



PETITION FOR ADJUSTMENT TO THE METHODOLOGY FOR NEED DETERMINATION FOR ADULT CARE HOME BEDS IN NORTH CAROLINA

ALG Senior LLC (the “Petitioner”) hereby submits this petition (the “Petition”) to adjust the need determination calculation methodology for adult care home (“ACH”) beds in the State Medical Facilities Plan (“SMFP”) due to the difficulty of projecting future need using the current methodology when there is a significant, albeit temporary, change in utilization, detrimentally impacting the safety and quality, access, and value of future ACH services.

1. PETITIONER

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2. STATEMENT OF THE PROPOSED CHANGE

Petitioner proposes revising the Healthcare Planning and Certificate of Need Section’s methodology for determining bed need to make it more flexible in the event of temporary decreases in ACH bed utilization. Petitioner proposes a change to the need determination calculation methodology either

- i. temporarily, by developing and using an alternative method only when there has been some temporary impact on census by something sweeping in a service area or statewide; or
- ii. permanently, by rethinking the methodology overall so that it is more sensitive to growth in senior populations across the board, and less inextricably tied to utilization.

Petitioner believes that the methodology ultimately needs to encourage steady development where there is steady growth in the elderly population, especially as the trend in development of ACH facilities is just a few larger providers accounting for the majority of Certificate of Need (“CON”) applications.

Petitioner does not propose to advise the Healthcare Planning Section of precisely how this should be accomplished, as the Section staff are the experts at working with the data the agency receives from providers.

3. STATEMENT OF REASONS FOR THE PROPOSED CHANGE

As set forth in the 2022 SMFP, ACH bed utilization statewide declined substantially due to the COVID-19 pandemic. The negative impact of COVID-19 on ACH utilization statewide essentially obliterated need determinations and deficiencies in ACH beds in the 2022 SMFP using current Agency methodology. This methodology was not designed to account for pandemic conditions or other temporary decreases in demand for ACH beds, and the COVID-19 pandemic has shown light on the difficulties with primarily relying on recent past bed utilization when projecting bed need for the future. The majority of the substantive census losses in long-term care settings may reasonably be expected to be temporary, even with the tragic deaths in the senior population and some lasting changes to the senior housing market due to COVID-19.

Petitioner, a consultant for over 100 ACH facilities in 65 counties in North Carolina, has continuous and updated access to ACH census data statewide. As a result, Petitioner can evaluate census and utilization trends of the communities it supports without having to wait for license renewal application (“LRA”) data to become available for other ACH facilities. Petitioner also supports facilities with a variety of payor mixes, providing a representative cross-section of ACH operational data. Utilizing data from this considerable dataset, Petitioner was able to illustrate the impacts of COVID-19 on ACH bed utilization that it believes to be representative industry-wide and statewide.

Across the total portfolio of facilities with which ALG has a consultancy relationship, total average census dropped from about 85% to approximately 62% during the worst of COVID-19. However, census numbers are improving, and portfolio-wide, utilization is now approximately 72%. Even with ACH bed utilization beginning to rebound, Petitioner is concerned that this period of low utilization will artificially suppress bed need for years to come because of the heavy dependence of the current ACH bed need calculations on actual utilization. The usefulness of the method is limited by its inability to adjust for events with wide-spread significant impacts on current or recent past utilization, such as those created by COVID-19. Petitioner believes that North Carolina ACH providers will not be prepared to meet the increased need that will result from the rapidly aging population, because the SMFP will underestimate need for several years to come.

The wide-reaching negative effects of the COVID-19 pandemic on ACH providers and residents have been undeniable. However, much of this negative impact appears to be slowly resolving as we move into a period during which effective vaccines are widely available, many existing residents and staff are vaccinated, transmission of COVID-19 is more localized, visitation and access to facilities are restored whenever possible, personal protective equipment (PPE) is widely available for use, and we better understand how to manage risks during localized outbreaks. Challenges remain, especially with the emergence of new strains of COVID-19, as we witnessed recently with the Omicron variant surge, but the need for long-term care is not going away—especially as growth of our senior population continues. North Carolina will

especially have a need for affordable long-term care that is accessible to a wider range of the aging population.

COVID-19's Impact on the Safety and Quality of ACH Care

The COVID-19 pandemic has had a significant impact on the safety and quality of existing care, causing providers to have to rethink operations to improve infection control, care of residents, staffing, and also address the rapidly accelerating medicalization of assisted living.

When COVID-19 was first recognized in the United States, news of illness and death in congregate care settings spread quickly. Without a clear understanding of the virulence and transmission of this deadly novel coronavirus, access to immunizations and adequate PPE, long-term care providers struggled to contain the deadly illness and to protect residents from harm. As disease containment measures became more effective, providers have struggled to educate a public that was frightened early on by the devastating deaths in skilled nursing settings about the care that had been taken to reduce risk to residents of ACH beds.

Measures taken to keep residents and staff safe from COVID-19 included limiting contact of facility residents with outside visitors, enacting strict infection control procedures, implementing routine testing for residents and staff, utilizing screening tools designed to keep symptomatic staff out of facilities, and last but not least, undertaking a large-scale campaign to immunize residents and staff. These important steps unfortunately also increased the isolation of residents, creating or exacerbating mental health challenges in residents, also demoralizing staff, families, and residents.

Additionally, as COVID-19 spread, most providers found it increasingly difficult to provide adequate staffing at facilities. ACH providers often had to create special COVID-19 treatment units when facing an outbreak. COVID-19 units typically had dedicated staff who could not work with healthy residents for days or weeks at a time. The need to fully staff multiple units increased the number of staff needed to meet regulatory minimums and, more importantly, to supply the actual needs of residents. It quickly became commonplace for care staff to need to work longer hours or to have to choose whether to work in COVID-19 units, potentially increasing risk of infection to those at home. Staff took on this responsibility while juggling child and family care needs, their own fears, financial impacts, supply shortages, and personal limitations from exposure to or illness from COVID-19. Over time, staffing challenges have persisted and new difficulties have arisen. Providers have found fewer individuals willing to work in healthcare jobs. The choice not to work in healthcare—or, indeed, not to work at all—has become increasingly feasible for some individuals due to the robust financial safety nets developed by the federal and state governments in response to COVID-19.

The effects of COVID-19 had broad negative impacts on the safety and quality of ACH care, created by supply chain disruptions reducing access to PPE and cleaning supplies, staffing shortages, stress and long hours suffered by remaining staff, and the health-compromising

effects of resident isolation and pervasive fear. Tragically, COVID-19 has cost the lives of nearly a million Americans,¹ and the increased susceptibility of the older population to severe disease and death due to COVID-19 has contributed to concerns about the safety of congregate care settings, in which close proximity of residents can make disease spread may be harder to control. Some resident families responded to the fear, uncertainty, isolation, and risks posed by COVID-19 by pulling loved ones out of congregate care settings. Others delayed admission of their loved ones to ACHs. The decreasing census in turn created financial and operational issues impacting the value of and access to care.

The early months of COVID-19 were characterized by uncertainty and fear. However, now that we have lived with COVID-19 for two years, safe and effective vaccines have become available, and infections have surpassed 78 million in the United States, some of that fear has given way to a sense of frustration with pandemic limitations, and many people are clamoring for a sense of normalcy. Our internal statistics show that people across North Carolina are increasingly becoming comfortable with placing loved ones in congregate care settings as part of their new normal, as we learn together to live with the long-term reality of COVID-19.

COVID-19 and the Impact on the Value of and Access to ACH Care

In most ACH settings, and especially those dedicated to providing affordable care, stable operations are achieved by having and maintaining good census at facilities. Losses of census to deaths, illness, and fear associated with COVID-19 has meant significant losses of revenue for ACH providers. Such revenue losses, if sustained for an undetermined period of time, may impact ACH providers' ability to provide affordable care and even to remain in business.

Many providers have had to make difficult choices as census has dropped. In some cases, rate increases have likely resulted, or will result, as providers aim to recover from the losses associated with COVID-19. Some facilities that went into COVID-19 in weak financial condition may struggle to recover and remain in business. We do not yet know the full impact of COVID-19 on ACH finances, but it is fair to assume that increasing costs and closed facilities will decrease the value of and access to ACH care over time.

Current Agency Need Determination Methodology Fails to Capture Actual Need for ACH Beds Now and in the Future

The SMFP need determination methodology, while instructive when utilization remains responsive to typical market pressures, was not designed to be responsive to catastrophic, temporary health crises like COVID-19. The methodology, due to its strong reliance on past utilization to determine future need, inadequately captures the impact of COVID-19 on utilization data when projecting need in the future. LRAs from 2022 (covering utilization from August 1, 2020, through July 31, 2021) and 2023 (August 1, 2021, through July 31, 2022), minimally, are

¹ U.S. Deaths 947,882. Centers for Disease Control and Prevention, COVID Data Tracker, Accessed March 2, 2022; https://covid.cdc.gov/covid-data-tracker/#trends_dailydeaths

likely to reflect utilization depressed by COVID-19. Given that there is a 5-year utilization look-back period included in the bed rate and need determinations, these temporarily depressed utilization numbers due to COVID-19 will likely be included in need calculations in SMFPs from 2022 (capturing the beginning of COVID-19’s impact) through 2028, as shown by the chart below:

**Projected Period of Impact of Depressed Utilization due to COVID-19
on Future Bed Rates and Need Determinations in the SMFP**

| 2022 SMFP | 2023 SMFP | 2024 SMFP | 2025 SMFP | 2026 SMFP | 2027 SMFP | 2028 SMFP | |
|-----------|-----------|-----------|-----------|-----------|-----------|-----------|--|
| 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | Years of utilization included in bed rate and need determination calculation |
| 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | |
| 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | Years of utilization included in bed rate and need determination calculations with COVID-19-related depressed utilization |
| 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | |
| 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | |

In the 2024, 2025, and 2026 SMFPs, when it is reasonable to expect that the entire impact of COVID-19 will be included in bed rates and need determinations, COVID-19’s impact is likely obscure the actual growing need for ACH beds statewide, effecting the development of new ACH beds well into the early 2030s. The disastrous result of this aspect of current methodology will be tremendous unmet need for ACH beds in the future (i.e., a ballooning need for ACH beds all at once).

ACH bed utilization has not completely recovered from COVID-19’s temporary depression as of February 2022, but census losses have reversed, and Petitioner reasonably expects ACH census to recover to pre-COVID-19 levels within the next year. Given the slowing losses of census and the likelihood of a return to utilization at pre-COVID-19 levels, Petitioner is concerned that unless corrections are made now that neutralize the impact of COVID-19 census losses on need determinations for the future, the artificially depressed utilization, combined with the growth projected for senior populations, will create a critical shortage of ACH beds in the future. In short, COVID-19’s effect on need determinations will likely last for years to come. Data from the low-utilization period caused by COVID-19 will contribute to an incorrect prediction that there is no need for ACH beds like we have already seen in the 2022 SMFP. Need determinations and calculations of bed surpluses and deficits must look to the future at least as much as they do to the recent past.

The disastrous result of this aspect of current methodology, combined with tremendous growth in the segment of the population typically most in need of ACH services, will be tremendous unmet need for ACH beds in the future (i.e., a ballooning need for ACH beds all at once).

Given the partial reversal of census losses and the likelihood of a return to utilization at pre-COVID-19 levels, Petitioner is concerned that unless corrections are made now that neutralize the impact of COVID-19 on need determinations for the future, the artificially depressed

utilization, combined with the growth projected for senior populations, will create a critical shortage of ACH beds in the future. In short, COVID-19's effect on need determinations will likely last for years to come. Data from the low-utilization period caused by COVID-19 will contribute to an incorrect prediction that there is no need for ACH beds, as became evident in the 2022 SMFP when bed deficiencies and need determinations were all but eliminated. The tables below illustrate the tremendous projected growth in the senior population over 20 years.

| 2020-2040 Population Growth Percentage - Ages 65+ | | |
|--|-------------------------------|-------------------------------|
| Net change | Percentage Change Ages 65+ | Percentage Change ALL Ages |
| 3,749 | 66.7% | 11.8% |
| <i>Only 12 NC counties are projected to have a greater percentage of growth in the 65+ population between 2020 and 2040, per the OSBM: (Iredell, 71.0%; Granville, 71.3%; Durham, 72.5%; Lincoln, 75.0%; Franklin, 75.3%; Chatham, 78.3%; Currituck, 79.8%; Cabarrus, 90.6%; Mecklenburg, 100.2%; Johnston, 106.0%; Wake, 118.4%; Union, 120.4%)</i> | | |

| 2020-2040 Population Growth Percentage - Ages 75+ | | |
|--|-------------------------------|-------------------------------|
| Net change | Percentage Change Ages 75+ | Percentage Change ALL Ages |
| 2,448 | 126.4% | 11.8% |
| <i>Only 12 NC counties are projected to have a greater percentage of growth in the 65+ population between 2020 and 2040, per the OSBM: (Chatham, 129.5%; Brunswick, 129.5%; Franklin, 129.8%; Durham, 130.1%; Currituck, 142.1%; Johnston, 152.8%; Orange, 155.5%; Mecklenburg, 160.5%; Union, 166.8%; Wake, 190.3%)</i> | | |

This statewide growth in individuals aging into the time of life when it is most likely that they will need ACH services is likely to increase the need for beds even as COVID-19 data suppresses need. Unfortunately, current Agency methodology fails to capture actual ACH bed need due to COVID-19 and other factors temporarily and artificially depressing ACH bed utilization.

A. Statement of the Adverse Effects on the Population to be Served

The Proposal will have no adverse effects on the population to be served or on competition. Instead, the Proposal will allow for appropriately scaled growth of services in North Carolina to meet the needs of those in search of ACH services.

B. Statement of the Alternatives Considered

The primary alternative to this proposal is to leave the methodology unchanged, which Petitioner believes will mean that providers lack the time and resources needed to plan ahead to meet the actual needs of the North Carolina population. The number of groups and individuals developing ACH facilities in North Carolina are relatively small. It takes tremendous time and human and

financial resources to see a facility from idea to reality, including the burdens of complying with the demands of the CON process. Development must be staggered to be effective. A future in which we have a “sudden” need statewide for 20 facilities is a future in which there are not enough resources to timely meet the need of the populace. If developers are willing to take on the financial risks of developing new facilities in the face of temporarily depressed utilization, then perhaps this is a risk they should be permitted to take, given the high probability that the growth in the senior population is likely to create significant need for beds rather rapidly over the next two decades. North Carolina cannot afford to wait for the methodology to catch up with the need.

4. The Proposed Change Will Not Result in an Unnecessary Duplication of Services

The entire aim of this proposal is to allow ACH providers to meet actual future needs that would otherwise be obscured by a temporary decrease in utilization due to COVID-19. As such, the proposal will not result in unnecessary duplication of services.

Given that beginning with the 2022 SMFP there are likely to be actual ACH bed deficits obscured by utilization data depressed by COVID-19, and that development of new facilities take significant time and financial outlay, the best opportunity to recognize and meet the growing need for ACH beds in North Carolina is now. Utilization statistics during COVID-19’s impact cannot be used to capture the real need for ACH beds across North Carolina

5. The Proposed Change is Consistent with the Three Basic Principles Governing the Development of the SMFP

The SMFP is designed to improve the safety and quality, access, and value of healthcare. A key to this end is accurately projecting need. Petitioner believes that unchanged, reliance on the current methodology will lead to tremendous unmet future need and will prevent the gradual development of new ACH beds where they are actually needed.

CONCLUSION

Petitioner strongly urges the Healthcare Planning and Certificate of Need Section to adjust its methodology for determining bed need to make it more flexible in the event of temporary decreases in ACH bed utilization. Such modification can be either temporary or permanent. Petitioner believes that the methodology ultimately needs to encourage steady development where there is steady growth in the elderly population, especially as the trend in development of ACH facilities is just a few larger providers accounting for the majority of Certificate of Need (“CON”) applications.