person support to individuals who are within 6 months of their anticipated death. Hospice provides physical, spiritual, psycho-social and bereavement support to individuals and their families at one of life's most vulnerable times.

The Carolinas Center supports the annual state medical facilities planning process and related Certificate of Need laws and regulations. We appreciate the opportunity to submit these comments to the State Health Coordinating Council for its consideration.

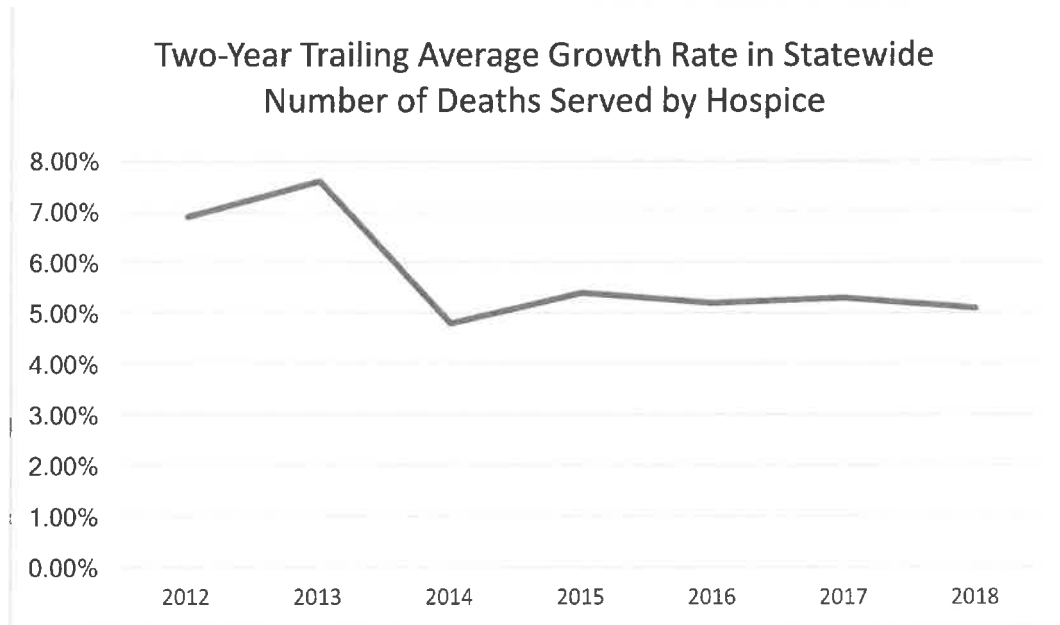
In particular, we would like to offer general comments on the three submitted petitions related to requests for Adjusted Need Determinations for Hospice Home Care Agencies in Harnett, Hyde and Mecklenburg Counties. In a year when one such petition would be an anomaly, having three petitions for an adjusted need determination suggests further study is needed. In fact, of the available archived petitions on the Division of Health Service Regulation's website dating back to 2008, there have been **zero** petitions asking for an adjusted need determination for a new hospice home care agency. Because of this year's unusual petition activity, we believe that it is important to pause and conduct a deeper analysis.

The state and national hospice landscapes are rapidly evolving. Hospice providers in North Carolina, many of which are community-based nonprofit organizations, are asked to meet increasing numbers of complicated and costly federal regulatory requirements. These federally-imposed changes come at a time of declining hospice lengths of stay – a 3.2-day decline (or 15.5%) in median length of stay since 2006, to 17.4 days in 2015.¹ Together with increased oversight of the industry and consolidation of hospice programs throughout the state through mergers, acquisitions and closings, it is difficult to understand why there might be additional need for hospice home care services in the three counties for which petitions were filed.



The Carolinas Center
Innovation and Excellence in Advanced Illness at End of Life

According to data presented in the State Medical Facilities Plans from 2012-2017 and in the proposed 2018 State Medical Facilities Plan, the two-year trailing average growth rate for hospice deaths served has been flattening. We do not believe this trend is in any way related to access, but rather, results from a complex set of factors related to the healthcare system's competing incentives and available services.



Data Source: 2012 – 2017 State Medical Facility Plans; 2018 Proposed State Medical Facilities Plan

Previously mentioned consolidation and competing provider incentives affect the decisions made by individuals about the healthcare they receive. Hospice service is an individual choice, currently only available to those willing to forego curative treatment. New (and promising) medical developments are being made in treating advanced and serious illness, resulting in later referrals (if any) to hospice. While hospice long has been understood to be the 'gold standard' of care in medicine, the complexity of facing one's end of life does not make it easy to choose hospice over other types of medical care.

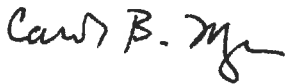
All three of the current petitions note that they support the current methodology for hospice home care agencies, though some of the petitioners put forward that the methodology was not working in two specific counties (Harnett and Hyde). The last time the Hospice Home Care methodology was reviewed was 2009 after some evidence that the prior methodology was not working as designed. Given the new set of petitions for adjusted need determinations, it seems prudent for the SHCC to appoint a Task Force to allow for the current hospice home care methodology to be studied.

In the case of the Harnett petition, it is noted that of the five-licensed hospice home care agencies located in the county, only three of them have provided services to Harnett County during the past three years. It should also be noted that Harnett County residents received hospice services from 22 different licensed providers,ⁱⁱ many of which are located in nearby counties. This latter point suggests that access to hospice services is not a problem in Harnett County. It does, however, raise one potential issue for further study around the alignment of Certificate of Need and Licensure and what constitutes an appropriate service area for hospice home care agencies.

The Carolinas Center believes that North Carolina's State Medical Facilities Planning process works and has served our state well as is evidenced by the excellent healthcare services available statewide. We ask the State Health Coordinating Council to exercise caution when considering the three petitions, as we believe the 2018 Proposed State Medical Facilities Plan reflects the true need of the state with respect to hospice home care agencies. We urge the State Health Coordinating Council to consider appointing a Task Force to study the Hospice Home Care methodology.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "Carol B. Meyer". The signature is fluid and cursive, with a long, sweeping tail on the final letter.

Carol B. Meyer
President & CEO

ⁱ NHPCO Facts and Figures 2015, 2012, National Hospice and Palliative Care Organization.

ⁱⁱ 2018 Proposed State Medical Facilities Plan, Table 13A.