

**GEORGIA STATE HEALTH PLAN
COMPONENT PLAN**

HOME HEALTH SERVICES

**HEALTH STRATEGIES COUNCIL
AND
GEORGIA DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF HEALTH PLANNING**
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Planning area map has been changed effective April 1, 2003

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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, public participatory process developed and monitored by the 27-member Governor-appointed Health Strategies Council. 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, Chapter 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:

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I. INTRODUCTION

A. Planning Process

The Health Strategies Council (HSC) (and its predecessors) and the Department of Community Health/Division of Health Planning, which staffs the Council, have a long history of planning for long-term care services in Georgia as is evidenced by the completion of the first Home Health Services Component Plan in January 1987.

In 1992, a Long-Term Care Technical Advisory Committee (LTC-TAC) was formed to provide a public forum where citizens could express their opinions and reach consensus about the future direction of long-term care services in Georgia. The LTC-TAC was comprised of members of the HSC's Long-Term Care Standing Committee, representatives of state agencies, consumers, advocates, elected officials, and healthcare provider groups. By state statute, the HSC is comprised of both consumers and health care providers, representing a wide variety of stakeholder groups.

The LTC-TAC held its first meeting on December 11, 1992. It established two Resource Groups, one to address Residential Care and the other to address Community and Home Care (which included Home Health Services). The Community and Home Care Resource Group (CHCRG) was charged with assisting the LTC-TAC by addressing issues and policies pertaining to community and home care, other home care services, Home and Community-Based Medicaid Waiver services and other non-residential long-term care services.

In 1994, after 18 months of work, the LTC-TAC and its resource groups issued a report to the Health Strategies Council which (1) defined long-term care, principles, and the array of long-term care services and settings; (2) defined levels of residential care; and (3) recommended policy initiatives in seven areas. The LTC TAC supported licensure of private home care providers (H.B. 1332) to enhance quality of care. This legislation passed the 1994 General Assembly without opposition.

In November 1995, the LTC-TAC recommended that the component plans for Home Health and Nursing Home Services be updated. The Community and Home Care Resource Group was charged with assisting the LTC-TAC by addressing issues pertaining to non-residential long-term care services. In May 1997 the HSC

adopted a new component plan and recommended rules for home health services.

Over the years, there has been expressed concern about the complexity of the current Home Health Need Methodology. Given the changes occurring in the long-term care industry, and Georgia's changing demographics, the Health Strategies Council convened another TAC in November 2000 to examine the need methodology and regulatory structure for home health services. The TAC revised the home health need methodology to one that was similar to the revised (August 2000) Nursing Home Need Methodology. They felt that this methodology would allow the home health services plan to be more easily integrated into a comprehensive long-term care plan. The Division of Health Planning will develop this comprehensive plan within the next year. The Home Health Services Need Methodology TAC completed its work on January 5, 2001. This revised plan is a product of the 2000 TAC's deliberations.

B. Home Health Services in the Context of the Care Continuum

The care continuum for long-term care services consists of a wide range of service options for seniors, persons with disabilities and others in need of transitional living and support services. Skilled and intermediate care nursing facilities provide services at the most restrictive and intensive end of the long-term care continuum. These facilities provide health care support and maintenance within a residential setting, ideally for individuals who could not otherwise be served in their own home or another community setting.

A wide range of home and community-based services also are available in the continuum, starting with residential services such as assisted living (known in Georgia as personal care homes) and ending with minimally restrictive programs such as adult day health care and home delivered meals. Many of these services are available to citizens through several waiver programs offered by the Department of Community Health through its Medicaid programs. Persons served through these home and community-based waiver programs must meet the potential criteria for nursing home or institutional care.

Home health service is one component of the long-term care continuum. It is a health care service that allows patients to receive services in their own homes or the home of a family member. Home health services also fill an important role in providing nursing services and therapeutic care for individuals transitioning out of an acute care setting. Home health is a very specific, specialized type of home care, requiring skilled nursing care, ordered by a physician. Visits are part-time or intermittent, and treatment plans have to be reviewed and

updated at least every two months. Medicare generally defines “intermittent” services as those provided or needed less than 7 days each week or less than 8 hours each day for period of 21 days or less. (Medicare Advisory: October 1998). Medicare and Medicaid reimburse most costs associated with the provision of home health services to qualified enrollees.

There are other services available through home and community-based programs. Personal support and private home provider services are other types of home care services. Many of these services and programs do require state licensure, but do not require a certificate-of-need for operation. Since these services are not provided as physician-directed health care, they are not reimbursable by Medicare. Many home and community-based services are reimbursed by Medicaid through their waiver programs. Because of the medically directed, costly nature of home health care, it is one of the few long term care services which require a Certificate of Need.

The regulatory structure for home health services should promote the development of needed services while ensuring cost-containment and program quality. Consumers need to be able to conveniently access home health services within their communities to meet their personal health care needs.

II. OVERVIEW

A. Trends and Issues

Home care is a cost-effective service, not only for individuals recuperating from a hospital stay but also for those who are unable to take care of themselves. It reinforces and supplements the care provided by family members and friends and maintains the recipient's independence. Most importantly, home care allows patients to take an active role in their care.

Home Health Services are those services which enable health care, medical care, social support services and other therapies to be delivered to individuals in their place of residence, wherever that may be, and is a chief component of home and community-based care. As Georgia's population ages and becomes more diverse, there is growing concern about how to assure provision of a continuum of long-term services.

Since home health care is a vehicle for the delivery of both acute and intermittent care, different types of agencies have emerged serving individuals in many different settings. The Certificate of Need (CON) Program covers only licensed home health agencies which are defined as: private organizations, which are primarily engaged in providing care to individuals who are under a written plan of care of a physician, on a visiting basis in the places of residence used as such individuals' home, part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse, and one or more of the following services:

- physical therapy;
- occupational therapy;
- speech therapy;
- medical-social services under the direction of a physician; or
- part-time or intermittent services of a home health aide.

One of the major concerns in planning for statewide services is the provision of home health services for Georgia's rural communities. Access to healthcare services is particularly problematic, given historical problems in recruitment and retention of health care personnel. Another major obstacle facing Georgia's rural communities is the time involved in traveling to patients' homes.

Several factors have influenced the provision of home care in over past years. Some of the factors are

discussed below:

- **Changing demographics, especially the aging of the population:** Since age and functional disability are likely predictors of the need for home health services, the aging of Georgia's population will impact the need for these services. The TAC felt that a revised home health need methodology should provide a better planning tool for state policy makers to better understand and address the true needs of differing population age groups.
- **Impact of Medicare's Prospective Payment System (PPS):** Shorter hospital stays for Medicare beneficiaries, as a result of the PPS, have resulted in more people discharged quicker and in frailer conditions. Also, more diagnostic and treatment procedures are being done on an ambulatory basis. During the 1980's Medicare's annual home care benefit increased significantly and the number of home care agencies had risen to over 10,000. More recently, the number of Medicare-certified home health agencies declined to 7,747, the direct result of changes in Medicare home health reimbursement enacted as part of the Balanced Budget Act of 1997. (National Association of Home Care, 2000)
- **Changes in technology:** Advances in complex medical care now allow many people to survive traumatic events and to live longer than ever before with serious health conditions. In recent years, technology has allowed home care to become increasingly high-tech, including intravenous infusions, parenteral nutrition, supplemental oxygen, monitoring devices, and respirators.
- **Increased consumer demand:** There continues to be a growing interest in finding ways to keep patients out of institutions treating patients in home or community settings. Home care supporters are quick to point out that care delivered in a patient's home should cost far less than similar care in a hospital or nursing home.

B. REIMBURSEMENT OF HOME HEALTH SERVICES

Medicare Reimbursement

Legislation in the late 1990's affecting Medicare reimbursement policies has created strong incentives and pressures for home health agencies to reduce costs per visit and number of visits per episode. This area has perhaps had the most profound change in the availability of home care providers. Medicare is the largest single payer of home care services. The National Association for Home Care (NAHC) reports that in 1997, Medicare spending accounted for about 40% of total estimated home care expenditures. Growth in the Medicare home

health benefit between 1990 and 1996 can be attributed to specific legislative expansions. Between fiscal years 1998 and 1999, Medicare spending fell from \$14 billion to \$9.5 billion, a 32% decrease. No other benefit in the Medicare program experienced proportionate reductions anywhere near the magnitude that home health experienced as a result of changes imposed by the Balanced Budget Act of 1997. The BBA's interim payment system (IPS) introduced a new per beneficiary limit, designed to reduce growth in Medicare home health expenditures. Home Health payments under the IPS were restricted to the lowest of agency's allowable costs, its per-visit cost limits, or its per-beneficiary cost limits. (National Association for Home Care, 2000).

The BBA mandated that HCFA develop a prospective payment system for Medicare home health, which is being enacted at this writing. It is hoped that a PPS system, which would be a national payment system, would encourage providers to offer more efficient services. This proposed system also includes payments for market differences. A major difference among the systems is the unit of payment. Hospitals are paid by the stay; skilled nursing facilities are paid by the day. In FY2000, the home health benefit accounted for four percent of total Medicare spending. HCFA projects that Medicare's share of home care services will decline through 2008 as Medicaid's share increases. (National Association for Home Care, 2000). It will be important to revisit Georgia's home health plan once the new PPS is fully implemented.

Medicaid Reimbursement

State Medicaid waiver programs are increasingly relying on home care to reduce their costs of providing long-term care. Medicaid payments for home care are divided into three main categories, traditional home health benefit that is a mandatory service provided by all states and two optional programs, the personal care option and home and community-based waivers. Together these three home health services represent a relatively small but growing portion of total Medicaid payments., close to half of the \$124 billion in Medicaid benefit payments in fiscal year 1997 were for hospital care and institutional services. Home care services comprised 9.8% of the payments (National Association for Home Care, 2000).

C. Home Care in Georgia and the United States

Data from the National Association for Home Care indicates that since 1997, utilization of home health services has decreased significantly. Not surprisingly, examination of 1997-1999 nationwide average patient payment rates showed an average decline of 38.5%. About 500,000 fewer beneficiaries used the benefit in 1998 than did in 1997. Visits per client and per client reimbursement have also declined since 1996 and remain below 1994 averages. (National Association for Home Care, 2000)

Statewide data for home health services mimic the national experience. Data from the 1996-1999 Annual Home Health Services Survey/Division of Health Planning indicates that the number of agencies providing home health services increased from 95 in 1996 to 114 in 1999. At the same time, the number of patients decreased 18.8% and the number of patient visits declined 61.00%. Decreasing reimbursement rates for this service, has led to significant decreases in the number of providers, it is unclear at this time of the impact of the new prospective payment system.

III. GUIDELINES

A. USE OF GUIDELINES

The following criteria and standards outline the guidelines for the development and delivery of Home Health Services in the State of Georgia as recommended by the Health Strategies Council.

B. DEFINITIONS FOR THE GUIDELINES

1. "Home health Department of Community Health/Division of Health Planning" means a public agency or private organization, or a subdivision of such an agency or organization, which is primarily engaged in providing to individuals who are under a written plan of care of a physician, on a visiting basis in the place of residence used as such individual's home, part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse, and one or more of the following services: physical therapy, occupational therapy, speech therapy, medical-social services under the direction of a physician, or part-time or intermittent services of a home health aide.

2. "Horizon year" means the last year of the three-year projection period for need determinations for a new or expanded home health Department of Community Health/Division of Health Planning.

3. "Geographic service area" means a grouping of specific counties that is comprised of the county in which the headquarters of the agency is located and some counties contiguous to that county within a planning area for which the home health agency is authorized to provide services to individuals residing in the specific counties pursuant to an existing or future certificate of need. For purposes of establishing a service area for a new home health agency or for an expansion of an existing agency, the geographic service area will be the county in which the agency headquarters is located and any counties contiguous to that county which show a need by the need formula shall consist of any individual county or combination of contiguous counties which have an unmet need as determined through the numerical need formula or the exception. For purposes of an expansion of an existing agency, the geographic service area shall consist of an individual county or any combination of counties which have an unmet need and which are within any planning area in which the home health agency already provides service; however, in no case may an existing home health agency apply to provide services outside the planning areas in which its current geographic service area is located.

4. "Nursing care" means such services provided by or under the supervision of a licensed registered professional nurse in accordance with a written plan of medical care by a physician. Such services shall be provided in accordance with the scope of nursing practice laws and associated rules.

5. "Official state component plan" means the document related to home health services developed by the Department of Community Health/Division of Health Planning, established by the Health Strategies Council and signed by the Governor of Georgia adopted by the Board of Community Health.

6. "Planning area" for all home agencies means the geographic regions in Georgia defined in the State Health Plan or Component Plan (See Appendix B).

C. STANDARDS FOR GUIDELINES

1. APPLICABILITY

These Guidelines apply to home health agency services.

2. AVAILABILITY

STANDARD 1 - NEED

1. The need for a new or expanded home health Agency shall be determined through application of a numerical need method and an assessment of the number of patients currently being served.

(i) The numerical need for a new or expanded home health agency in any planning area in the horizon year shall be based on the estimated number of annual home health patients within each planning area as determined by a population-based formula which is a sum of the following for each county within the planning area:

- (I) a ratio of 4 patients per 1,000 projected horizon year civilian noninstitutional (CNI) population age 17 and younger;
- (II) a ratio of 5 patients per 1,000 projected horizon year civilian noninstitutional (CNI) population age 18 through 64;
- (III) a ratio of 45 patients per 1,000 projected horizon year civilian noninstitutional (CNI) population age 65 through 79; and
- (IV) a ratio of 185 patients per 1,000 projected horizon year civilian noninstitutional (CNI) population age 80 and older.

(ii) The net numerical unmet need for home health services shall be determined by subtracting the projected number of patients for the current calendar year from the projected need for services as calculated in (C)(1)(I). The projected number of patients for the current calendar year is determined by multiplying the number of patients having received services in each county, as reported in the most recent survey year, by the county population change factor. The county population change factor is the percent change in total population between the most recent survey year and the current calendar year.

RATIONALE FOR STANDARD 1: The 2000 Technical Advisory Committee (TAC) recommended the adoption of an objective need methodology for home health services, particularly one that examines the varying utilization of services by different age cohorts. The TAC examined the home health need methodologies that are currently being used in several states, including Kentucky, State of Washington, Tennessee, New York, North and South Carolina. They agreed to adopt a method comparable to that of the State of Washington. This methodology is similar to the State of Georgia's current nursing home services need methodology that was

adopted in August 2000. Projected future need is determined by an established rate for a defined population cohort. Projected service capacity is then subtracted from the projected need to determine unmet need.

Provider survey data serves as the primary basis for determining projected service capacity within a given planning area. However, the survey data is reported after the close of the year so the data could be at least a year old. The TAC felt strongly that service data as reported through the survey process should be adjusted by a population change factor to ensure that the projected service capacity was more reflective of probable services provided in the calendar year in which the need methodology is being calculated. Each county's population change factor is determined by the percent change in population between the year of the survey data and the current year.

STANDARD 2: THRESHOLD MINIMUMS

2. (i) The Division shall authorize the submission of applications as enumerated below

- (I) If the net numerical unmet need in a given planning area is 250 patients or more, the Division shall authorized the submission of applications for an expanded home health agency; or
- (II) If the net numerical unmet need in a given planning area is 500 patients or more, the Division shall authorize the submission of applications for a new home health agency as well as an expanded home health agency.

(ii)An applicant must propose to provide service only within a geographic service area comprised of a county or group of counties, each of which reflects a numerical unmet need, and contained within the given planning area for which the Division has authorized the submission of applications.

RATIONALE FOR STANDARD 2: During their deliberations, TAC members felt that some minimum number of patients should be established to determine the need for new or expanded services. Members spent considerable time discussing minimum thresholds. They agreed that need for a new service should be set at a minimum threshold of 500 patients to ensure agency viability. An existing service could also seek to expand to address this unmet need. The minimum need threshold for an expanded service should be set at 250 patients.

After considerable discussion, the TAC agreed to discard of the concept of a headquarter county for the provision of service. Instead, for expansions, the applicant must propose to provide service within the given planning area for which the home health agency already provides service and within which the Division has authorized the submission of applications. For new applications, the proposed service area must include

contiguous counties. These criteria ensure that counties with unmet need have access to new services while protecting against potential “cherry picking”. In any application, the proposal may only address the provision of service in counties with unmet need.

STANDARD 3 - EXCEPTION TO NEED

The Division of Health Planning may allow an exception to the above need methodology if the following circumstance exists:

- (i) The applicant for a new or expanded home health agency can show that there is limited access in the proposed geographic service area for special groups such as, but not limited to, medically fragile children, newborns and their mothers, and HIV/AIDS patients. For purposes of this exception, an applicant shall be required to document, using population, service, special needs and/or disease incidence rates, a projected need for services in the planning area of at least 200 patients within a defined geographic service area. A successful applicant applying under this section will be restricted to serving the special group or groups identified in the application within the county or counties stipulated in the application.

RATIONALE FOR STANDARD 3: This standard recognizes the potential existence of groups with special needs, which are not being met. The exception to need standard allows an applicant to show that there is limited access in the proposed geographic service area for special groups such as, but not limited, medically fragile children, newborns and their mothers, and HIV/AIDS patients. Members recommended a minimum threshold of 200 patients, because of the likelihood that many of these patients could potentially be located in rural counties of the state, which are less populated, and because of the small proportion of people who would potentially fall into these categories in a particular area. TAC members encouraged Division of Health Planning staff to be more judicious about sanctioning those providers who violate CON provisions by not serving those consumers that they proposed to serve under this exception standard.

STANDARD 4 - COMMUNITY LINKAGES

An applicant for a new or expanded home health a agency shall provide a 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

focusing on coordinated, integrated systems which promote continuity rather than acute, episodic care. Working agreements with other related community services might include the ability to streamline referrals to other appropriate services and to participate in the development of cross-continuum care plans with other providers.

RATIONALE FOR STANDARD 4: Increasing concern with continuity of care makes it imperative that attention be focused on coordinated care. Among the factors influencing continuity of care is the expectation that higher acuity care will be provided by home health agencies. This heightens the necessity for a community linkage plan such that high acuity patients can be triaged in a timely manner to an appropriate level of care. Providers are encouraged to establish working agreements with community service agencies to enhance and to assure continuity of care through the streamlining of patient referrals and the development of cross-continuum care plans.

STANDARD 5: LICENSURE REQUIREMENTS

An applicant for a new or expanded home health agency shall provide a written statement of its intent to comply with all appropriate licensure requirements and operational procedures required by the Office of Regulatory Services of the Georgia Department of Human Resources.

RATIONALE FOR STANDARD 5: Georgia's licensure rules and regulations for Home Health Agencies were established to provide some basic minimum requirements pertaining to the operation and management of home health agencies. The Department of Community Health is committed to ensuring that the citizens of Georgia receive the highest quality level of services. All healthcare facilities are required to meet these minimum operational standards.

Standard 6: VIOLATIONS AND DEFICIENCIES

An applicant for a new or expanded home health agency (ies) owned and/or operated by the applicant or its parent organization shall have no history of uncorrected or repeated conditional level violations or uncorrected standard deficiencies as identified by licensure inspections or equivalent deficiencies as noted from Medicare or Medicaid audits.

RATIONALE FOR STANDARD 6: A new or expanded Home Health agency should participate in both

Medicaid and Medicare, both of which provide access to care for large number of Georgians. Each Home Health agency should furnish previous Medicaid and Medicare violation reports, deficiency reports, investigational reports, audit reports, and cost reports to substantiate their present status and to support their position that any previously noted deficiencies/violations have been corrected on a timely basis

STANDARD 7: FRAUD CONVICTION

An applicant for a new or expanded home agency owned and/or operated by the applicant or its parent organization shall have no previous conviction of Medicaid or Medicare fraud.

RATIONALE FOR STANDARD 7: A new or expanded Home Health Agency owned and/or operated by a parent organization should have no previous conviction of Medicaid or Medicare fraud. One initiative supporting this effort is the establishment of the Division of Medical Assistance's Section on Fraud. This section was established with a main goal of eliminating fraud and abuse in Georgia's Medical Assistance Program. Much emphasis is being placed on the work of this unit.

STANDARD 8: PERSONNEL REQUIREMENTS

An applicant for a new or expanded home health agency shall provide a written plan which demonstrates the intent and ability to recruit, hire and retain the appropriate numbers of qualified personnel to meet the requirements of the services proposed to be provided and to endure that such personnel are available in the proposed geographic service area.

RATIONALE FOR STANDARD 8: A new or expanded Home Health agency should have in place a plan, which specifies measurable strategies for staff selection, training, and retention. In order to promote improved outcomes for consumers, providers must focus on staff. The agency's ability to meet this standard should include, but not be limited to, the following areas:

- (1) Developing professional and direct care staff by implementing continuing education/training;
- (2) Ensuring that the documented costs of personnel are accurately reflected in the agency's proforma and cost projections;
- (3) Providing documentation that all staff who will provide the proposed services possess state licensure's specified levels of education, credentials, experience and training to provide the proposed services in a manner consistent with high quality; and demonstrating agency's intent to obtain

appropriate levels and numbers of professional and paraprofessional staff to meet the requirements of the services proposed, and that the specified personnel are available in the proposed geographic service area.

STANDARD 9: ACCREDITATION REQUIREMENTS

An applicant for a NEW home health agency shall provide evidence of the intent to meet the appropriate accreditation requirements of the Joint Commission for Accreditation of Health Care Organizations (JCAHO), the Community Health Accreditation Program, Inc. (CHAP), and/or other appropriate accrediting agencies.

STANDARD 10: ACCREDITATION REQUIREMENTS

An applicant for an EXPANDED home health agency shall provide documentation that they are fully accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO), the Community Health Accreditation Program, Inc. (CHAP), and/or other appropriate accrediting agencies.

RATIONALE FOR STANDARDS 9 & 10: Two major accreditation bodies are the Joint Commission on Accreditation of Health Care Organization (JCAHO) and the Community Health Accreditation Program, Inc. (CHAP). Accreditation by these organizations is recognized nationwide as a "seal of approval". Such an approval indicates that an organization meets certain performance standards. Because these standards reflect state-of-the-art performance expectations, organizations that meet these standards improve their ability to provide quality patient care. Both of these organizations perform on-site visits and establish standards for many aspects of home health agencies including, but not limited to, patient advocacy, governance, administration, quality of care, quality assurance and medical records. Home Health Agencies that are surveyed and certified by CHAP and/or JCAHO have deemed status with Medicare and the Department of Human Resources/Office of Regulatory Services. Accreditation may also be a condition of reimbursement for certain insurers and other payers.

STANDARD 11: QUALITY IMPROVEMENT

An applicant for a new or expanded home health agency shall provide its existing or proposed plan for a comprehensive quality improvement program.

RATIONALE FOR STANDARD 11: All providers should have comprehensive quality improvement programs in

place consisting of outcomes data and up-to-date industry benchmarks, which address the following areas: patient outcomes, consumer satisfaction, consumer demand, and patient/consumer rights.

STANDARD 12: FINANCIAL ACCESSIBILITY

An applicant for a new or expanded home health agency shall assure access to services to individuals unable to pay and to all individuals regardless of payment source or circumstances by:

- (i) Providing evidence of written administrative policies that prohibit the exclusion of services to any patient on the basis of age, disability, gender, race, or ability to pay;
- (ii) Providing a written commitment that services for indigent and charity patients will be offered at a standard which meets or exceeds three percent of annual, adjusted gross revenues for the home health Agency or, in the case of an applicant providing other health services, the commitment to services for indigent and charity patients may at the discretion of the applicant be applied to the entire facility;
- (iii) Providing documentation of the demonstrated performance of the applicant, and any facility in Georgia owned or operated by the applicant's parent organization, of providing services to Medicare, Medicaid, and indigent and charity patients;
- (iv) Providing a written commitment to participate in both the Medicare, Medicaid and PeachCare programs; and
- (v) Providing a written commitment to participate in any other state health benefits insurance programs for which the home health service is eligible.

RATIONALE FOR STANDARD 12: Providing financially accessible home health services is an essential component of Georgia's State Health Plan. In the assessment of financial access for a new or expanded Home Health Agency, all of the provisions of the financial accessibility standards, as delineated above, must be met. Particular attention should be given to the applicant who commits to seeking measurable ways to locate alternative services/payor sources for those unable to pay and implements innovative strategies for providing services to those unable to pay through such programs as outreach and primary and preventative care interventions. A new or expanded Home Health Agency should make a firm commitment to remain and or become an active participant in the Georgia Medicaid Program, PeachCare and SHBP. Medicare is the largest single payor of home care services and growing exponentially faster than the population is aging. A new provider should make a firm commitment to become/continue as an active participant in the Medicare Program by entering into an Agreement with Medicare to provide care and treatment to Medicare beneficiaries.

STANDARD 13: CHARGES

An applicant for a new or expanded home health Agency shall demonstrate that their proposed charges compare favorably with the charges of existing home health agencies in the same geographic service area.

RATIONALE FOR STANDARD 13: A new or expanded Home Health Agency should have charges that compare favorably with the charges of existing Home Health Agencies providing similar services in the same geographic service area. Average charges for home health care services can vary significantly from one geographic area to another. Medicare's home health cost caps recognize geographic differences and generally allow higher per visit payments to agencies in urban areas. Comparing charges with other services in the same or a similar geographic area also helps ensure equitable charges within individual communities.

STANDARD 14: INFORMATION REQUIREMENTS

An applicant for a new or expanded home health Agency shall document an agreement to provide Division with requested information and statistical data related to the operation and provision of home health services and to report that data to the Division in the time frame and format requested by the Division.

RATIONALE FOR STANDARD 14: Uniform data is important to assess changing patterns and projected service needs relevant to the provision of this service. As additional emphasis is placed on data analysis, quality and patient outcomes, and community benefit. The collection of data will allow more precise assessment of these factors as well as others, which are important to health planning. A new or expanded home health agency should provide the Division with requested information and statistical data related to the operation and provision of home health services.

STANDARD 15: SERVICE ACQUISITION

When an existing Agency is acquired by another existing Agency, and the acquiring Agency wishes to merge its pre-existing service area with the acquired Agency's service area, and the resultant merger of service areas would result in the dissolution of the acquired agency, along with its separate license and provider numbers, and the expansion of the geographic service area of the acquiring agency, the acquiring agency may apply, outside of a regular batching cycle, for a Certificate of Need to expand its authorized service area in this manner:

- (i) The applicant must show that the merger and subsequent expansion of its authorized geographic service area will promote maximum efficiency and geographic accessibility to the patients of the proposed service area; and
- (ii) The applicant must show that patients of the acquired and dissolved agency will be served with minimal or no disruption in patient care.

RATIONALE FOR STANDARD 15: Consolidation of services, through acquisition of an existing provider, would likely result in enhanced administrative efficiencies and will increase the acquiring agency's market share. This consolidation could also be advantageous to new and existing patients by maintaining access to care and continuity of care in their local areas. In the absence of previously existing services, an existing provider should be encouraged and incentivized to continue to offer services locally. The ability of an existing provider to apply for need, outside of the batching cycle, facilitates this process and assures local residents access to care with minimal disruption.

IV. GOALS, OBJECTIVES AND RECOMMENDED ACTIONS

A. GOAL

To ensure that Georgia citizens have access to cost-effective, efficient, and quality home health services.

B. OBJECTIVES

1. Improve access to cost effective, quality home health services by authorizing these services based on a demand-based numerical need methodology.
2. Ensure quality and patient safety through compliance with appropriate standards and guidelines.
3. Assess availability, quality and effectiveness of services being provided through information and statistical data.
4. Encourage continuity of Home Health Services.
5. Improve access to Home Health Services by encouraging the provision of services on a non-discriminatory basis.
6. Improve financial access to Home Health Services by encouraging the provision of services to indigent and charity care patients and participation in public reimbursement programs.

C. RECOMMENDED ACTIONS

The Home Health Services Need Methodology, Technical Advisory Committee discussed and recommended the following actions:

1. Implement Certificate of Need (CON) rules for Home Health Services consistent with this Component Plan and approve CON applications accordingly;
2. Adopt an objective need standard for determining home health services.
3. Adopt need regulations, which promote and support efficient, quality service providers while still allowing new development in situations of sizable service areas. This new methodology would allow existing providers to apply for need anywhere in a given planning area, rather than having to start a new agency.

4. Encourage the Department of Community Health/Division of Health Planning to be more judicious about sanctioning providers who violate CON provisions, particularly those who received CONs under the "Exception to Need" standard;
5. Encourage the Department 's Division of Medical Assistance and providers to work together to find effective ways to improve services to medically fragile children;
6. Reconvene the TAC after one year to review changing service and utilization patterns following the implementation of the new Medicare payment system.

PLAN ADDENDUM

Georgia State Health Plan Home Health Services - Component Plan

A new component plan and regulatory guidelines for home health services were adopted in February 2001, following the work of a Technical Advisory Committee (TAC). Based on changing patterns of reimbursement and utilization, the plan set forth new criteria for establishing and expanding home health services in the state. Recognizing that the service and reimbursement landscape were undergoing even further change, the TAC recommended that the TAC be reconvened after one year to review progress and to determine whether any additional changes would be needed.

During the time following the issuance of the new rules the Department received several inquiries regarding service deficiencies, service projections, quality patient care and financing. Because of the Department's and the TAC's ongoing commitment to a fluid health planning process, the Home Health Services TAC was reconvened. The TAC met and reviewed the current regulatory framework and the impact of the new Medicare financing system on the home health industry. They also clarified and reaffirmed several key areas of the plan and rules. This addendum outlines the specific areas where changes were made. The changes were adopted by the Health Strategies Council at their May 31, 2002 meeting and approved by the Board of Community Health on June 12, 2002.

1. Issues of Applicability:

Following the changes made to the plan and rule during early 2001, the TAC felt it was no longer appropriate to require the otherwise non-reviewable acquisition of another home health agency to go through a modified CON application process. This requirement was tied to the previous rules to allow for expansion outside the batching application process. Under the new plan, this type of consolidation would simply promote efficiency and would not infringe on the need and application processes. These rule changes are proposed to address this minor change:

272-2-.09 (11) (a) Applicability.

1. A Certificate of Need for a home health agency will be required prior to the establishment of a new home health agency or the expansion of the geographic service area of an existing home health agency unless such expansion is a result of a non-reviewable acquisition of another existing home health agency.

(c) Standards.

~~15. When an existing agency is acquired by another existing agency, and the acquiring agency wishes to merge its pre-existing service area with the acquired agency's service area, and the resultant merger of service areas would result in the dissolution of the acquired agency, along with its separate license and providers number, and the expansion of the geographic service area of the acquiring agency, the~~

~~acquiring agency may apply outside of a regular batching cycle for a Certificate of Need to expand its authorized service area in this manner.~~

~~(i) The applicant must show that the merger and subsequent expansion of its authorized geographic service area will promote maximum efficiency and geographic accessibility to the patients of the proposed service area; and~~

~~(ii) The applicant must show that patients of the acquired and dissolved agency will be served with minimal or no disruption in patient care.~~

2. Exceptions to Need:

The Division and TAC members were aware of several instances where home health agencies have been granted a Certificate of Need for a county but have provided little or no services in that county. Members unanimously agreed that each provider should be required to provide services to some minimum number of patients/per approved county on an annual basis in order to maintain the CON for that county. The plan therefore incorporates an exception statement to allow the Department to authorize an existing provider to provide these services if some minimum service thresholds have not been reached. Such an expansion would be limited to providing services in contiguous counties or those within a limited mile radius. The exception is proposed as follows:

3. The Division may ~~allow~~ authorize an exception to 272-2-.09(11)(c)(1) if:

(i) the applicant for a new or expanded home health agency can show that there is limited access in the proposed geographic service area for special groups such as, but not limited to, medically fragile children, newborns and their mothers, and HIV/AIDS patients. For purposes of this exception, an applicant shall be required to document, using population, service, special needs and/or disease incidence rates, a projected need for services in the planning area of at least 200 patients within a defined geographic service area. A successful applicant applying under this section will be restricted to serving the special group or groups identified in the application within the county or counties stipulated in the application.

(ii) a particular county is served by no more than two (2) home health agencies and less than one percent of the county's population has received home health services or the agencies have demonstrated a failure to adequately serve Medicaid patients as evidenced by a level of service to such individuals that is less than the statewide average, within each of the past two years as reported on the Annual Home Health Services survey. For purposes of this exception, an applicant must already be approved to provide service in a contiguous county or be approved to provide service in a county which is no further than 15 miles from the county authorized through the exception. In all other aspects of the application process, the applicant shall be required to comply with provisions applicable to expanded home health agencies.

3. Clarification of Plan Guidelines and Rules:

The TAC clarified and reaffirmed the following points from the Plan issued in February 2001:

a. Applicants seeking an expansion of a home health agency must be accredited by JCAHO, CHAP or other appropriate body. (See Component Plan, Standard 10 or 272-2-.09(11) (c) (10)).

b. Applicants for new home health agencies must project to serve at least 500 patients and applicants for expanded home health agencies must project to serve at least 250 patients. These thresholds, required to trigger need for new or expanded services, are deemed minimal for successful new or expanded service operation. (See Component Plan, Standard 2 or 272-2- .09(11) (c) (2)).

c. The Division should balance the applicant's projected patient service volume with performance history, quality and cost. Once the applicant meets the minimum service volume requirements, that factor alone should not be weighted more heavily than other performance issues. TAC members encouraged the Division to closely examine, among other things, the applicant's pro forma, the range of services that the provider is currently offering (depth and breath of services), the reasonableness of the service projections, the number of counties that the provider actually serves and the applicant's track record of providing services in the review of a CON application. These data collectively would give a better assessment of the worthiness of the application as opposed to placing a greater emphasis on the projected volume of patients since the Division has no mechanism to determine the validity of the applicant's projections or the volume of patients that the applicant will actually serve.

V. REFERENCES

Basic Statistics about Home Care, March 2000, National Association for Home Care, Washington DC.

"Health Care Financing Administration/Customer Information System, 1999. Medicare HHA National State Summary-Preliminary,

Georgia Department of Community Health/Division of Medical Assistance (DMA). Policies and Procedures for Home Health Services. Provider Manual, Part II, January 1, 2001.

Georgia State Health Plan
Home Health Services Component Plan

APPENDIX A

Rules Home Health Services

**RULES OF THE
GEORGIA DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF HEALTH PLANNING
CHAPTER 272-2
CERTIFICATE OF NEED**

272-2-. 09 Standards and Criteria. Amended.

(11) Home Health Services

(a) Applicability.

1. A Certificate of Need for a home health agency will be required prior to the establishment of a new home health agency or the expansion of the geographic service area of an existing home health agency unless such expansion is a result of a non-reviewable acquisition of another existing home health agency.

(b) Definitions.

1. "Home health agency" means a public agency or private organization, or a subdivision of such an agency or organization, which is primarily engaged in providing to individuals who are under a written plan of care of a physician, on a visiting basis in the place of residence used as such individual's home, part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse, and one or more of the following services: physical therapy, occupational therapy, speech therapy, medical-social services under the direction of a physician, or part-time or intermittent services of a home health aide.

2. "Horizon year" means the last year of the three year projection period for need determinations for a new or expanded home health agency.

3. "Geographic service area" means a grouping of specific counties within a planning area for which the home health agency is authorized to provide services to individuals residing in the specific counties pursuant to an existing or future certificate of need. For purposes of establishing a service area for a new home health agency, the geographic service area shall consist of any individual county or combination of contiguous counties which have an unmet need as determined through the numerical need formula or the exception. For purposes of an expansion of an existing agency, the geographic service area shall consist of an individual county or any combination of counties which have an unmet need and which are within any planning area in which the home health agency already provides service; however, in no case may an existing home health agency apply to provide services outside the planning area in which its current geographic service area is located.

4. "Nursing care" means such services provided by or under the supervision of a licensed registered professional nurse in accordance with a written plan of medical care by a physician. Such services shall be provided in accordance with the scope of nursing practice laws and associated rules.

5. "Official state component plan" means the document related to home health services developed by the Department established by the Health Strategies Council and adopted by the Board of Community Health.

6. "Planning area" for all home agencies means the geographic regions in Georgia defined in the State Health Plan or Component Plan (See Appendix B).

(c) Standards.

1. The need for a new or expanded home health agency shall be determined through application of a numerical need method and an assessment of the projected number of patients to be served by existing agencies.

(i) The numerical need for a new or expanded home health agency in any planning area in the horizon year shall be based on the estimated number of annual home health patients within each health planning area as determined by a population-based formula which is a sum of the following for each county within the planning area:

A. a ratio of 4 patients per 1,000 projected horizon year civilian noninstitutional (CNI) population age 17 and younger;

B. a ratio of 5 patients per 1,000 projected horizon year civilian noninstitutional (CNI) population age 18 through 64;

C. a ratio of 45 patients per 1,000 projected horizon year civilian noninstitutional (CNI) population age 65 through 79; and

D. a ratio of 185 patients per 1,000 projected horizon year civilian noninstitutional (CNI) population age 80 and older.

(ii) The net numerical unmet need for home health services shall be determined by subtracting the projected number of patients for the current calendar year from the projected need for services as calculated in (C)(1)(i). The projected number of patients for the current calendar year is determined by multiplying the number of patients having received services in each county, as reported in the most recent survey year, by the county population change factor. The county population change factor is the percent change in total population between the most recent survey year and the current calendar year.

2. (i) The Division shall authorize the submission of applications as enumerated below

A. If the net numerical unmet need in a given planning area is 250 patients or more, the Division shall authorize the submission of applications for an expanded home health agency; or

B. If the net numerical unmet need in a given planning area is 500 patients or more, the Division shall authorize the submission of applications for a new home health agency as well as an expanded home health agency.

(ii) An applicant must propose to provide service only within a geographic service area comprised of a county or group of counties, each of which reflects a numerical unmet need, and contained within the

given planning area for which the Division has authorized the submission of applications.

3. The Division may authorize an exception to 272-2-.09(11)(c)(1) if :

(i) the applicant for a new or expanded home health agency can show that there is limited access in the proposed geographic service area for special groups such as, but not limited to, medically fragile children, newborns and their mothers, and HIV/AIDS patients. For purposes of this exception, an applicant shall be required to document, using population, service, special needs and/or disease incidence rates, a projected need for services in the planning area of at least 200 patients within a defined geographic service area. A successful applicant applying under this section will be restricted to serving the special group or groups identified in the application within the county or counties stipulated in the application; or

(ii) a particular county is served by no more than two (2) home health agencies and less than one percent of the county's population has received home health services, or the agencies have demonstrated a failure to adequately serve Medicaid patients as evidenced by a level of service to such individuals that is less than the statewide average, within each of the past two years as reported on the Annual Home Health Services survey. For purposes of this exception, an applicant must already be approved to provide service in a contiguous county or be approved to provide service in a county which is no further than 15 miles from the county authorized through the exception. In all other aspects of the application process, the applicant shall be required to comply with provisions applicable to expanded home health agencies.

4. An applicant for a new or expanded home health agency shall provide a 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 focusing on coordinated, integrated systems which promote continuity rather than acute, episodic care. Working agreements with other related community services may include the ability to streamline referrals to other appropriate services and to participate in the development of cross-continuum care plans with other providers.

5. An applicant for a new or expanded home health agency shall provide a written statement of its intent to comply with all appropriate licensure requirements and operational procedures required by the Office of Regulatory Services of the Georgia Department of Human Resources.

6. An applicant for a new or expanded home health agency or agency(ies) owned and/or operated by the applicant or its parent organization shall have no history of uncorrected or repeated conditional level violations or uncorrected standard deficiencies as identified by licensure inspections or equivalent deficiencies as noted from Medicare or Medicaid audits.

7. An applicant for a new or expanded home health agency or agency(ies) owned and/or operated by the applicant or its parent organization shall have no previous conviction of Medicaid or Medicare fraud.

8. An applicant for a new or expanded home health agency shall provide a written plan which demonstrates the intent and ability to recruit, hire and retain the appropriate numbers of qualified

personnel to meet the requirements of the services proposed to be provided and that such personnel are available in the proposed geographic service area.

9. An applicant for a new home health agency shall provide evidence of the intent to meet the appropriate accreditation requirements of the Joint Commission for Accreditation of Health Care Organizations (JCAHO), the Community Health Accreditation Program, Inc. (CHAP), and/or other appropriate accrediting agencies.

10. An applicant for an expanded home health agency shall provide documentation that they are fully accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO), the Community Health Accreditation Program, Inc. (CHAP), and/or other appropriate accrediting agency.

11. An applicant for a new or expanded home health agency shall provide its existing or proposed plan for a comprehensive quality improvement program.

12. An applicant for a new or expanded home health agency shall assure access to services to individuals unable to pay and to all individuals regardless of payment source or circumstances by:

(i) providing evidence of written administrative policies that prohibit the exclusion of services to any patient on the basis of age, disability, gender, race, or ability to pay;

(ii) providing a written commitment that services for indigent and charity patients will be offered at a standard which meets or exceeds three percent of annual, adjusted gross revenues for the home health agency or, in the case of an applicant providing other health services, the applicant may request that the Division allow the commitment for services to indigent and charity patients to be applied to the entire facility;

(iii) providing documentation of the demonstrated performance of the applicant, and any facility in Georgia owned or operated by the applicant's parent organization, of providing services to Medicare, Medicaid, and indigent and charity patients;

(iv) providing a written commitment to participate in the Medicare, Medicaid and PeachCare programs; and

(v) providing a written commitment to participate in any other state health benefits insurance programs for which the home health service is eligible.

13. An applicant for a new or expanded home health agency shall demonstrate that their proposed charges compare favorably with the charges of existing home health agencies in the same geographic service area.

14. An applicant for a new or expanded home health agency shall document an agreement to provide Division requested information and statistical data related to the operation and provision of home health services and to report that data to the Division in the time frame and format requested by the Division.

15. The department may authorize an existing home health agency to transfer one county or several counties to another existing home health agency without either agency being required to apply for a new or expanded certificate of need, provided the following conditions are met:

(i) the two agencies agree to the transfer and submit such agreement and a joint request to transfer in writing to the department at least thirty (30) days prior to the proposed effective date of the transfer;

(ii) the two agencies document within the written request that the transfer would result in increased and improved services for the residents of the county or counties including Medicare and Medicaid patients;

(iii) the agency to which the county or counties are being transferred currently offers services in at least one contiguous county or within the planning area(s) in which county or counties are located; and

(iv) the two agencies are in compliance with all other requirements of these rules; such compliance to be evaluated with the written transfer request.

No such transfer shall become effective without written approval from the department.

Georgia State Health Plan
Home Health Services Component Plan

APPENDIX B

Map
STATE SERVICE DELIVERY REGION

GEORGIA

STATE SERVICE DELIVERY REGIONS

