March 22, 2018

VIA ELECTRONIC MAIL
(DHSR.SMFP.Petitions-Comments@dhhs.nc.gov)

North Carolina Division of Health Service Regulation
Healthcare Planning and Certificate of Need Section
2704 Mail Service Center
Raleigh, NC 27699-2704

Re: Opposition to Petition Submitted by LeadingAge North Carolina Proposing Policy Change for Home Health Agencies

Dear Sirs and Madams:

The Association for Home and Hospice Care of North Carolina ("AHHC") appreciates the opportunity to provide written comments in opposition to the petition submitted by LeadingAge North Carolina ("Petition"). On behalf of our hundreds of provider members and the hundreds of thousands of patients they serve, AHHC requests that the State Health Coordinating Council ("SHCC") deny the Petition outright for the following reasons:

- **The Petition does not meet the basic requirements for a petition seeking a policy change, as set forth in the 2018 State Medical Facilities Plan ("SMFP").** LeadingAge has provided no data showing the need for this policy change. LeadingAge has also offered no argument on how the broader trends highlighted in its Petition are not adequately captured in the existing home health need methodology or how its proposed carve-out for LeadingAge's members would actually address the growth of home health and the elderly population. Simply put, the proposed policy is a solution in search of a problem.

- **The Petition would create a biased playing field.** LeadingAge seeks a carve-out for one type of provider while requiring every other type of provider to go through the full Certificate of Need ("CON") process. In so doing, continuing care

retirement communities ("CCRCs") would be given preferential treatment over all other providers currently providing home health services or interested in providing home health services.

- **The Petition raises a host of patient care and regulatory compliance problems and is <u>inconsistent</u> with the Basic Principles.** The Petition states that it intends to limit competition. The Petition does not adequately address the serious concerns with providing home health services and meeting the Medicare Conditions of Participation with such a small census of potential patients. In fact, LeadingAge cannot even provide an estimate of how many patients that CCRCs would project to serve if they were granted this exemption.

For these reasons and the reasons detailed below, we ask that the Division of Health Service Regulation ("DHSR") recommend that the Petition be denied and that SHCC deny LeadingAge's Petition. Because of the complex and important issues underlying the Petition and the several misleading statements that LeadingAge makes in its Petition, we begin our comments by providing a detailed background on the following: (1) AHHC and its involvement in the health care planning process in North Carolina; (2) the history of health care planning for home health agencies in North Carolina; (3) the dearth of demonstrated CCRC interest in home health CONs; (4) the prior <u>legislatively driven</u> carve-outs for CCRCs for skilled nursing and adult care home beds; (5) LeadingAge's failed legislative efforts to obtain similar legislation exempting CCRCs from home health CON requirements; and (6) the distinguishing factors involved in the South Carolina health plan policy for CCRCs. After providing this background, AHHC sets forth its reasons the Petition should be denied in its entirety.

BACKGROUND

AHHC

AHHC is a comprehensive association, representing the full continuum of home care, private duty, companion-sitter, skilled home health care, hospice and palliative care (both outpatient and inpatient), and Program for All-inclusive Care for the Elderly ("PACE") providers. AHHC is one of the nation's oldest and is the largest full-continuum state home care and hospice association in the United States. AHHC represents more than 825 licensed agencies serving patients in all 100 North Carolina counties. In 2017, North Carolina home health, home care, and hospice agencies employed over 100,000 people and provided home care, home health, or hospice services to over 350,000 North Carolinians. AHHC members work closely with their CCRC partners to provide home health and hospice to residents of CCRCs that are eligible for these services.

AHHC has been a steadfast contributor to and supporter of the dynamic and forward-looking need methodology that has been a part of the planning process for home health agencies since the SMFP's inception. AHHC has had numerous members serve on SHCC in at-large seats and the dedicated seats for home health and hospice.

Brief History of Home Health Agency Health Care Planning in North Carolina

Since 1977, when the current CON law was enacted by the General Assembly, the development or other establishment of a home health agency has required a CON. N.C. Sess. Law 2011-1977; *see* N.C. Gen. Stat. § 131E-176(9b), (12), (16). Under current law, a "home health agency" is defined as "a private organization or public agency, whether owned or operated by one or more persons or legal entities, which furnishes or offers to furnish home health services." *Id.* § 131E-176(12).

> "Home health services" means items and services furnished to an individual by a home health agency, or by others under arrangements with such others made by the agency, on a visiting basis, and except for paragraph e. of this subdivision, in a place of temporary or permanent residence used as the individual's home as follows:
>
> a. Part-time or intermittent nursing care provided by or under the supervision of a registered nurse;
>
> b. Physical, occupational or speech therapy;
>
> c. Medical social services, home health aid services, and other therapeutic services;
>
> d. Medical supplies, other than drugs and biologicals and the use of medical appliances;
>
> e. Any of the foregoing items and services which are provided on an outpatient basis under arrangements made by the home health agency at a hospital or nursing home facility or rehabilitation center and the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in his home, or which are furnished at such facility while he is there to receive any such item or service, but not including transportation of the individual in connection with any such item or service.

Id. As stated in the 1986 SMFP: "[t]he objective of home health services is to restore, rehabilitate, or maintain patients in their own homes by providing professional care and/or supervision." 1986 SMFP p. 94. Although the methodology for determining need for new home health agencies has evolved over the years, the methodology has always

been based on population growth and utilization.

Since its inception, the home health methodology has led to reasonable growth in home health agencies. For example, the 1986 SMFP states: "The number of home health agencies in this State has gradually increased over the past ten years." *Id.* At that time, North Carolina had 117 certified home health agencies. *Id.* 99 of 100 counties had a home health agency operating. *Id.* Residents in all 100 counties had access to home health services. *Id.*

Ten years later, in 1996, the number of certified home health agencies had increased to 233. 1996 SMFP p. 103. The SMFP adjusted the methodology, including increasing the projected deficit needed to justify a new agency from 150 patients to 250 patients. *Id.* The 1996 SMFP also included an adjusted need determination for six new agencies. *Id.* at 107.

Roughly a decade later, the methodology had evolved. The projected unmet need in a county to justify a new agency or office was 400 patients or more. 2007 SMFP p. 206. As of Fall 2006, North Carolina had 214 Medicare-certified home health agencies. *Id.* at 205. Residents in all 100 counties had the choice of agencies. *Id.* at 209–23.

As of Fall 2017, North Carolina has 210 Medicare-certified home health agencies. 2018 SMFP p. 245 (2018). The relative stability of the number of home health agencies over the past ten years is misleading. There have been a number of consolidations and closures in the industry due to reimbursement changes and other issues. The current projected unmet need in a county to justify a new agency or office is 325 patients or more. *Id.* at 246. The need determination methodology has continued to produce the need for new home health agencies. These recent home health need determinations are summarized in the below table. *See* Table 1.

Table 1: New Home Health Agencies or Office Need Determination in 2005–2018 SMFPs		
SMFP Year	**# of New Home Health Agencies**	**Counties**
2005	1	Mecklenburg
2007	1	Wake
2009	1	Mecklenburg
2010	1	Wake
2012	3	Mecklenburg, Wake
2013	2	Forsyth, Brunswick
2017	1	Mecklenburg
2018	2	Wake
TOTAL	**12**	
Source: 2005–2018 SMFPs		

Lack of CCRC Applications or Adjusted Need Petitions by CCRCs to Obtain CON for Home Health Agency

Despite the addition of these new home health agencies or offices, as acknowledged by the LeadingAge representative at the March 5, 2018 public hearing ("Public Hearing"), no CCRC has ever applied for a home health CON. To our knowledge, no CCRC has sought to obtain a home health CON through a transaction either.

The counties identified as having a need for home health agencies since 2005 also align with where CCRCs are located. The below table shows the number of CCRCs located in the counties identified as having a need for a new home health CON. *See* Table 2. For CCRCs not located in these counties, there is also the adjusted need petition process. To our knowledge, no CCRC has filed an adjusted need petition for a home health CON.

Table 2: Select Counties with CCRCs	
Counties	**# of CCRCs**
Brunswick	0
Forsyth	3
Mecklenburg	9
Wake	7
Source: North Carolina Department of Insurance, Licensed Continuing Care Retirement Communities in North Carolina (as of 1/25/2018)	

Prior Legislatively Driven Carve-Outs for CCRCs in the SMFP

In its Petition, LeadingAge references the "precedents" for exemptions for CCRCs. Petition 5–6. The 2018 SMFP contains two carve-outs for CCRCs: NH-2 and LTC-1. The history of these policies, however, easily distinguishes these *institutional bed* policies from the *home health agency* policy proposed in the LeadingAge Petition.

Under the applicable insurance requirements, CCRCs are expected to offer three levels/stages of care offered by CCRCs:

> 1. Independent Living – is for individuals who are capable of doing the basic chores of everyday life but who may need occasional help from others.
>
> 2. Assisted Living – provides assistance for residents with chronic care needs excluding complete 24-hour skilled nursing care. Assisted living services include helping a resident with bathing, dressing, taking medications, and other daily activities.
>
> 3. Skilled Nursing Care – generally provides 24-hour nursing care, rehabilitative services, and assistance with activities of daily living to the chronically ill as well as those who have been

> hospitalized for an illness or operation and require a short period of rehabilitation before returning home.

N.C. Dep't of Insurance, Continuing Care Retirement Communities 2017 Reference Guide I, *available at* http://www.ncdoi.com/SE/Documents/CCRC/CCRC_Guide_2017.pdf; *see* N.C. Gen. Stat. § 58-64-1 (defining "continuing care" to mean "[t]he furnishing to an individual other than an individual related by blood, marriage, or adoption to the person furnishing the care, of lodging together with nursing services, medical services, or other health related services, under a contract approved by the Department in accordance with this Article effective for the life of the individual or for a period longer than one year"); 11 NCAC 11H .0101(a)(2) (defining "health related services" to mean "domiciliary (rest home) care or Homes for the Aged, skilled or intermediate nursing, nursing home or rest home admission, or priority admission into a facility, unit, or bed providing any of the above-named services"). Unlike adult care home beds and nursing home beds, nothing in the applicable statutes and rules requires a CCRC to offer or provide home health services.

CCRCs are the successors of "life care" or "care for life" institutions. In 1983, recognizing that some of these institutions should be permitted to develop skilled nursing facilities or intermediate care facilities for their residents, the General Assembly enacted legislation that temporarily exempted some of these institutions from the need determination process under the SMFP. *See* N.C. Sess. Law 1983-920. The exemption language in the legislation was similar, though not identical, to the current NH-2 policy. For example, the exemption only applied to certain types of life care institutions. The most notable difference between the legislation and the current NH-2 policy is that the legislation actually prohibited the facilities from being certified for participation in the Medicaid program or the Medicare program.

In 1985, the General Assembly again enacted legislation that exempted certain life care facilities from the need determination process and required the Department of Health Resources (the precursor to the Department of Health and Human Services) to study the feasibility and

impact of applying the exemption to all life care facilities. This legislation generated Policy C.1—"Development or Conversion of Beds in Continuing Care Facilities"—which eventually became Policy NH-2. This policy, first included in the 1985 SMFP, permitted CCRCs to develop new or additional skilled nursing and intermediate care nursing beds or convert domiciliary care beds to nursing beds. 1986 SMFP p. 35. Like the 1983 and 1985 legislation, the initial policy prohibited CCRCs from certifying these beds for participation in Medicaid or Medicare. *Id.* at 36. Eventually, the restriction for Medicare participation was removed.

In 2001, the General Assembly enacted legislation that subjected adult care home beds to CON regulation. In that legislation, however, the General Assembly specifically stated that the CON requirement would not apply to adult care home beds that were part of a continuing care facility. N.C. Sess. Law 2001-234.

As noted in the 2002 SMFP, in response to this legislation, a new policy LTC (which eventually became LTC-1) was developed to permit CCRCs to develop or add adult care home beds without regard to the need determination process. 2002 SMFP p. 15. This policy was consistent with the CCRC's obligation to provide this level of care to its residents and the legislature's direction to exempt CCRCs from the need determination process. Neither factor is present in LeadingAge's Petition to exempt CCRCs from a home health agency need determination.

As stated in the 2018 SMFP, Policy LTC-1 and NH-2 both limit the beds created under either policy to people who have a continuing care contract and who have lived in the CCRC for at least 30 days. Tellingly, LeadingAge's proposed policy for home health does not include any residency requirement.

The development and history of these policies that would become Policy NH-2 and Policy LTC-1 both underscore the specific charge of CCRCs and the need for General Assembly direction. They, however, do not serve as "precedent" for LeadingAge's proposed policy change for home health.

Prior Failed Legislative Attempts to Exempt CCRCs from CON

Prior to filing the current Petition, for the past several years, LeadingAge has lobbied for legislation that would completely exempt CCRCs from the home health CON requirement. In 2013, LeadingAge was able to get a bill introduced. N.C. House Bill 900 (2013). More recently, LeadingAge lobbied for legislation that would create a pilot program that would exempt ten CCRCs from the home health CON requirement. N.C. House Bill 941 (2015). Neither piece of legislation was passed by either chamber. Still, both pieces of legislation attempted to limit CCRCs' ability to provide services only to residents. The 2015 legislation offered to limit the number of CCRCs that could be exempt and put an 18-month time limit on its pilot. LeadingAge has abandoned all of these limitations in its current Petition.

Carve-Out for CCRCs in South Carolina

In its Petition, LeadingAge references and quotes the South Carolina Health Plan language that permits a CCRC to provide home health services. Unlike the proposed policy change in the Petition, the South Carolina exemption is limited to patients who actually reside in a CCRC unit. As acknowledged by LeadingAge, there are "differences in methodologies from state to state regarding Certificate of Need regulations." Petition 7.

In South Carolina, there are a total of 93 licensed home health agencies. 12 of these agencies are CCRC-based. S.C. Dep't of Health & Env't Control, Home Health Agencies (Mar. 6, 2018), *available at* http://www.scdhec.gov/Health/Docs/LicensedFacilities/hrhha.pdf. With one exception, the CCRC-based home health agencies have restrictions on their license that only permit them to serve campus residents. *See id.* More importantly, none of these CCRC-based home health agencies are certified to participate in the Medicare program. *See* Home Health Compare Website, https://www.medicare.gov/homehealthcompare/. This means that they are not required to comply with the extensive and burdensome Medicare Conditions of Participation.

LeadingAge's Petition does not prohibit CCRCs from participating in Medicare. In fact, one of the aims stated by the LeadingAge representative at the Public Hearing was to allow CCRCs to tap into the additional Medicare revenue. LeadingAge's entire gambit into this space is predicated on its ability to tap into additional revenue sources, as demonstrated in this slide prepared by the national LeadingAge organization.

REASONS WHY THE PETITION SHOULD BE DENIED

This extensive background makes obvious why LeadingAge's Petition should be denied. Before turning to the more substantive reasons for denial, we first explain why the Petition should be summarily denied because the Petition fails to meet the basic requirements under the 2018 SMFP.

I. The LeadingAge Petition Should Be Summarily Denied for Not Meeting the SMFP Requirements.

The 2018 SMFP sets forth the requirements for any petition requesting a proposed change to the policies. The SMFP requires the petition to include the following:

> a. A statement of the adverse effects on the providers or consumers of health services that are likely to ensue if the change is not made, and
>
> b. A statement of alternatives to the proposed change that were considered and found not feasible.

2018 SMFP p. 7.

The Petition is devoid of any evidence of harm to providers if the proposed change is not made. The reality is that CCRCs are not harmed by the existing policy. They are in the same position as any other health care provider. They can compete for a CON, acquire a CON through transaction, and request an adjusted need determination or submit an adjusted need petition. No evidence has been presented showing an inability for CCRCs to compete for new home health CONs or to acquire existing CONs. CCRCs are able to compete for and acquire CONs just like any other healthcare provider. As admitted at the Public Hearing, CCRCs have simply chosen not to apply for new CONs. The Petition rewards them for standing on the sideline.

Similarly, the Petition lacks any evidence of harm to consumers of health services if the change is not made. According to the statements made in support of the Petition at the Public Hearing, it would appear that the intended "beneficiaries" of this policy change are CCRC residents. As detailed below, however, the proposed policy does not create any such limitation. At the Public Hearing, the LeadingAge representative had to admit that there is no existing concern that CCRC residents lack access to home health services or have any quality issues with their home health services. The closest thing to evidence is LeadingAge's reference to Patient Satisfaction Scores. But these

statements are mere speculation.

The SMFP also requires that petitions provide "[e]vidence that the proposed change would not result in unnecessary duplication of health resources in the area." *Id.* The Petition does not even reference the possibility of unnecessary duplication. On its face, however, the proposed policy change would do exactly like that. Every CCRC resident currently has a choice of multiple home health agencies. Adopting the proposed policy change would create additional home health agencies for these residents (and potentially others) beyond any need shown in the existing methodology.

Finally, the SMFP requires that petitions provide "[e]vidence that the requested change is consistent with the three Basic Principles governing the development of the North Carolina State Medical Facilities Plan: Safety and Quality, Access, and Value." *Id.* at 8. Although the Petition makes passing reference to the three Basic Principles, the Petition does not provide any evidence that the proposed policy is consistent with Safety and Quality, Access, and Value.

The Petition fails to present any data showing issues for patients under contract with CCRCs with access to care, quality of care, or provider choice. Current CCRC residents who require home health services are currently being seen by Medicare-certified home health agencies with valid CONs. At the Public Hearing, the proponents had to admit that they did not have any evidence of quality or access concerns for CCRC residents receiving home health services. As discussed below, the proposed policy is inconsistent with the three Basic Principles.

II. The Proposed Policy Change Does Not Address the Larger Trends Identified in LeadingAge Petition.

The Petition cites dated statistics showing the growth of home-based care and the elderly population. While both of these trends are true, they are adequately captured by the existing need methodology for home health services in the SMFP. The proposed policy creates a carve-out for a specific provider type. By LeadingAge's own admission,

CCRCs serve a small fraction of the aging population. The Petition is devoid of any data showing how the proposed policy would actually address the larger trends noted.

LeadingAge did not produce any data on the number of CCRC residents that receive home health services. Assuming the highest home health use rate in the 2018 SMFP, and based on the number of CCRC residents who live on campus but do not reside in a skilled nursing facility bed, the total population is probably less than 2,500 people. All of these individuals already have access to quality home health services.

The Petition also references the development of value-based payment models. AHHC and its members are actively involved in the development of and participation in these models. The Petition, however, fails to describe how CCRCs are participating in these reforms or how providing them a carve-out from the home health CON need determination requirement will address the movement from volume to value.

The only argument that the Petition makes for the policy change that is actually connected to the proposed policy change is that CCRC residents supposedly want to be served by CCRC home health agencies. This claim, however, is unsupported by any evidence. The proponents at the Public Hearing admitted that they do not have any data to support this claim—only anecdotes. The Petition also asserts resident "confusion" and a potential reduction in Patient Satisfaction Scores but again fails to provide any evidence of this actually occurring.

III. The LeadingAge Petition would Create a Biased Playing Field.

AHHC believes in and appreciates efforts to reform and improve the CON system in our State. The LeadingAge Petition, however, is not reform. This request simply gives preferential treatment to one type of provider.

Unlike the prior policies for CCRCs, the proposed change is not tied to the applicable licensure requirements. CCRCs are not required to offer home health services to their residents. As explained in the Background section, the proposed change is not legislatively driven, in contrast to Policy LTC-1 and NH-2. In fact, the General Assembly has rejected prior legislative attempts by LeadingAge for a CON exemption for home health.

Further, the argument for CCRCs to develop nursing home and adult care home beds without regard to the SMFP need determination is more consistent with the CCRC model. Residents of CCRCs who desire to remain on campus while their needs are changing can do so by moving into different bed types on campus. By permitting CCRCs to develop nursing home and adult care home beds, CCRC residents can remain on campus while their level of care increases. No such argument exists for home health services. These services already are provided on campus and will continue to be provided by Medicare-certified home health agencies.

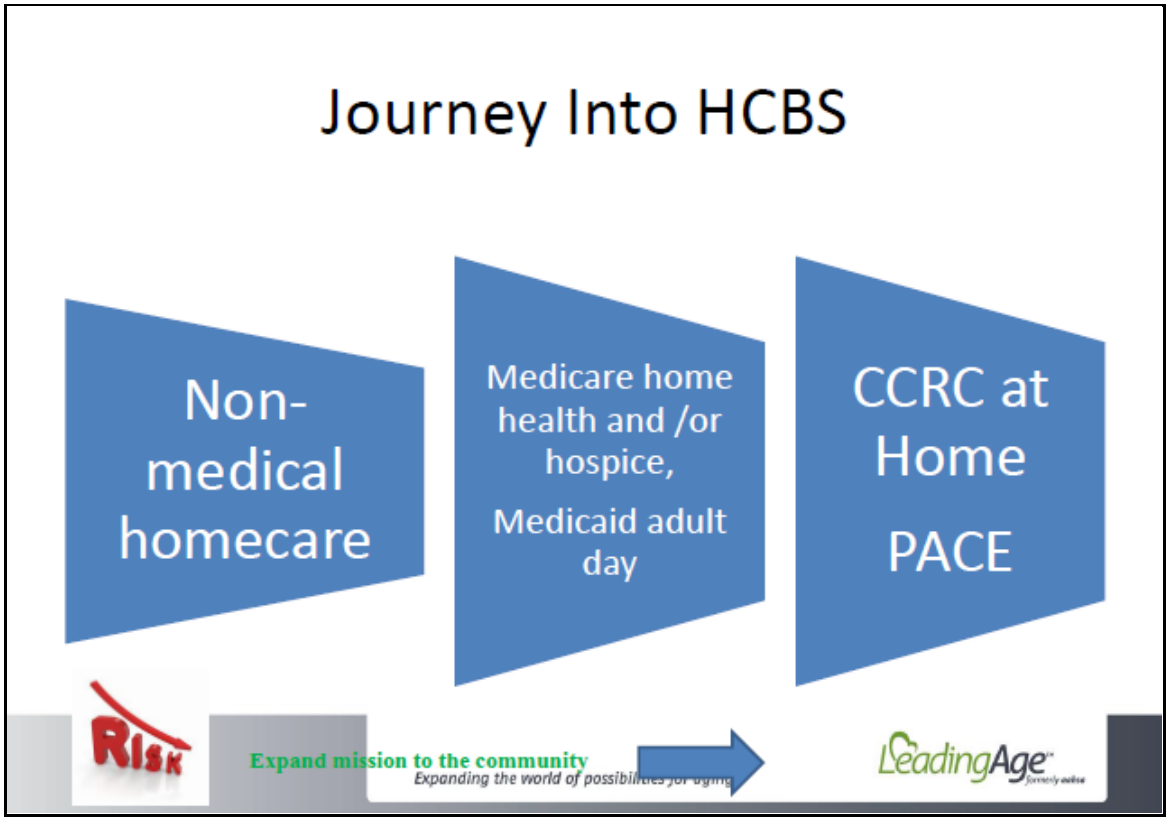
All existing home health agencies had to compete with other providers for a Certificate of Need. This was true regardless of whether they were hospital-based, independent, connected to a nursing home, or otherwise. After that investment, home health agencies then had to undergo surveys, accreditation processes, quality assurance, and license reviews, all in order to be able to provide quality, cost-effective services to patients, many of whom are Medicare and Medicaid recipients.

If the proposed change were made, the result would be two classes of providers: one class that had to go through the CON process, one class that did not. If approved, other providers would likely seek similar exemptions, arguing that their patients or residents also wanted to receive home health (or other CON-regulated health care services) from them. If LeadingAge can obtain this policy exemption without a scintilla of evidence, what is to prevent home health agencies from arguing that their patients want to receive surgical procedures from the home health agency and therefore should be exempt from the need determination for operating rooms?

This concern is not hypothetical. CCRCs have already expanded existing exemptions beyond their original intent. CCRCs have also tipped their hand that home health is just a stepping stone to hospice. Historically, CCRCs in North Carolina obtained narrow, conditional exemptions and then expanded them. For example, the initial legislative exemption for nursing home beds for CCRCs was conditioned on the beds not being certified for Medicare. Now, the CCRC beds can be Medicare-certified, and CCRCs rely upon Medicare as a significant revenue source.

LeadingAge's national organization has framed expansion into home health as part of a "journey" into PACE and hospice. *See, e.g.*, Peter Notarstefano, Expanding Into Home & Community-Based Services 14, *available at* http://www.leadingagedc.org/wp-content/themes/leading/custom/images/2016/07/1045-session-LeadingAgeDC2016-Expanding-HCBS.pdf.

The following slide from a recent LeadingAge presentation illuminates CCRCs' larger ambitions.



IV. The Proposed Change is Inconsistent with the Value Principle.

The degrading of CON protection for home health has proven costly in other states. There are examples of the grave consequences of creating exemptions for home health in many states, including Texas and Florida. The result is increased healthcare costs and increased taxpayer bills to cover the Medicaid and Medicare program. The CON process for home health ensures that North Carolina has a sufficient number of providers while avoiding the pitfalls we have seen in other states.

North Carolina has the lowest Medicare home health expenditures in the region and does so while maintaining excellent quality measures. These accomplishments are due in large part to the CON process for home health in North Carolina.

LeadingAge's conflation of skilled nursing facilities with home health agencies throughout the Petition suggests that CCRCs do not appreciate the difference between these two health care delivery models and the need for them to operate separately. When LeadingAge has advocated for this change in the past, its representatives have argued that CCRC residents would be able to have the same nurse across service lines. The sharing of staff would not be feasible under the Skilled Nursing Facility Conditions of Participation and Home Health Conditions of Participation.

V. The Proposed Change is Inconsistent with the Safety & Quality Principle.

Providing quality home health services only within the confines of a CCRC campus would not be feasible and would create quality-of-care concerns. The LeadingAge Petition makes no attempt to capture the number of CCRC residents that would be eligible for home health services and would choose to receive these services from a CCRC.

Given the small percentage of a CCRC's population that would be eligible for home health services, a CCRC would not come anywhere close to the 325-patient threshold needed for a new agency. The largest

CCRC in North Carolina has a total of 734 residents. In order for the CCRC to have a sufficient census to justify a new home health agency, half of its residents would have be to home health eligible, none would have to access other providers, or, if they did, all of the eligible residents would have to choose the CCRC to receive home health services. Of course, none of these assumptions is realistic. The largest community actually has only 674 residents who could *potentially* be eligible for home health since those occupying nursing home beds could not be eligible. If we applied the highest use rate (for individuals 75 and older for 2016), only 16.3% of these individuals would likely be eligible to receive home health services. That would mean a *highest* potential census of 110 home health patients. In the county in which that CCRC is located, 18 home health agencies served residents in 2016.

The only CCRC that spoke in favor of the Petition at the Public Hearing had 221 non-nursing home bed residents. With a 16.3 percent home health rate (the highest use rate in the 2018 SMFP), that CCRC would have the highest potential census of 36 patients, assuming these residents all chose the CCRC-based home health agency over the 26 existing Medicare-certified home health agencies that served that county's residents in 2016. Simply put, the numbers do not add up.

With such a small number of patients, it would be impractical for the CCRCs to meet the state and federal requirements necessary to provide quality care.

VI. The Proposed Change is Inconsistent with the Access Principle and Would Raise Other Compliance Problems.

As previously discussed, and as admitted by LeadingAge, there is no access issue for CCRC residents. The analysis of the Access Principle should not end there. If the CCRCs served more than their own residents (which the proposed change would permit them to do), the proposed change would be likely to create access issues with home health by diluting the home health market and making it unsustainable for some existing home health agencies to continue to operate. Moreover, because LeadingAge's intention is to limit competition on its campuses, the current CCRC residents who have access to their choice

of multiple home health agencies would find themselves being pressured to only use the CCRC-based home health agency.

Contrary to LeadingAge's promises at the Public Hearing, the proposed policy language does not appear to preclude the CCRC from serving nonresidents. In fact, LeadingAge has abandoned its prior legislative proposals (and the restrictions in the nursing home and adult care home bed policies) that create a 30-day residency requirement.

With CCRCs' new "campus without walls" philosophy, essentially any Medicare patient could be considered a CCRC resident so long as he entered into a contract with the CCRC. The CCRC industry, led by LeadingAge, has made the expansion of continuing care beyond the existing campuses a top priority in recent years. The industry refers this service creep as "CCRCs without walls" or "Continuing Care at Home." Carlo Calma, "Providers Continue to Expand CCRC Without Walls Model," Senior Housing News (Sept. 4, 2017), *available at* https://seniorhousingnews.com/2017/09/04/senior-living-providers-love-ccrcs-without-walls/; LeadingAge, "Evolution of the Continuing Care at Home Business Model," Education Spotlight, *available at* http://www.leadingage.org/distance-learning/education-spotlights/continuing-care-home/evolution-continuing-care-home-business (last visited Mar. 20, 2018).

As Stephen Maag, director of residential communities for the national LeadingAge was quoted as saying in a 2012 *New York Times* article: CCRCs are "now getting a recognition there is a significant market out there of people we haven't been serving, and that represents an opportunity." Judith Graham, "A Choice of Community Care, in Your Own Home," N.Y. Times (Sept. 17, 2012). According to the most recent survey of the 150 largest CCRCs, approximately 54% offer some type of home and community-based services to non-residents. LeadingAge Ziegler 150, at 11 (14th ed. 2017), *available at* http://eziegler.com/Files/LZ150-2017_FINAL.pdf.

The Petition, if granted, would raise serious provider choice issues. Although LeadingAge pays lip service to patient choice, its

intention to limit competition and patient choice is made obvious in its own words: "This Petition aims to provide some alleviation to the confusion and fragmentation of post-acute care by limiting the number of service providers caring for the CCRC population." Petition p. 10 (emphasis added).

Even if LeadingAge were to propose restricting the policy change to only CCRC residents, Medicare would not recognize such a limitation. In our discussions with Medicare and its administrative contractor, Palmetto GBA, the enrollment as Medicare home health provider gives the provider the ability to serve any eligible Medicare beneficiary. Medicare would not be able to enforce and would not choose to enforce any restriction tied to a beneficiary's residence on a particular campus. Thus, CCRCs would be able to serve any Medicare beneficiary and would compete with all home health agencies on an unfair playing field.

If CCRCs voluntarily limited their services to CCRC residents, the inadequate census and CCRC's impression that they can borrow staff from other services is indicative of the likely failure to meet the myriad Medicare Conditions of Participation. Because CCRCs in South Carolina are not certified to participate in Medicare, they do not appreciate the significant regulatory burdens required.

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On behalf of our member agencies, AHHC thanks DHSR for the opportunity to provide these comments. We would be happy to provide any additional information that would benefit DHSR or SHCC in its review of the LeadingAge Petition.

Sincerely,

Tracy Colvard
Vice President of Government Relations and Public Policy
Association for Home and Hospice Care of North Carolina