GEORGIA STATE HEALTH PLAN

COMPONENT PLAN

NURSING FACILITIES

HEALTH STRATEGIES COUNCIL
AND
DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF HEALTH PLANNING
2 Peachtree Street, Suite 34.262
Atlanta, Georgia 30303

Adopted by the Health Strategies Council
AUGUST 18, 2000

Planning area map has been changed effective April 1, 2003

TABLE OF CONTENTS

PREFACE

This Component Plan is a product of the Health Strategies Council and the Georgia Department of Community Health, Division of Health Planning, operating pursuant to the provisions of O.C.G.A. 31-5A-1, et seq., and 31-6-1, et seq. The purpose of the Plan is to identify and address health issues and recommend goals, objectives and system changes to achieve official state health policies.

This Plan has been produced through an open, participatory process developed and monitored by the Health Strategies Council appointed by the Governor. The Plan is effective upon approval by the Council and the Board of Community Health, and supersedes all related sections of previous editions of the State Health Plan and any existing related Component Plan.

For purposes of the administration and implementation of the Georgia Certificate of Need (CON) Program, criteria and standards for review (as stated in the Rules of the Georgia Department of Community Health, Chapters 272-1, 272-2 and 272-3) are derived from this Component Plan. The Rules, which are published separately from the Plan and which undergo a separate public review process, are an official interpretation of any official Component Plan which the review function has the legal authority to implement. The Rules are reviewed by the Health Strategies Council (prior to their adoption by the Board of Community Health) for their consistency with the Plan. The Rules, as a legal document, represent the final authority for all Certificate of Need review decisions.

Any questions or comments on this Component Plan should be directed to:

Department of Community Health
Division of Health Planning/ Planning and Data Management Section
2 Peachtree Street, NW
Suite 34-262
Atlanta, Georgia 30303

Telephone: (404) 656-0655

INTRODUCTION

A. PLANNING PROCESS

The Health Strategies Council (Council) and the Department of Community Health/Division of Health Planning (Division), which staffs the Council, have a long history of planning and regulation of long-term care services as is evidenced by the adoption of Georgia's original Nursing Home Component Plan in 1981. Subsequent revisions and amendments were made to this plan in 1986, 1989, 1990 and 1997. The Nursing Facilities Component Plan, one of five existing component plans related to long-term care, provides the framework and rationale for the allocation of resources for nursing home services in the state of Georgia.

Adoption of a component plan is a deliberate process by the Council and involves the establishment of a Technical Advisory Committee (TAC). TAC members represent a wide variety of constituent groups and geographic regions of the state. The TAC which oversaw the development of this document, was comprised of members of the Council's Long-Term Care Standing Committee, state agencies, consumers, advocates, and provider groups to provide an open public participatory forum to plan for the long term care needs of Georgians.

In July 1996, the Division changed its procedures for reviewing Certificate of Need (CON) applications for nursing home beds by adopting a batching review process. Under this process, all applications for nursing home beds are reviewed simultaneously, at six-month intervals. The Division will only accept and review applications in counties within planning areas where an identified need for nursing home beds exists. On January 9, 1997, the Health Strategies Council adopted a new Nursing Facilities Component Plan.

In light of the Council's commitment to revisit the plan as significant changes occur in the long term care industry, the Health Strategies Council appointed the Technical Advisory Committee to begin work in May 1999 specifically, to reexamine the Nursing Home Bed Need Methodology. The TAC examined the Nursing Home Bed Need Methodology of several states, as well as changing demographics and use patterns in Georgia. After much discussion and several data runs, utilizing Georgia data, the TAC felt that the approach that stratified the population into four age categories (specifically 0-64, 65-74, 75-84, and 85+ age groups) would be best suited for the state of Georgia. This methodology places higher weights on the 75-84 and 85+ age groups, those population groups with the highest nursing home utilization. The TAC felt that this methodology was most reflective of community needs, service experience and state policy expectations. Furthermore, they agreed to maintain the following standards, as outlined in the Skilled Nursing and Intermediate Care Facilities Rules that were adopted and/or reissued in 1997:

- Three-year Planning Horizon;
- Urban/Rural/Retirement Bed Size Requirements;
- Favorable Consideration Standard and;
- Exceptions to Need Standard

TAC members agreed that systemic efficiencies could be achieved by maximizing the cost-efficiency of long term care resources. Hence, they made the following recommendation to the Need Methodology:

- Regardless of location or type (freestanding or hospital-based), a minimum occupancy threshold of 95% must be met or exceeded within the planning area, during the most recent past survey year, in order for the batching cycle to be opened for new or expanded nursing home applications to be considered.

The TAC will submit these recommendations to the Strategies Council for approval; the proposal will then be forwarded to the Board of Community Health for adoption.

B. CARE CONTINUUM

The Council and the previous LTC-TAC and Resource Groups spent a considerable amount of time defining the array of long-term care settings including community, home and residential, with emphasis placed on the linkage among all of the settings and the quality of services provided between them. The Council supports the continued development of a long-term care system, which embodies the following guiding principles in the care continuum:

- Consumer-centered system
- Consumer choices with the right to take considered risks
- Maximum functional independence for consumers
- System visible to potential users
- A flexible and creative array of services provided in a variety of settings
- Needs assessment as an essential part of the system
- Coordination of services and care management
- Effective quality control, enforcement, and training.

II.
OVERVIEW

A. DEVELOPMENTS IMPACTING THE NURSING HOME INDUSTRY

Nationally, the nursing home industry is undergoing a period of unprecedented change and is expected to continue to do so. The growing number of elderly seniors, coupled with constrained Medicare and Medicaid funding, the public funds that many elderly rely on to pay for their care, are creating systemic challenges to the nursing home industry. Furthermore, less intensive and/or expensive care options, including adult day care, home care, assisted living, and continuing care retirement communities will afford seniors an array of options beyond the traditional nursing home market.

Medical advances, coupled with emphasis on preventive health have contributed to the longevity of American population. Today, the average American can expect to live for nearly 76 years. Demographic changes such as the aging population and increased life expectancy will continue to impact the need for all types of long-term care services. A 1998 report by HCIA/Andersen indicates that the elderly population is expected to more than double by the year 2030 to 70 million people, 20% of the total population. This same report mentions that the 85+-population group is expected to grow at the fastest comparative rate of all population groups and is anticipated to double by 2030, to become almost 3% percent of the total population. (HCIA Inc. & Andersen, 1998, The Nursing Home Guide, pg. vii.)

The number of elderly Americans requiring some level of long-term care is expected to double over the next 25 years. As demand for long-term care continues to grow, public expenditures to fund such programs continue to increase rapidly as well. According to the Health Care Financing Administration (HCFA), total spending on nursing home care reached approximately $87.3 billion in 1998, about 7.6 percent of the country's total health care expenses, up from $78.5 billion in 1996. (American Health Care Association, *The Nursing Facility Sourcebook, 1998)*.

Alternative financing methods for nursing homes and alternative placements to nursing homes are being sought and developed. Included in these methods are ways to more effectively integrating acute and long-term care services, including a substantial number of demonstration projects which are underway. One example of a demonstration project in Georgia is the Health Strategies Council's Alternative Healthcare Model (AHM). The Division of Health Planning is given flexibility to apply service-specific CON rules for proposed projects, which are new and/or innovative ways of providing healthcare services. These models embody the concepts of health promotion, financial accessibility, deinstitutionalization, regionalization, cost containment, health planning and citizen participation, personnel recruitment and retention, and health data and information systems accountability. During 1996 two models were proposed: *Integrated Continuum of Care for Geriatric Services and Comprehensive Center for Alzheimer's Patients*. The *Integrated Continuum of Care for Geriatric Services model* was selected. Applicants were required to show how this model would allow residents to age in one location, improve access to appropriate services by allowing residents to move in a seamless system of care, and save money for

residents, payors and the health care system by providing needed services in the least restrictive setting. Seven applications were approved to illustrate this model.

During 1998, three models were selected, *Comprehensive Regional Specialty Pediatric Centers, An Integrated Delivery System for Children and Adolescents With Behavioral Health Disorders and Comprehensive Center for Alzheimer's Disease Patients.* The first model was selected because of the need to examine the coordinated continuum of care for children living in targeted regions of the state. The second model was selected because the Council recognized the need for the timely availability of services for this population, particularly with the closing of four regional psychiatric hospitals. The last mentioned model was selected as a reaffirmation of the Council's support for this category in 1996. This model was not implemented at that time because of the need for additional clarifying research. All of these models will be required:

- To demonstrate the feasibility of operating this model in Georgia;
- To demonstrate how this model of care will be impacted by payors and regulatory entities;
- To demonstrate how this model will reduce costs to consumers, third party payors and the systems as a whole;
- To demonstrate the potential of this model to support research, new service development, health professional education and training;
- To demonstrate the potential of the model to maintain or improve the standards of healthcare quality in some measurable fashion;
- To demonstrate how this model will provide increased choices for consumers to the continuum of long term care services within the target community.

Nearly a dozen such demonstration projects have been approved for development. The Alternative Healthcare Model Rules allow the implementation of these models over a five-year period.

Based on a 1998 report of HCIA/Arthur Andersen, the percentage of long term care Medicaid funds going to institutional care are steadily declining. According to the National Conference of State Legislatures, the percentage has fallen over the last ten years, from 90% in 1987 to 80% in 1996. As a result, many care providers, including nursing homes, have been expanding their service offerings to include some of the less intensive or less costly alternatives in order to capture some of the non-institutional public funding and revenue (HCIA & Andersen, The Guide to the Nursing Home Industry, 1998). Information about alternative settings appears below:

Assisted Living provides housing and services for residents who need assistance with activities of daily living (ADLs) but do not require the intense medical care provided in the skilled nursing environment. Because this market is almost 100 percent private pay, it offers a source of alternative cash flow for the provider (assisted living is not Medicaid financed in Georgia except for limited slots under the Community Care Services Program). Ownership of an assisted living facility provides the nursing facility a potential discharge site for lower acuity patients and in so doing retains patient flow and patient revenues, while at

the same time controlling costs.

The assisted living industry continues to expand. 1998 data from HCIA/Andersen indicate that the industry has grown to an $18.6 billion industry, with about 30,000 facilities, caring for approximately 1.25 million elderly and disabled Americans. While many assisted living facilities are unregulated, some tightening of restrictions is anticipated. In Georgia, assisted living can be referred to as personal care and is regulated through state licensure and CON for certain personal care homes. Recent data from the Department of Human Resources/Office of Regulatory Services Recent indicates that Georgia has 1808 licensed personal care homes.

Home Health Care includes skilled nursing and physical, occupational and speech therapy; medical and social services, and home health aids. It had been one of the fastest growing sectors of the health care industry. According to a 1998 document by HCIA/Andersen, the number of elderly people receiving home health services from 1990 to 1997 doubled from two million to four million, this resulted in an increase in the total number of visits from 70 million in 1990 to an estimated 306 million in 1997.

Trends in home health care may be changing. Recent data from the Georgia Department of Community Health indicates that after steady increases in the number of patients receiving home health services from 1990-1996, the number declined slightly in 1997 (159,097) and even more in 1998 (147,293). The average number of visits per home health patient also declined, falling from 69.6 visits per patient in 1995 to 62.6 visits per patient in 1997 to 40.7 visits per patient in 1998. According to a recent report on Medicare by the Congressional Budget Office, the number of Medicare beneficiaries receiving home health care dropped from 3.6 million in 1997 to about 3 million in 1998. This report further notes that Medicare spending on home health care dropped 45 percent in the last two fiscal years, from $17.5 billion in 1997 to $9.7 billion in 1999. (American Association of Homes and Services for the Aging, *Currents*, Vol. 15, No. 6, Pg. 9).

Decreasing dollars to support the home health industry will likely result in the loss of access to a level of care that could potentially preempt hospitalization or nursing home care. Medicare is the largest payor of home health care services. Through the Balanced Budget Act of 1997, HCFA implemented a prospective payment system for home health agencies. However, an interim payment system was established which has resulted in the inability of many home health agencies to meet their costs. Consequently, many agencies have closed. In order to remain viable many home health agencies will have to reduce their costs and provide the same level of service. Many also will consolidate to receive greater economies of scale. These and other trends in the long-term care industry will continue to be monitored by the Division.

Adult Day Care programs offer services to people who have elderly family members at home. Nationwide, the number of adult day care centers doubled between 1989 and 1997 to about 4,000 centers. Although this area has been largely unregulated, some industry standards are expected to be published in the near future.

The Health Strategies Council's Long-Term Care Technical Advisory Committee of 1997 spent some time

developing a residential care model for Georgia. This model integrates the concept of levels of care including independent living, assisted living and nursing home services. Public debate continues as to the most appropriate and cost-effective method of fully implementing such a continuum of care.

B. LONG TERM CARE TRENDS AND DEVELOPMENTS IN GEORGIA

The Division of Medical Assistance (DMA), the largest division in the Georgia Department of Community Health, administers the Medicaid program. This program provides health care for persons in low-income brackets or who are aged, blind, disabled, or indigent. Recent data from the Division indicates that they spend $3.1 billion to provide services to 1.2 million Georgians annually.

As the need to streamline the Medicaid Budget intensifies, there is constant pressure to establish initiatives that will assist the Division to meet that goal. One such initiative is a series of waiver programs. These home and community-based waivers offer states broad discretion to provide care for individuals who would otherwise require costly institutional care. States may, under a waiver program, add services and limit the number of individuals who may receive the services or limit the availability of services geographically. Georgia has five home and community-based waivers, two freedom of choice waivers, and two demonstration projects that have been approved by HCFA. The following summaries provide information about some of Georgia's innovative waiver programs that most directly relate to long-term care:

Community Care Services Program (CCSP) - The CCSP for the Elderly Act was passed by the Georgia General Assembly in 1982. It mandated the coordination of existing services and the development of new services to provide a range of home and community-based care as alternatives to nursing home care. Georgia's Medicaid CCSP waiver program provides home and community-based services to people who are functionally impaired or disabled. The program helps eligible recipients remain in their own homes, the homes of caregivers, or in other community settings as long as possible. Individuals serviced through the CCSP program must meet the medical and functional criteria for placement in a nursing facility. The Georgia Medicaid Program with federal and state matching funds reimburses provider agencies for services through an optional 1915(c) waiver.

Independent Care Waiver Services Program, which began in May 1992, offers services that help a limited number of adult Medicaid recipients, with physical disabilities, to live in their own homes or in the community instead of a hospital or nursing facility. Services are available statewide and include case management, personal support services, specialized medical equipment and supplies, occupational therapy, respite care services, counseling, home modification, and personal emergency response services. Documents from the Georgia Department of Community Health indicate that in 1999, the program served 386 recipients. There were 114 providers participating in the program. This program is primarily for people who are unnecessarily hospitalized or are at risk of being unnecessarily hospitalized.

Independent Care Waiver Services Program for Traumatic Brain Injury, offered since 1995 this program helps adult Medicaid recipients with traumatic brain injury live in their own homes or in the community instead of institutional settings. In fiscal year 1999, this program served approximately 41 people.

The Mental Retardation Waiver Program (MRWP) is a home and community-based waiver for persons who have been diagnosed with mental retardation and/or a developmental disability. Services for the

MRWP program began April 1, 1989. In fiscal year 1999, MRWP services were provided to 2,370 people. Thirteen regional mental health boards attached to the Department of Human Resources, plan services and coordinate service delivery with enrolled Medicaid providers. Recent data indicate that there are approximately 181 enrolled providers in the state.

Waivered Home Care Services Program, also called the Model Waiver, was designed in 1982 to serve children up to three years old who were ventilator-dependent. The waiver has since been amended to include oxygen-dependent children up to age 21. The purpose of the program is to provide primarily skilled nursing care in a community setting to recipients who would otherwise require institutional care. The program is appropriate for recipients who need continued nursing supervision and monitoring and whose medical and nursing needs can be met adequately in the recipient's residence or in a day care facility. In fiscal year 1999, 151 eligible Medicaid recipients used the Model Waiver program's services.

Community Habilitation and Support Services Waiver (CHSS) - is a home and community-based program for persons who were moved out of institutions as a result of the closure of Brook Run, a state ICF/MR facility, which closed in 1997. The program also serves some individuals who were on the waiting list for community waiver services. Services for the CHSS began October 1, 1997. The CHSS waiver provided services to 722 individuals in fiscal year 1999.

Services Options Utilizing Resources in a Community Environment (SOURCE), an innovative, community-based project established to provide comprehensive case management and support services, closely linked with primary care, helps frail elderly or disabled people to remain in the community and avoid unnecessary hospitalization and nursing facility care. SOURCE, now in its third full year of operation, operates in the Savannah, Augusta, Atlanta, and Hinesville areas.

Georgia continues to explore ways to manage the financing of long-term care. Because of uncertainties inherent in projecting the breath of future long term care needs of Georgians, Governor Roy Barnes signed an executive order in December 1999 creating a Blue Ribbon Task Force on Home and Community-based Services. The task force is charged with providing recommendations about the current and future status of community-based services and developing general funding suggestions. Their report will be issued in mid-2000.

C. CHANGES IN THE DEMOGRAPHICS OF THE NATION AND GEORGIA

The population of the United States is growing older, with people 65 years of age and older now recognized as the fastest growing segment of the population. By 2010, women will have an average life expectancy of 86 years. The average life expectancy for men will be 76. While life expectancy will be greater, advances in medical technologies and health care resource options may mitigate against expansion of intensive long-term care services. Further complicating future planning for health services is the recent work conducted by the World Health Organization (WHO) which underscores the anticipated

impact of morbidity, particularly costs associated with chronic disease and disability. In short, people will live longer and probably healthier overall, but individuals may also suffer from disabling conditions requiring ongoing care and support. (*Health and Healthcare 2010, pp. 17 - 23).*

The country will also become more ethnically diverse over the next ten years. On the national level, minority ethnic and racial groups are expected to account for some 32 percent of the total population in the year 2010. This pattern of diversity will be reflected throughout the Southern states. Beyond population and diversity, economic indicators point to increasing household income for a sizeable portion of citizens. This trend is positive in that greater financial resources are associated with improved health status and expanded care options. However, it is important to recognize that while many Americans are moving into higher income brackets, the pattern of income distribution indicates a widening gap between the upper income brackets and the poor. These patterns require planners to be mindful that culturally competent care and publicly funded resource options will continue to be of significant importance. (Health and Healthcare 2010, pp. 18 - 25.)

As Georgia's population ages and becomes more diverse, there is growing concern about long-term care and how to assure provision of needed long-term care services. Population projections for the year 2000, developed by the Governor's Office of Planning and Budget based on 1998 Census estimates, indicate the state now has some 959,120 citizens (civilian, non-institutional) aged 65 and older. These newly developed projections alone reflect a 35% increase in the year 2000 population for this age cohort, simply by virtue of adjusting for more recent patterns of growth and migration. By the year 2010, Georgia's population aged 65 and over is expected to reach 1.1 million. The state's changing demographics mirror those of the nation, and they mandate a planning approach, which couples this information with the expanding options and demands of health care in general, and long-term care in particular.

III.
REIMBURSEMENT AND REGULATION OF NURSING HOME SERVICES

A MEDICARE AND MEDICAID REIMBURSEMENT

An interesting paradox is occurring in the long-term care industry and is particularly impacting nursing homes. While the elderly population continues to increase, particularly those 85 years and older, the public financial resources that have historically been used to finance care rendered to this population are dwindling.

Over the last several years, Medicare and Medicaid programs have been scrutinized by federal and state governments looking to alleviate budget crises. In 1997, HCFA implemented the Balanced Budget Act (BBA) as a mechanism to curb health care spending. This Act authorized payment to providers prospectively instead of the retrospective methodology that had been used in the past. In 1998 a prospective payment system for skilled nursing facilities was introduced. The retrospective methodology was criticized as inefficient and one that subsidized unnecessary services. The Prospective payment system (PPS) was designed to offer nursing homes an incentive to reduce costs. Although nursing homes derive less than 10% of their revenues from Medicare, many are struggling to survive under the PPS. Some nursing homes, particularly those that belong to large nursing home chains, increased their profitability by expanding into ancillary services.

The Balanced Budget Refinement Act of 1999 (BBRA) was established as an initiative to aid nursing homes in the face of payment inadequacies. It funded temporary increases for selected resource utilization groups, implemented refinements to address appropriate payment for medically complex patients and provided across the board payment adjustments for FY2001-2002 These provisions are expected to restore $1.4 billion to skilled nursing facilities over five years. HCFA will publish its final rule in August 2000 with implementation scheduled for October 2000. The American Health Care Association is closely monitoring all of the changes that the Health Care Financing Administration intends to implement.

B. FRAUD AND ABUSE

Nationwide, intensive scrutiny of many nursing homes has uncovered several cases of Medicare and Medicaid fraud and abuse. Many nursing homes have been fined large amounts of money for over-billing, misrepresenting the diagnosis to justify payment, and falsifying certificates of medical necessity among other abuses. Nursing home representatives cite misinterpretation of the federal rules and regulations as the core reason for the rise in the number of these cases.

The Department of Health and Human Services/Administration of Aging has initiated educational programs in more than 35 states, Puerto Rico and the District of Columbia to recognize fraud and abuse. These

programs teach Medicare beneficiaries how to detect and report over-billing and unnecessary services.

Targeting all healthcare providers, Georgia's Division of Medical Assistance 's commitment to preventing and combating fraud and abuse received added support in Fiscal Year (FY) 1999 from the Governor and the General Assembly, with the allocation of 50 additional positions. The division's program integrity section was responsible for savings, recoupment and court-ordered restitution totaling $41.5 million in FY99.

C. LONG TERM CARE INSURANCE

One of the challenges facing most states is how to bring more private resources into the long-term care system. Recent data from HCIA/Anderson (1999) indicate that, at present, long-term care insurance is gaining popularity. This growth is due primarily to the uncertainty surrounding what has historically been long term care safety net resources including Medicare, Medicaid, and Social Security. Additionally, research conducted by the Health Insurance Association of America indicates that premiums reported by leading insurers have remained stable, if not decreased over time

Long-term care insurance has grown in recent years. The number of policies sold between 1992 and 1998 went from about three million policies to almost six million policies. By June 1998, 119 companies had sold over 5.8 million long-term care insurance policies. The market has grown an average of 21% each year between 1987 and 1997. (Health Insurance Association of America, "Long Term Care Insurance," 1997-1998, March 2000)

When long term care insurance policies were first introduced, coverage was limited to nursing homes and required minimum hospital stays before the benefit would begin. Today, there are greater policy choices, many of which can be tailored to meet the needs of each individual. Furthermore, many companies now waive their preexisting condition limitations as long as pertinent medical conditions are disclosed at the time of the application. Age limits for purchasing these policies are also expanding, ranging from 18 to as old as 99. The average age of employees electing this coverage is 43 years old.

The number of employer-sponsored policies has been increasing. By mid-1998, over 2,100 employers were offering a long-term care insurance plan to employees and retirees. This number has increased from 58 in 1990. (Health Insurance Association of America, "Long Term Care Insurance," 1997-1998, March 2000).

By June 1998, 119 companies had sold over 5.8 million long-term care insurance policies. The majority of long-term care insurers continue to sell policies in the individual market. As of June 1998, approximately 80% of the 5.8 million long-term care policies had been sold through the individual and group association markets. Health Insurance Association of America predicts that further growth will continue, particularly among medium-sized and large-sized employers. (Health Insurance Association of America, "Long Term Care Insurance," 1997-1998, March 2000)

While long-term care insurance continues to grow in most regions of the nation, sales remain concentrated in a few states. Data from the Health Insurance Association of America indicate that by end of 1997, half of all individual and group association policies had been sold in California, Florida, Illinois, Iowa, Missouri, Ohio, Pennsylvania, Texas, and Washington. It will be interesting to monitor future developments in the long-term care insurance industry.

IV.
NURSING HOMES IN GEORGIA AND OTHER STATES

In 1998, general nursing homes in Georgia reported an available bed capacity of 38,779 beds. There are some 3,000 additional beds in specialty nursing homes, which, in most cases, are operated by state or federal government programs (e.g., for persons with disabilities and for veterans). The focus of this Component Plan is restricted to the general nursing home population.

The reported gender and racial characteristics of nursing home residents have remained fairly constant over the past several years. Females and Caucasians constitute three-quarters of nursing home residents. Males and Other Races appear to have had only slight increases in their relative use of nursing homes since 1994.

According to the survey reports, persons with mental retardation and mental illness constitute more than 15 percent of general nursing home residents. Individuals with Alzheimer's Disease make up about 20 percent of the patient population. These data point to the challenges of the long-term care system to provide a range of appropriate, quality care for persons with ongoing habilitation and care needs.

For many years, Georgia has relied on a simple bed need methodology, which projected supply requirements at a rate of 47 beds per 1,000 population aged 65 and older. Bed Need is determined at a sub-state level using standard Planning areas (HPA) developed in the 1980's by the state's health planning system. This methodology was similar to that used in other states during the time it was adopted. Based on 1998 survey data and the previous population estimates, Georgia's actual nursing home bed availability was some 56 beds per 1,000 persons aged 65 and over. Other states range from a low of about 20 beds per 1,000 to an outlier high of 84 beds per 1,000 in this age group. (HCIA/Arthur Andersen, 1998; p. 137). However, the reported bed rate for Georgia exceeds all other states in the Southeast, which ranged from 29 beds to 53 beds per 1,000 persons aged 65 and older. (HCIA/Arthur Andersen, The Guide to the Nursing Home Industry, 1998; p. 137).

As care systems have changed and the population has become healthier and older, this simple type of ratio methodology may not be sufficiently robust. Many other states have moved to need methodologies, which factor different supply expectations for various age cohorts. In viewing Georgia's 1998 bed utilization patterns by age cohorts, one finds widely differing reliance on nursing home care (See Appendix A.) Persons aged 65 to 74 are reported to have used nursing home beds at a rate ranging from about 8.5 to nearly 21 beds per 1,000, depending upon the planning area under review. Persons aged 75 to 84 had a reported utilization ranging from 30.8 beds to 51.2 beds. Those aged 85 and older were reported to have used somewhere between 124 and 180 beds per thousand. It is also important to recognize that a small number of citizens under the age of 65, most often those with disabilities or chronic care needs with limited other options, are using nursing home services. (Annual Nursing Home Survey, 1998.)

The age distribution in Georgia's nursing home is quite reflective of what other states have sought to acknowledge in their need methodologies. In short, persons of all ages may need to rely on nursing home care but their utilization patterns will differ greatly. This type of approach to **bed supply** seems particularly sound given the rapidly changing demographics and care environment.

Admission and utilization data points to another interesting trend. Admissions to nursing homes in Georgia have increased steadily and they neared 39,000 in 1998. These numbers reflect almost a doubling in the number of admissions since 1991. Yet, actual occupancy rates are falling, so the admission numbers appear to substantiate the conventional wisdom that seniors and others are using nursing homes with less permanence and more turnover.

The national median occupancy rate for nursing homes in 1997 had fallen below 93%, and a downward trend appears in many states. (HCIA/Arthur Andersen, 1999; p. xii.) Georgia's 1998 occupancy rates, a measure of actual days of bed occupancy to available bed days, are reported to have fallen below 93 percent on a statewide basis. In the metropolitan Atlanta planning area, the reported occupancy rate has fallen below 90 percent. Rural regions generally continue to have relatively higher rates of occupancy, which may reflect more limited access to service options and financing resources. Nonetheless, this trend speaks to an important consideration, which has been incorporated in other states' bed need calculations. That is, the principle of **bed demand**.

In many other states, the bed supply is determined through weighted, rate-based age calculations and bed demand reflects actual patterns of utilization. This dual need methodology ensures a rational, objective formula is linked with actual patterns of behavior. Given the broad range of utilization experiences across Georgia's diverse population, this dual methodology would appear to have the necessary demographic elasticity coupled with the certainty of market behavior to ensure sound resource planning. Further, the dual system would recognize and be responsive to Georgia's expanding diversity of needs and care options. Appendix B contains certain data and information from the nursing homes survey.

V. GUIDELINES

A. USE OF GUIDELINES

The following criteria and standards outline the guidelines for the development and delivery of Nursing Facility Services in the State of Georgia as recommended by the Health Strategies Council. The Planning horizon for all types of nursing facilities is three (3) years. Planning for nursing facilities should continue to be based on twelve (12) fixed geographic regions. (See Appendix C).

B. DEFINITIONS FOR THE GUIDELINES

Several different organizations with different authorities control the development and delivery of nursing facility (nursing home) services in Georgia. The definitions presented below apply to this Plan.

1. "Nursing Facility" means a facility classified as either a skilled nursing facility, an intermediate care facility or an intermingled facility, which admits patients by medical referral and provides for continuous medical supervision via 24-hour-a-day nursing care and related services in addition to food, shelter, and personal care.

2. "Skilled Nursing Facility" (SNF) means a public or private institution or a distinct part of an institution which is primarily engaged in providing inpatient skilled nursing care and related services for patients who require medical or nursing care or rehabilitation services for the rehabilitation of the injured, disabled, or sick persons.

3. "Intermediate Care Facility" (ICF) means an institution which provides, on a regular basis, health related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide but who, because of their mental or physical condition, require health-related care and services beyond the provision of room and board.

4. "Intermingled Facility" means a facility, which provides both skilled and intermediate levels of care.

5. "Hospital-based Nursing Facility" means a nursing facility which meets the current definition of "Hospital-Based Nursing Facilities" as defined in the current *Policies and Procedures for Nursing Facility Services* by the Georgia Department of Community Health/Division of Medical Assistance. A new hospital-based nursing facility can only result from conversion of existing space on the hospital's campus.

6. "Retirement Community-based Nursing Facility" means a nursing facility which operates as a lesser part of a retirement community which is a planned, age-restricted, congregate living development which offers housing, recreation, security, dietary services, and shared living areas accessible to all

residents.

7. "Urban County," means a county with a projected population for the horizon year of 100,000 or more and a population density for that year of 200 or more people per square mile. All other counties are considered to be "rural."

8. "Planning area" for all nursing facilities, with the exception of state nursing facilities, means the geographic regions in Georgia defined in this component plan (See Appendix C). "Planning area" for a state nursing facility means the State of Georgia.

9. "State Nursing Facility" is a facility which meets the definition of a Nursing Facility as defined above and is owned and operated by a branch or branches of government of the State of Georgia.

10. "Medicare Distinct Part Skilled Nursing Unit" means a unit which meets the current definition of "Distinct Part of an Institution as SNF" as defined in the current *Medicare Part A Intermediary Manual* by the Health Care Financing Administration of the U. S. Department of Health and Human Services.

C. STANDARDS FOR GUIDELINES

APPLICABILITY

These Guidelines apply to nursing facility services as provided by skilled nursing facilities, intermediate care facilities, and/or intermingled facilities.

AVAILABILITY

Standard 1 - Need:

Need for nursing facility beds in a planning area should be based on two factors:

- (1) Whether the Division determines that a numeric need exists; and
- (2) Whether the minimum occupancy threshold of 95%, within the planning area, for all facility types, during the most recent survey year has been met.

These conditions will determine whether the Department of Community Health/Division of Health Planning opens the batching cycle for Nursing Facilities Certificate of Need applications.

Rationale for Standard 1: The 1999 Long-Term Care Technical Advisory Committee (LTC-TAC) recommended that each of the above-mentioned criteria must be present in order to accept Certificate of Need applications for Nursing Home Facilities. A numerical need, coupled with a 95% minimum occupancy threshold, must exist within the planning area for all facility types during the most recent survey year. Additionally, the application must be submitted during the established batching cycles of March and September.

Persons of all ages may need to rely on nursing home care but their utilization will differ greatly. The revised Numerical Need Methodology factors different supply expectations for various age cohorts. Bed supply is determined through weighted, rate-based age calculations and bed demand reflects actual patterns of utilization. Rates that were used for each age stratification were developed based on Georgia's historic patterns coupled with observations from other states. This four-tiered stratification is similar to ones used in North Carolina, Tennessee, Mississippi, Virginia and Connecticut and ensures a rational, objective formula is linked with actual patterns of behavior. The broad range of utilization patterns across the state makes this system most reflective of the nursing home trends in Georgia. The numerical need for a new or expanded nursing facility in any planning area in the horizon year shall be determined by a population-based formula which is a sum of the following:

- a ratio of 0.43 beds per 1,000 projected horizon year civilian noninstitutional (CNI) population age 64 and younger;
- a ratio of 9.77 beds per 1,000 projected horizon year civilian noninstitutional (CNI) population age 65 through 74;

- A ratio of 32.5 beds per 1,000 projected horizon year civilian noninstitutional (CNI) population age 75 through 84; and
- A ratio of 120.00 beds per 1,000 projected horizon year civilian noninstitutional (CNI) population age 85 and older.

The demand for services in each planning area will be measured by the cumulative facility bed utilization rate during the most recent survey year period. The utilization rate shall be determined by dividing the bed days available for resident care by the actual bed days of resident care.

In order to improve utilization of existing resources, to coordinate care between providers and to maximize all of the resources in the planning area, the TAC recommended that a minimum occupancy threshold of 95% should be maintained. The only exception to this Need standard is applications submitted under the Exception to Need standard.

Standard 2 - Desired Bed Size for a Nursing Facility:

The desired bed size for a new nursing facility should consider economies of scale, type of facility, and rural/urban variations. Rural/urban designation should be based on the county within which a proposed or existing facility is located.

Rationale for Standard 2: New nursing facility construction costs should be based on economies of scale relative to the costs of land, materials, construction, labor, etc., in the area where the new development is planned. Minimum and maximum bed numbers should reflect the variations in such cost in rural and urban areas. The actual configuration of a project should demonstrate economy in the use of space, planning of patient care areas to support optimal access to each patient from each nursing station, and the most efficient use of staff. This rural/urban designation also allows for the differences in the demand for nursing home services and the availability of staff to provide long-term care services. A 1991 literature survey of nursing home size guidelines (Department of Community Health/Division of Health Planning, 1991) provides information for minimum, average and ideal sizes for freestanding facilities, hospital-based units, and nursing units as part of a freestanding facility and are as follows:

The required bed size for a new nursing facility in a rural or urban county is as follows: (Rural/urban designation shall be based on the county within which the proposed facility is to be located.)

- (i) A freestanding nursing facility in a rural county: a minimum of 60 beds;
- (ii) A freestanding nursing facility in an urban county: a minimum of 100 beds;
- (iii) A hospital-based nursing facility in a rural county: a minimum of 10 beds and a maximum of 20 beds;
- (iv) A hospital-based nursing facility in an urban county: a minimum of 20 beds and a maximum of 40 beds;
- (v) A retirement community-based nursing facility: 1 nursing home bed for each 4 residential units, with a minimum of 20 beds and a maximum of 30 beds.

Standard 3 - Favorable Consideration:

Favorable consideration should be given to a nursing facility which proposes to include services for special needs populations, such as but not limited to, persons with Alzheimer's and related disorders, medically fragile children, or persons with HIV/AIDS.

Rationale for Standard 3: This standard recognizes the potential existence of groups with special needs, which are not being met. All requirements of the Need Methodology must still be met.

Standard 4- Exceptions to Need:

The Division may allow an Exception to the Need standard for the purpose of establishing a Medicare distinct part skilled nursing unit exclusively for serving Medicare recipients if the proposed unit is to be located in a county that does not have an existing Medicare unit; and if there is limited access in the proposed planning area for skilled nursing services for Medicare patients and (2) there is limited access to nursing facility services for special groups such as but not limited to, medically fragile children and HIV/AIDS patients.

Rationale for Standard 4: Limited access means that existing nursing facilities have not provided the proposed services in response to a demonstrated demand for the services over the three (3) most recent years. A Medicare Distinct Part skilled nursing unit provides short term, intensive, rehabilitation services to patients at higher acuity levels. In those areas of the state where no Medicare beds are available, this type of unit would provide access to care for patients whose primary payment source for nursing services is Medicare.

The second exception recognizes the potential existence of groups with special needs, which are not being met.

Beds approved under the 'Exceptions to Need' standard are restricted to the limited purpose in the application and are not included in the bed inventory. Documentation should include principle and additional diagnoses of the patients expected to be served by the proposed facility.

Standard 5 - Continuity of Care:

A new or expanded nursing facility should provide continuity of care by the following:

< (1) Providing a marketing and community linkage plan which demonstrates factors such as, but not limited to, referral arrangements with appropriate services of the healthcare system and working agreements with other related community services assuring continuity of care; and

< (2) Documenting the existence of proposed or existing referral agreements with a nearby hospital to provide emergency services and acute-care services to residents of the proposed or existing facility; and

< (3) Providing existing or proposed rehabilitation plans for services to facility residents; and

< (4) Providing existing or proposed discharge planning policies.

Rationale for Standard 5: The provision of quality care can only be ensured through an entire spectrum of services that help to ensure prevention and rehabilitation as well as treatment. Increasing concern with continuity of care makes it imperative that attention be focused on coordinated, integrated systems, which promote continuity rather than episodic care.

Working referral arrangements with a nearby hospital enhance can assure continuity of care so that high acuity patients will be transferred/triaged in a timely manner to an appropriate level of care, as needed.

Agreements with other related community services to enhance and to assure continuity of care might include provisions such as the following: (1) ability to streamline referrals to other appropriate services; and (2) ability to participate in development of cross-continuum care plans with other providers.

Standard 6 - Quality of Care:

A new or expanded nursing facility should provide evidence of intent to meet all appropriate requirements regarding quality of care as follows:

< Compliance with all appropriate licensure requirements and operational procedures required by the Office of Regulatory Services of the Georgia Department of Human Resources; and
< No uncorrected operational standards in any existing Georgia nursing homes owned and/or operated by the proposed facility or by the facility's parent organization. Plans to correct physical plant deficiencies should be provided;
< No previous conviction of Medicaid and/or Medicare fraud;
< The intent and ability to recruit, hire and retain qualified personnel to meet the current Medicaid certification requirements of the Division of Medical Assistance for the services proposed to be provided and that such personnel are available in the proposed geographic service area; and
< Provision of a plan for a comprehensive quality improvement program which includes, but is not limited to, procedures and plans for staff training and a program to monitor specific quality indicators and measure the facility's performance and patient outcomes accordingly; and
< Intent to meet accreditation requirements of appropriate accrediting agencies for which special consideration should be given by the Division of Health Planning.

Rationale for Standard 6: This standard represents a broadened approach covering several facets of quality.

Licensure Requirements: Compliance with licensure requirements pertains to the successful operation and management of nursing facilities.

No History of Violations and Deficiencies: There should be no uncorrected operational standards and/or a specific plan to correct deficiencies.

No Previous Fraud Conviction: One initiative supporting this effort is the Department of Community Health/Division of Medical Assistance/Program Integrity Section, which was established to eliminate fraud and abuse in the Medicaid Program. A nursing facility should show no previous conviction of Medicaid and/or Medicare fraud by providing all requested documents pertaining to Medicaid and Medicare including, but not limited to, indictments, cost reports, audit reports, investigational reports and any other information to support the applicant's position. Great emphasis continues to be placed on the work of this section.

Quality Staff: A plan should be provided which specifies measurable strategies for staff selection, training, and retention. In order to promote improved outcomes for patients and families, providers must focus on staff. The applicant's ability to meet this standard should include, but not be limited to, the following areas:

< Developing professional and direct care staff by offering continuing education/training;
< Ensuring that the documented costs of personnel are accurately reflected in the proforma and cost projections;
< Providing documentation that all staff, particularly those who will provide the proposed services, possess state licensure's specified levels of education, credentials, experience and training to provide high quality services;
< Demonstrating the organization's intent to obtain appropriate levels and numbers of professional and paraprofessional staff to meet the requirements of the proposed services, and that the specified personnel are available in the proposed geographic service area.

Accreditation for Nursing Facilities: Accreditation bodies include the Joint Commission on Accreditation of Health Care Organization (JCAHO) and others. Accreditation by JCAHO is recognized nationwide as a "seal of approval" which indicates that an organization meets certain performance standards. Because these standards reflect state-of-the-art performance expectations, organizations that meet these standards can be regarded as having the infrastructure to provide high quality patient care. Accreditation may also be a condition of reimbursement for certain insurers and other payers.

Quality Improvement Program: Quality is data supported, not data driven. A primary way to

monitor quality is to institute a comprehensive quality improvement program. Outcome data should be compared to industry benchmarks, which address the following specific areas: (1) measuring patient outcomes; (2) high consumer satisfaction; (3) meeting consumer demand; and (4) consideration of patient/consumer rights.

Standard 7 - Financial Accessibility:

A new or expanded nursing facility should assure financial access to its services by providing each of the following:

< Providing a written commitment of intent to participate in the Medicaid and Medicare programs;

< Demonstrating an appropriate case-mix of Medicaid, Medicare and private pay patients; and

< Documenting policies and practices of nondiscrimination by past performance of the facility and all facilities owned or operated by the facility or its parent organization.

Rationale for Standard 7: Providing financially accessible services in nursing facilities is an essential component of Georgia's State Health Plan. Essential elements of financial access include, but are not limited to, the following:

< A written commitment to participate in both the Medicaid and Medicare Programs; and

< A proposed case-mix of Medicare, Medicaid, and private pay patients.

Standard 8 - State Nursing Facilities:

A new or expanded state nursing facility may be exempted from the provision of these guidelines designated as Availability, and Financial Accessibility when the said facility meets each of the following:

< Documentation that the proposed facility will be, or the existing facility is, owned and operated by the State of Georgia; and

< Documentation that the proposed facility will admit patients from any of Georgia's counties with a primary focus on a predesignated multi-county area or region; and

< Documentation that the facility intends to be accessible to patients whose care, because of income and other limitation or special considerations, would normally come under the jurisdiction of the State; and

< Such other considerations as may be considered necessary by the Department of Community Health/Division of Health Planning.

Rational for Standard 8: State-owned and operated facilities are exempted because these facilities serve

a broad statewide or regional population groups. Furthermore, the state-owned facilities may be uniquely qualified to serve special population groups who might not otherwise be appropriately served in the private sector.

Standard 9 - Information and Data Requirements:

A new or expanded nursing facility should provide the Division with requested information and statistical data related to the operation and provision of skilled nursing services.

Rationale for Standard 9: Uniform data is essential to assess changing patterns and projected service needs relevant to the provision of this service. As additional emphasis is place on managed care, quality, patient outcomes, cost and other efficiency indicators, collection of data will allow more precise assessment of these factors as well as others which are important to health planning.

IV.
GOALS, OBJECTIVES AND RECOMMENDED ACTIONS

A. GOAL

To reflect the changing demographics and patterns of use of nursing facilities in the state of Georgia.

B. OBJECTIVES

< Encourage continuity of and access to appropriate healthcare within communities;

< Monitor long term care trends, including demographics and financing issues, in order to anticipate the healthcare needs of Georgia's communities;

< Reconvene Technical Advisory Committee, as necessary.

C. RECOMMENDED ACTIONS

< Implement Certificate of Need (CON) Rules for nursing facility services consistent with this Component Plan and approve CON applications accordingly;

.

< Support research and demonstration projects which will promote a seamless, coordinated system of both acute and long-term care services based on the principles and models developed by the Health Strategies Council;

< Improve survey methodology to capture needed data in a timely and usable manner that decreases redundancy and the burden on providers. Implicit in this process is the requirement that the state collect and report diagnosis, manpower and patient origin data for long term care;

< Implement case-mix financing approaches to be sure that patients are receiving the most appropriate care in the most suitable setting;

< The Health Strategies Council should convene another TAC to develop a Need Methodology which incorporates the multiple long term care service options in the care continuum;

< The Health Strategies Council and the Department of Community Health should work with educational institutions and providers to address healthcare workforce shortages.

V.

REFERENCES

American Association of Homes and Services for the Aging, *Currents*, Vol. 15, No. 6.

American Health Care Association, The Nursing Facility Sourcebook,1998, Research & Data, Executive Summary.

American Hospital Association, "Regulatory Advisory", May 31, 2000, Baltimore, MD.

Department of Community Health/Division of Health Planning, "Survey of Nursing Home Size Guidelines", Atlanta, GA.1991, (a literature review).

Department of Community Health/Division of Health Planning, "Survey of States Need for Nursing Home Beds", 1995, Atlanta, GA.

Department of Community Health/Division of Health Planning. (1991-1998), "Annual Survey of Nursing Home Facilities ", Atlanta, GA.

Georgia Department of Medical Assistance, "FY 1999 Annual Report".

Georgia Department of Community Health, Division of Health Planning, (1991 - 1998), Annual Survey of Guidelines. 1991, (a literature review).

Georgia Office of Planning and Budget, (2000) "2000-2010 Population Projections Using 1998 Census Estimates, Atlanta, GA.

Health Insurance Association of America, "Long-Term Care Insurance 1997-1998", March 2000.

HCIA, and Arthur Andersen LLP, (1999), The Guide to the Nursing Home Industry, "Nursing Homes Face A New Millennium", 1999.

Lewin-VHI, Inc. for the U. S. Department of Health and Human Services, (November 1995), Executive Summary, Subacute Care Study, Washington, D.C.

Strahan, G. W., "An Overview of Nursing Homes and Their Current Residents: Data from the 1995 National Nursing Home Survey", Centers for Disease Control & Prevention, No. 280, January 23, 1997.

The Institute for the Future, Health and Health Care 2010, Jossey-Bass Publishers, San Francisco, CA.

Wiener, J. M., & Stevenson, D. G., Long Term Care for the Elderly: Profiles of Thirteen States, The Urban Institute, 1998, Occasional Paper #12.

Georgia State Health Plan
Nursing Facilities Component Plan

Appendix A

NURSING HOME BED NEED PROJECTION
(2003 POPULATION PROJECTIONS)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH, DIVISION OF HEALTH PLANNING

NURSING HOME BED NEED PROJECTION (2003 POPULATION PROJECTIONS)

(CALCULATED FOR DETERMINATION OF UNMET NEED, SEPTEMBER 2000)

Bed Need

(0.43 X 1000 Pop., 0-64) + (9.77 X 1000 Pop., 65-74) + (32.5 X 1000 Pop., 75-84) + (120 X 1000 Pop., 85 and Over)

Health Planning Area	Population 0 - 64	0.43 Bed Rate	Population 65 - 74	9.77 Bed Rate	Population 75 - 84	32.5 Bed Rate	Population 85 OVER	120 Bed Rate	Estim Total
1	524,746	**226**	51,261	**501**	35,960	**1,169**	10,313	**1,238**	**3,133**
2	290,913	**125**	29,436	**288**	20,660	**671**	5,853	**702**	**1,786**
3	3,353,292	**1,442**	188,541	**1,842**	114,602	**3,725**	34,794	**4,175**	**11,18**
4	304,316	**131**	20,717	**202**	16,914	**550**	5,294	**635**	**1,518**
5	359,524	**155**	26,693	**261**	22,393	**728**	6,938	**833**	**1,976**
6	398,273	**171**	36,210	**354**	25,255	**821**	7,484	**898**	**2,244**
7	363,073	**156**	29,598	**289**	21,506	**699**	6,886	**826**	**1,971**
8	282,216	**121**	26,330	**257**	20,668	**672**	6,314	**758**	**1,808**
9	104,510	**45**	10,097	**99**	9,426	**306**	2,965	**356**	**806**
10	409,978	**176**	32,937	**322**	25,079	**815**	7,488	**899**	**2,212**
11	288,333	**124**	26,603	**260**	22,855	**743**	7,341	**881**	**2,008**
12	186,226	**80**	14,371	**140**	12,664	**412**	3,870	**464**	**1,096**
13	283,035	**122**	24,095	**235**	18,930	**615**	5,353	**642**	**1,615**
State Totals/Avg.	**7,148,435**	**3,074**	**516,889**	**5,050**	**366,912**	**11,925**	**110,893**	**13,307**	**33,35**

NOTES:

(1) Population Figures are 2003 CNI Projections from the Georgia Office of Planning and Budget, using 1998 Census Estimates.

(2) Current Bed Data is based on data from the agency bed inventory and the 1999 Annual Nursing Home Survey. In case of discrepancy, the lower number is used.

(3) Occupancy Data is calculated on days of patient utilization, using data from the 1999 Annual Nursing Home Survey.

Georgia Comparison		
CURRENT BEDS	**BED SURPLUS OR DEFICIT (-)**	**1999 OCCUPANCY**
3,579	446	94.9
1,942	156	95.8
10,879	-305	88.0
1,596	78	91.8
2,396	420	96.3
3,282	1,038	93.0
2,585	614	93.4
2,260	452	93.6
1,448	642	92.8
2,891	679	89.4
2,167	159	96.8
1,532	436	94.9
2,004	389	92.3
38,779	**5,423**	**92.1**

(2) Current Bed Data is based on data from the agency bed inventory and the 1999 Annual Nursing Home Survey. In case of discrepancy, the lower number is used.

(3) Occupancy Data is calculated on days of patient utilization, using data from the 1999 Annual Nursing Home Survey.

Georgia State Health Plan
Nursing Facilities Component Plan

Appendix B

Annual Nursing Home Questionnaire
Selected Data and Information

DEMOGRAPHIC CHARACTERISTICS OF NURSING HOME PATIENTS

AGE OF NURSING HOME PATIENTS
Georgia, 1991 - 1998

Patient Age	Age Category as a Percent of Total Patient Census							
	1991	1992	1993	1994	1995	1996	1997	1998
<15	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
15-64	9.0	8.5	8.3	8.3	8.2	8.5	8.4	8.7
65-74	16.1	15.9	15.7	15.6	15.4	15.4	15.4	15.6
75-84	37.9	37.0	37.3	37.1	36.8	36.2	35.2	36.0
85+	37.0	38.5	38.7	39.0	39.6	39.9	41.0	40.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total 65+	91.0	91.5	92.0	91.7	91.8	91.5	91.6	91.3

RACE OF NURSING HOME PATIENTS
Georgia, 1994 - 1998

Race	Race Category as a Percent of Total Patient Census		
	1994	1996	1998
White	27,321 (75.3%)	27,132 (74.9%)	26,478 (73.4%)
Non-White	8,965 (24.7%)	9,502 (25.9%)	9,598 (26.6%)

GENDER OF NURSING HOME PATIENTS
Georgia, 1994 - 1998

Gender	Gender Category as a Percent of Total Patient Census		
	1994	1996	1998
Female	27,483 (75.7%)	27,478 (75.0%)	26,969 (74.6%)
Male	8,803 (24.3%)	9,156 (25.0%)	9,193 (25.4%)

DIAGNOSTIC CHARACTERISTICS OF NURSING HOME PATIENTS

DIAGNOSTIC CATEGORIES REPORTED FOR NURSING HOME PATIENTS
Georgia, 1994 - 1998

Diagnostic Category	Category as a Percent of Total Patient Census		
	1994	1996	1998
Mental Retardation	1,215 (3.3%)	1,219 (3.3%)	1,146 (3.1%)
Mental Illness	4,066 (11.2%)	5,105 (13.9%)	4,556 (12.5%)
Alzheimer's Disease	6,450 (17.8%)	7,957 (21.7%)	7,557 (20.7%)
HIV/AIDS	16 (< .01%)	13 (< .01%)	80 (0.2%)
All Other	24,539 (67.6%)	22,340 (61.0%)	23,162 (63.5%)

SOURCE: **1991-1998 Annual Nursing Home Questionnaires (***1998 Data is Unedited***)**
Division of Health Planning, Georgia Department of Community Health

GENERAL NURSING HOME BED CAPACITY
PER 1000 POPULATION AGE 65+
GEORGIA, 1991-1998

YEAR	REPORTED BED CAPACITY	CNI POPULATION* AGE 65 AND OLDER	BEDS PER 1000 POPULATION 65 AND OLDER
1991	36,805	627,575	60.0
1992	37,065	636,142	59.7
1993	37,750	644,888	59.8
1994	37,865	653,432	59.5
1995	38,133	662,532	59.2
1996	38,406	670,706	59.2
1997	38,699	679,432	57.0
1998	38,779	687,996	56.4

Source: **1990-1998 Annual Nursing Home Questionnaires (*1998 Data is Unedited*)**
Division of Health Planning, Department of Community Health
***Civilian, Non-Institutional (CNI) Population Projections Developed by the Georgia Office of Planning and Budget**

SUMMARY OF GENERAL NURSING HOME UTILIZATION
Georgia, 1991-1998

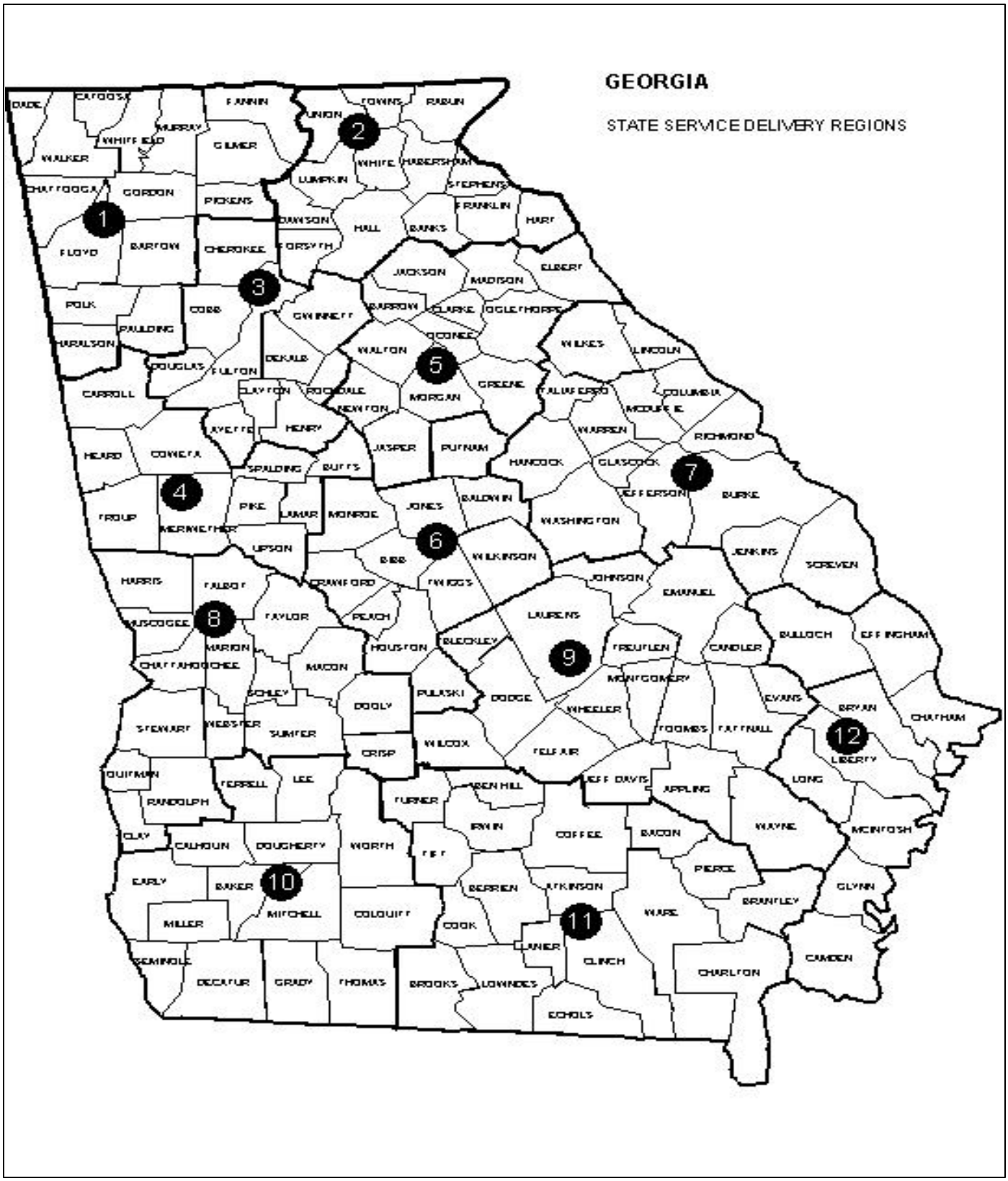
	1991	1992	1993	1994	1995	1996	1997	1998
Number of Nursing Homes	**344**	**344**	**349**	**349**	**352**	**355**	**356**	**358**
Reported Bed Capacity	**36,805**	**37,065**	**37,750**	**37,865**	**38,133**	**38,406**	**38,699**	**38,779**
Admissions	**21,509**	**21,615**	**23,431**	**25,128**	**27,085**	**29,656**	**31,958**	**35,578**
Patient Days	12,648,264	12,856,754	12,976,631	13,173,419	13,181,118	13,364,633	13,235,366	13,152,246
Occupancy Rate (Available Bed Days)	**94.3**	**95.3**	**95.3**	**95.4**	**94.9**	**95.3**	**93.7**	**92.9**

Source: **1991-1998 Annual Nursing Home Questionnaires (*1998 Data is unedited.*)**
Division of Health Planning, Department of Community Health

Georgia State Health Plan
Nursing Facilities Component Plan

Appendix C

Map
STATE SERVICE DELIVERY REGION


GEORGIA
STATE SERVICE DELIVERY REGIONS
1
2
3
4
5
6
7
8
9
10
11
12

Georgia State Health Plan
Nursing Facilities Component Plan

Appendix D

Membership List
Long Term Care Need Methodology
Technical Advisory Committee

Georgia State Health Plan
Component Plan Nursing Facilities
Membership, Long Term Care Bed Need Methodology Technical Advisory Committee

Committee Chair

William L. Minnix, Jr., D.Min.
President, Wesley Homes, Inc.

Members, Long Term Care Committee of the Health Strategies Council

Troy A. Athon
Elizabeth Brock
Neal Brook
Iris Feinberg
Lola Fitzpatrick
Leonora Ginn
John H. (Howdy) Thurman
Kay Wetherbee, R.N.
Lewis H. Williams, D.D.S.

Governor's Blue Ribbon Task Force on Community-Based Services

Hunter Hurst, Task Force Co-Chair
Director of Regional Affairs
St. Joseph's/Candler Health System

Georgia Hospital Association

Carolyn Cotton-Bayless
Director, Long Term Care Division
Northeast Georgia Health Resources
Gainesville, Georgia

Georgia Nursing Home Association

Dean Shuford
Chief Financial Officer, Golden Age Properties
Hawkinsville, Georgia

R. Lawrence Williams
Chief Operating Officer, UHS-Pruitt Corporation
Toccoa, Georgia

American Association for Retired Persons

Sonia P. Smith
Health Advocacy Services, Local Coordinator
Atlanta, Georgia

Council on Aging

Martha Eaves
Chair, Council on Aging
Conyers, Georgia

Medical Association of Georgia

Bob Lanier, M.D.
Chair, MAG Long-Term Care Committee
Atlanta, Georgia

Georgia State University

Frank J. Whittington, Ph.D.
Director, Gerontology Center
Georgia State University

Georgia Association of Homes and Services for the Aging

Dr. Frank McElory, Jr.
CEO, Presbyterian Homes of Georgia
Quitman, Georgia

Georgia - Assisted Living Federation of America

Genia Ryan, Executive Director

Department of Human Resources Division of Aging

Jeffrey A. Minor
Director, Division of Aging

Department of Human Resources Office of Regulatory Services

David Dunbar
Director, Long-Term Care Section

Department of Community Health Division of Medical Assistance

Linda Kendall, Program Director
Nursing Homes and New Program Initiatives