MARYLAND Health Care Commission

Randolph S. Sergent, Esq., Chairman
Ben Steffen, Executive Director

Hospice Issue Brief: Need Determination

History and Status:
Historically the MHCC has included in the Chapter a need projection formula (methodology) for regulated services, including hospice services. Earlier methodologies focused primarily on cancer patients. Later methodologies included all diagnoses and users age 35+.

Methodology Pros and Cons:
The most recent methodology, developed in conjunction with the Hospice & Palliative Care Network of Maryland, addressed many of the concerns previously raised regarding methodologies. It is based on baseline hospice use rates. It takes into account the ability of hospices to increase utilization by employing a compound annual growth rate. It uses the 35+ population, which accounts for about 95% of hospice use. It also includes a volume threshold (median number of deaths statewide) to determine the capacity above which a new hospice is needed to provide services.

This current methodology focuses on hospice use rates. It therefore projects need in jurisdictions that have low utilization and a large population base, such as Baltimore City and Prince George's County. The current methodology does not address smaller, rural areas served by a single provider.

One of the challenges of projecting need for a home-based service is that it is not a "bricks and mortar" service that includes specific numbers of beds. Since hospice services can be expanded or contracted by changes in staffing, it is harder to specify need. Since the potential capacity of a hospice program fluctuates, it is difficult to define and to measure. Another critique is that use rates vary (urban/rural; white/non-white; etc.). Taking into account all of these variables may make cell sizes too small and a methodology too complex.

Alternative Approaches:
We have surveyed other states to assess how hospice need is defined, but most methodologies focus on cancer care (an older concept) and use rates (current approach). Alternatively, a model that can be considered is the approach that is used for the most recent update to the Home Health Agency Chapter of the State Health Plan. In that Chapter, a jurisdiction is opened up for CON reviews if: the jurisdiction has insufficient consumer choice of HHAs; a highly concentrated HHA service market; or an insufficient choice of

HHAs with high quality performance. For hospices, this approach could be modified to include 3 components:

- Lack of Consumer Choice (sole provider jurisdictions) **OR**
- Lack of Access to Quality Providers (60% of patients served by poor quality providers) **OR**
- Jurisdictions with below average use rates

There would need to be specification on what is meant by "good quality," (i.e., above average performance on standard quality measures). This process would need to be operationalized in terms of qualified applicants and qualified jurisdictions in order to structure CON reviews.

Questions for Discussion:

Since the Hospice Chapter was last updated, progress has been made on identifying standard measures of hospice quality that can be used to assess performance. The seven individual components of the Hospice Item Set, CAHPS© measures, as well as the Hospice Care Index (when complete) can be used as a starting point.

- How should "high quality" performance be defined? Can this be done with the Hospice Item Set, and CAHPS©?
- How can hospice use rates be incorporated into this approach?
- Are there measures beyond Hospice Compare that could help define high quality and experienced hospice providers?
- How would such an approach address some of the weaknesses of the current methodology?
- What other factors should be considered?