Approved by the Governor
Date: 11/13/96

HOME HEALTH SERVICES

I. INTRODUCTION

Planning for the provision of health care services has often been related to identifying duplicative services and cost containment measures. However, the primary goal of the planning process should be for the establishment of a rational allocation of services and resources, noting of course, that prevention of duplicative services and cost containment measures play a key role. New and expanded services and facilities should serve the public interest. The focus on containing health care costs through efficient utilization of resources while ensuring the availability of adequate and quality health care services must be the underpinning of health planning. The goal is to encourage a system that provides more effective and appropriate care and more accountability for the outcomes and costs incurred.

The standards written to address these principles and goals must demonstrate the following: consistency with the State Health Plan, need and accessibility, health care/social services systems' interrelationships and linkages, costs, economic feasibility, resource availability and quality of services. These standards should complement and coordinate with the fiscal plans of appropriate state planning, regulatory, and payor agencies.

These standards address an immediate need to regulate the full range of home health services. They will need revision to further address the additional issues of competition, economies of scale, integrated systems, consolidation, and the special needs and circumstances of home health care providers and managed care organizations as the home health delivery system evolves during a period of significant change based on market forces. These revisions will be submitted to Governor Caperton by October 31, 1996.

II. DEFINITIONS

A. Additional office: May include but is not limited to sub-units, branches, satellites, and is defined for purposes of these standards as any additional office located in West Virginia and identified with the home health agency.

B. Capital expenditure: An expenditure by or on behalf of a health care facility which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance, and as more fully set out in West Virginia Code §16-2D-2(f).

C. Coordination and standardization of care: The provision of home health services in accordance with patients' need and with protocols established by a home health agency so that all patients of the agency receive the following aspects of service in a standardized, consistent manner: screening for agency admission and discharge, case management if applicable, follow-up of health related problems, and referrals to other agencies and service providers for care that is not offered by the home health agency.

D. Plan of care: Originally called plan of treatment and changed by Medicare statute to plan of care; is developed in consultation with the agency staff and covers all pertinent diagnosis, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential , functional limitations , activities permitted, nutritional requirements, medications and treatments.

E. Home health agency: An organization primarily engaged in providing professional nursing services either directly or through contract arrangements and at least one (1) of the following services: home health aide services, other therapeutic services, physical therapy, speech therapy, occupational therapy, and nutritional services or medical social services to persons in their place of residence on a part-time or intermittent basis.

F. Office: Place of business which is staffed and equipped to provide the identified services in the manner stated in the application for Certificate of Need.

G. Patients' rights: The level of treatment and care that patients are entitled to receive, written and verbal information in a language patients can understand, the right of patients to express grievances, and the manner in which corrective action is taken.

H. Service area: County/counties in which an application for certificate of need has been made or granted and/or in which a facility has expanded through a determination of nonreviewability.

III. CERTIFICATE OF NEED APPLICATION PROCESS

A. Determination of Reviewability: Organizations planning relocation of offices, service changes, acquisitions, and/or addition/deletion of any new services need to submit a request to the HCCRA for a determination of reviewability prior to initiating any action. That request should be concluded with a notarized verification of the signature of the person authorized by the provider organization to sign in its behalf pursuant to W. Va. C.S.R. 65-7-25. Additional offices within an existing approved service area may be added without undergoing certificate of need review; the HCCRA should be notified of these additional offices by the organization submitting a request for a determination of reviewability.

B. Letter of Intent: The initial step in the Certificate of Need Process is the submission to the HCCRA of a letter of intent. The letter should include:

1. Name and brief description of the entity applying for the certificate of need;

2. Brief description of the proposed project, including anticipated individuals to be served and services to be provided;

3. Identifying the county(ies) in the proposed service area;

4. Estimate of anticipated capital expenditure associated with the project; and,

5. Signature of individual authorized to sign for the organization.

C. Application: The HCCRA reviews the letter of intent and determines the type of application which is appropriate. An application form and certain data and materials which should be helpful in its completion are sent to the applicant. The receipt by the HCCRA of a completed application and accompanying application filing fee initiates the CON application review process. For details on time frames, notices, hearings and appeal processes, refer to W. Va. Code §16-2D-1 et seq. and 65 C.S.R. 7.

D. Decisions: Decisions of the HCCRA are issued in the form of orders which outline the details of applications, the HCCRA analysis, findings and conclusions, the decision and opportunities for reconsideration and/or appeals. No decision will be issued to an entity which is not in full compliance with the Health Care Financial Disclosure Act (West Virginia Code §16-5F-1 et seq.).

E. Public Notices: Actions of the HCCRA, including receipt of letters of intent, applications declared complete, decisions of the Board, scheduled hearings and time frames for hearing requests appear in the "Health Care Cost Review" newsletter published weekly by the HCCRA, in the State Register, and in the Charleston newspapers every Saturday.

IV. Certificate of Need Application Review Process

A. Minimum criteria for review

West Virginia Code §16-2D-6 and 9 contain the statutory review criteria. West Virginia Code §16-2D-9(b) requires that an applicant demonstrate need and consistency with the State Health Plan. Additionally, the HCCRA must make the West Virginia Code §16-2D-6(e) findings in order for a CON to be granted.

In the Certificate of Need determinations issued by the Health Care Cost Review Authority, the following, inter alia, is taken into consideration:

1. The proposed facility/service(s) demonstrates an analysis of the needs of the population to be served;

2. A need for the proposed facility/service(s) still exists in the proposed service area after a determination that there is efficient utilization of resources currently providing the same or similar service to the same or similar population;

3. The proposed facility/service(s) would not result in overcapacity within the service area; and,

4. The costs of the proposed facility/services(s) are reasonable and will not increase patient cost.

B. Recommendations from state regulatory, planning and payor agencies

One aspect of the analysis is a coordinated review by regulatory, planning and and payor agencies of state government. The HCCRA takes into consideration in reviewing CON applications, the programmatic and fiscal plans of appropriate state agencies. Any recommendations sought are for "comment only" purposes. The HCCRA has final approval on applications.

V. NEED METHODOLOGY

Planning is particularly crucial for those segments of the health care system which are rapidly growing, such as home health care. Planning methodology and criteria should ensure that there are an adequate number of providers of quality health programs with services readily accessible to those in need. Planned growth of home health services helps contain health care costs.

Since the primary payors for home health care services (Medicare and Medicaid) currently operate on a cost reimbursement system, increased competition does not create cost savings, but may well increase the cost per unit of service. Expansion of services and the addition of new providers should be planned such that they occur in areas with clearly documented unmet need. The need should be based on measurable and readily available data in such a manner that the health care system is not negatively impacted.

A. ASSUMPTIONS

The assumptions underlying the projection of need for home health facility/service(s) are as follows:

- The need for home health facility/services will be determined on a county by county basis.

- More than one county may be included in an application; service areas must consist of contiguous counties. Documentation of need is required for each county included in the application.

- The smallest service area for an application to provide home health services shall be one (1) county.

- The unmet need for home health services in a county is determined by a process that compares current county-to-state utilization data.

- An adjustment of 229 home health recipients has been added to the formula to allow for the development of agencies approved for CON in the previous 12 months. An unmet need will exist if the need methodology yields a threshold of at least 229 projected home health recipients. The threshold/adjustment factor of 229 is the median number of home health recipients receiving care from an agency identified in the 1995 West Virginia Health Care Cost Review Authority Home Health Services Survey Summary. The HCCRA shall consider adjusting the threshold/adjustment factor at the time it updates the need calculations.

- Population data are for the year 1995.

- Data sources are obtained from the HCCRA documents listed in the Sources of Data below.

B. SOURCES OF DATA

The HCCRA will provide the applicant with the following:

1. Agencies Awarded a Certificate of Need To Provide Home Health Services: HCCRA listing of agencies having a certificate of need to provide home health services and their authorized service areas as well as a listing of agencies receiving CON approval in the previous 12 months.

2. West Virginia Health Care Cost Review Authority Population Projections By County: Official HCCRA population projections by county (1990-2020).

3. West Virginia Health Care Cost Review Authority Home Health Services Survey Summary: Annual HCCRA document required of home health agencies providing services to West Virginia residents which contains operation, utilization, and financial data.

C. DETERMINING UNMET NEED FOR HOME HEALTH SERVICES

Need calculations based on 1995 data have been completed by HCCRA using the following methodology. (See appendix for calculations). The HCCRA shall update the need calculations and shall consider updating the threshold/adjustment factor on a yearly basis. These calculations performed by the HCCRA shall be used to determine unmet need; this is the only demonstration of need that the HCCRA shall consider. They shall remain in effect until updated by the HCCRA.

The need methodology is comprised of four (4) calculations. The four calculations must be completed for each county to be served. As the HCCRA is responsible for performing and providing the need calculations, pursuant to the methodology, one need only look to the calculations in the Appendix to determine if a need exists in a certain county. The HCCRA has, however, provided the methodology within these standards for the public's information. A description of the methodology follows.

Calculation I compares the county and state home health utilization rates.

Calculation 2 determines the extent of potential home health recipients in the county to reach the state utilization level.

Calculation 3 determines the number of home health recipients in the county below the state home health utilization rate.

Calculation 4 involves an adjustment factor for the agencies receiving Certificate of Need approval in the previous 12 months to allow for their initiation and development of home health services. Each agency is allowed a 229 home health recipient adjustment factor for each county in the approved service area. An unmet need or threshold of at least 229 projected home health recipients must occur in the county before consideration will be given to issuing another Certificate of Need for the county.

The following is the methodology employed by HCCRA to determine if a need exists in a specific county. An example using Berkeley County is included in the Appendix.

1. CALCULATION OF THE ACTUAL TOTAL COUNTY HOME HEALTH UTILIZATION RATE
(This compares current county and state home health utilization rate).

a. Show total number of home health recipients for county for current year from the HCCRA Home Health Survey. _____
b. Show county population for current year. _____
c. Divide a by b. _____
d. Multiply c by 1000 for the current county home health utilization rate. _____

e. List current state home health utilization rate from HCCRA Home Health Survey. _____

f. Is the current county home health utilization rate below the state rate? yes/no

If yes, continue with the following. If no, an unmet need does not exist.

2. CALCULATION OF THE ACTUAL NUMBER OF HOME HEALTH RECIPIENTS NEEDED TO OBTAIN THE STATE UTILIZATION RATE.

A. Components of formula - a, b, c.

a = List number of current home health recipients for county for current year (1.a) _____

b = List county home health utilization rate for current year (1.d) _____

c = List state home health utilization rate for current year (1.e) _____

Formula a x c / b = d

1. Multiply a x c _____
2. Divide a x c by b _____

d = Number of home health recipients for county to meet state utilization rate _____

3. CALCULATION OF THE ACTUAL NUMBER OF HOME HEALTH RECIPIENTS BELOW THE STATE RATE.

Formula a - b = c

a. List number of home health recipients for county to obtain state rate (2.d) _____

b. List current number of home health recipients for county (1.a) _____

c. Subtract b from a to obtain the number of current county home health recipients below the state rate. _____

4. CALCULATION OF THE THRESHOLD (ADJUSTMENT FACTOR)
(This calculation is done only if there are agencies in the proposed county which received CON approval in the previous 12 months.)

Formula a - b = c

a. List the current county home health recipients below state rate (3.c) _____

b. Subtract adjustment factor for agencies receiving CON approval in previous 12 months. _____

c. Number above threshold adjustment. _____

Conclusion:

If the threshold is at least 229 projected home health recipients, an unmet need exists.

VI. QUALITY AND ACCESS

A. REQUIREMENTS

All applicants shall demonstrate that they will meet the following requirements:

1. All home health care facility/services(s) must:
   a. apply for a Certificate of Need;
   b. meet current Medicare certification requirements and standards; and,
   c. notify Office of Health Facility Licensure and Certification.

2. The applicant must submit a copy of a West Virginia certificate of authority and/or business license in accordance with West Virginia Code §31-1-53.

3. Applicants must clearly identify their company (including all existing subsidiaries) and list all names used, i.e., doing business as (d/b/a) and any and all linkages.

4. If the applicant's main office is located outside the boundaries of West Virginia, an in-state office in the proposed service area must be established before services can be provided.

5. No person can be denied services on the basis of age, sex, race, nationality, ability to pay, disability/diagnosis or geographic area of residence.

6. Home health facility/service(s) must cover the geographic area of an entire county and must serve residents throughout the entire county.

7. Home health facility/service(s) must make available their array of services to all patients.

8. Home health facility/service(s) must participate in the provision of services to the patient who does not have the means to pay for care, i.e., charity care.

9. The home health facility/services(s) must ensure all professional employees and personnel, staff and contract, have current licenses and /or registration.

10. The home health facility/service(s) must assure that patients' rights are protected and promoted by providing documentation to the patient of his/her rights. The home health facility/service(s) must make available a corrective action to all patients if applicable.

11. The provision of home health services must be coordinated and standardized so that all patients receive services in a consistent manner.

12. Services must be delivered in a manner that maintains the patients' privacy, confidentiality, and dignity.

13. The established plan of care must note participants in the plan, how it is updated, and what procedures are followed when the plan needs to be altered.

14. There must be a mechanism for handling emergencies on a 24 hours per day, 7 days per week, basis.

15. The provision of home health service(s) to a patient must be directed by a physician. One or more professional nurses must supervise the delivery of these services.

16. An in-service educational program for full-time, part-time, and contractual staff must be conducted on an ongoing basis.

17. There must be clearly identified lines of authority between administration, professional staff, and the programs/units/divisions.

18. There must be a quality assurance program which includes a review mechanism for the patient's medical plan of care.

19. A description of the health care delivery system must be submitted which includes the number and kinds of physicians, the number of nurses, therapists, and the identification of all the health care facilities/services in the proposed service area. Describe how the proposed home health service will integrate with the current health care delivery system.

VII. FINANCIAL FEASIBILITY

The applicant must demonstrate the financial feasibility of the project by the conclusion of the third years' operation. The factors to be considered must include:

1. Utilization by discipline by payor classification.

2. Current and projected rates.

3. Statements of (a) revenues and expenses, (b) balance sheets, (c) statements of changes in fund balances, and (d) statements of cash flow for each of last two fiscal years. Audited financial statements, if prepared, must be submitted. If 10-K Reports are required to be submitted to the Securities Exchange Commission by either the applicant or a related entity, these must be submitted for the preceding three (3) years.

4. A preliminary financial feasibility study which must, at a minimum, include: (a) revenues and expenses, (b) balances sheets, (c) statements of changes in fund balances, and, (d) statements of cash flow for each of the last two fiscal years, the current fiscal year and future fiscal years prior to the project's implementation, and the first three years after the project's implementation. The financial feasibility study must take the form of a compiled forecast with all disclosures, as those terms are defined by the American Institute of Certified Public Accountants and must also include all assumptions used, including projected payor mix, charges and/or revenues for each category of payor.

5. Sources of revenue/reimbursement by payor classification.

6. The applicant must demonstrate that the costs and charges associated with the project are comparable to the costs and charges of similar providers offering similar services.

7. The applicant must demonstrate compliance with W. Va. Code §16-5F-1 et seq., "The Health Care Financial Disclosure Act," and 65 C.S.R. 13, the "Financial Disclosure Rule."

8. The applicant shall develop a policy regarding charity patients. The policy must address the issues of sliding scale fee schedules and/or free care to the extent that such care is financially feasible.

9. Preference will be given to applicants who demonstrate intent to provide a full array of services to all patients, without regard to their ability to pay.

VIII. SUBSTANTIAL COMPLIANCE

Any person holding a CON for home health services is required to submit to the HCCRA a written progress report outlining the progress toward completion of the approved project, according to the timetable outlined in the application. 65 C.S.R. §7-20.1.

In addition to the information required to be included in the report, pursuant to regulation, the applicant shall include the following:

1. Utilization, by discipline by payor classification, from the date of issuance of the CON to the date of the progress report;

2. Evidence of Medicare certification, if applicable;

3. Evidence of notification of the Office of Health Care Facility Licensure and Certification;

4. Evidence of scope of coverage of counties within service area;

5. Evidence of an in-state office, if an out-of-state facility;

6. Number of referrals (by service category) and identification of sources of referrals from the date of issuance of the CON to the date of the progress report;

7. Number of full-time and part-time administrative staff, professional service staff, and contractual staff, and staff to patient ratio, all as the date of the progress report;

8. Evidence with respect to the provision of array of home health services;

9. Current rates;

10. Sources of revenue/reimbursement by payor classification, amounts for bad debt and charity care; and,

11. Copies of all survey, audits or reports that have been issued by regulatory agencies with respect to the project.

If the HCCRA finds that the project is not in substantial compliance with its CON, the HCCRA may withdraw the CON and the HCCRA may direct that any license to operate the new service be revoked or denied, or the HCCRA may impose fines and/or seek an injunction against the use or operation of the new service.

IX. APPENDIX

Part I. Information Sources

West Virginia Board of Physical Therapists
Box 306
Lost Creek , WV 26385

West Virginia Board of Examiners for Licensed Practical Nurses
101 Dee Drive
Charleston, WV 25311

West Virginia Board of Examiners for Registered Professional Nurses
101 Dee Drive
Charleston, WV 25311

West Virginia Board of Occupational Therapy
119 South Price Street
Kingwood, WV 26531

West Virginia Board of Social Work Examiners
Post Office Box 5459
Charleston, WV 25361

West Virginia Speech-Language-Hearing Association
c/o Department of Speech Pathology and Audiology
805 Allen Hall
West Virginia University
Morgantown, WV 26506

West Virginia Medical Institute is an organization that has a contract with the Health Care Financing Administration to review the health care services or items furnished or proposed to be furnished to Medicare beneficiaries.

West Virginia Office of Health Facility Licensure and Certification reviews and acts on recommendations regarding participation in Medicare and Medicaid programs for home health agencies. The state agency used by HCFA to perform survey and review functions for Medicare.

West Virginia Department of Health and Human Resources Bureau For Medical Services is West Virginia's Medicaid agency.

Part 2. Identification of Surveys and Audits

West Virginia Health Care Cost Review Authority Home Health Services Survey.

Facility/service(s) receiving certificate of need approval shall be required to complete and return the HCCRA's Survey of Home Health Agencies and to submit a complete cost report on an annual basis, or more frequently, if requested by the HCCRA. Unless otherwise specified by the HCCRA a separate survey shall be completed for each county served by the agency. This survey may include, but not be limited to, questions regarding the number of

clients served according to age groupings, types (for example, skilled nursing, occupational therapy and social work), unskilled and number of visits provided, number of visits according to reimbursement source (including no-pay visits to medically indigent patients), and agency charges for services rendered.

West Virginia Office of Health Facility Licensure and Certification.

Oversight reviews are performed at predescribed intervals, and are based on detailed facility certification inspections, correspondence, complaint investigations, supporting certification file data and the degree of compliance that these facilities demonstrate. Appropriate action for noncompliance may consist of intermediate sanctions (monetary fines or decertification).

X. NEED METHODOLOGY EXAMPLE - BERKELEY COUNTY

1. CALCULATION OF THE ACTUAL TOTAL COUNTY HOME HEALTH UTILIZATION RATE.

(This compares county and state home health utilization rate).

a.	Show number of total home health recipients for county for current year from the HCCRA Home Health Survey.	733
b.	Show county population for current year.	64962
c.	Divide a by b.	.011284
d.	Multiply c by 1000 for the current county home health utilization rate.	11.28
e.	List current state home health utilization rate from HCCRA Home Health Survey.	20.70
f.	Is the current county home health utilization rate below the state rate?	yes/no

If yes, continue with the following. If no, an unmet need does not exist.

2. CALCULATION OF THE ACTUAL NUMBER OF HOME HEALTH RECIPIENTS NEEDED TO OBTAIN THE STATE UTILIZATION RATE.

A. Components of formula - a, b, c.

a = List number of current home health recipients for county for current year (1.a)	733
b = List county home health utilization rate for current year (1.d)	11.28
c = List state home health utilization rate for current year (1.e)	20.70

Formula a x c / b = d

1. Multiply a x c 15173.1
2. Divide a x c by b 1344

d = Number of home health recipients for county to meet state utilization rate 1344

3. CALCULATION OF THE ACTUAL NUMBER OF HOME HEALTH RECIPIENTS BELOW THE STATE RATE.

Formula a - b = c

a. List number of home health recipients for county to obtain state rate (2.d) 1344

b. List current number of home health recipients for county (1.a) 733

c. Subtract b from a to obtain the number of home health recipients below the state rate. 611

4. CALCULATION OF THE THRESHOLD (ADJUSTMENT FACTOR)
(This calculation is done only for agencies receiving CON approvals in previous 12 months.)

Formula a - b = c

a. List the current county home health recipients below state rate (3.c) 611

b. Subtract adjustment for agencies receiving CON approval in previous 12 months. 0

c. Number above threshold adjustment. 611

Conclusion:

If the threshold is at least 229 projected home health recipients, an unmet need exists.