Approved by the Governor
April 27, 2023

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.These standards address the need to regulate the full range of home health services.

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. 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.

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:

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

2. 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.

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

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

B. SOURCES OF DATA

The Authority may provide the applicant with the following:

1. The Population Projections By County: Official).The link for population projectionshttps://business.wvu.edu/research-outreach/bureau-of-business-and-economic-research/data

2. The Authority Home Health Services Survey Summary: The Survey document is 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 FY 2021 data have been completed by the Authority using the following methodology. (See appendix for calculations). The Authority shall update the need calculations and shall consider updating the threshold/adjustment factor on a yearly basis. These calculations performed by theAuthority shall be used to determine unmet need; this is the only demonstration of need that the Authority shall consider. They shall remain in effect until updated by the Authority .

The need methodology consists of three (3) calculations. The three-calculations must be completed for each county to be served. The Authority 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 Authority has, however, provided the methodology within these standards for the public's information.

A description of the methodology follows.

Calculation 1 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.

The following is the methodology employed by the Authority 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 the county, for the current year from the Authority 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 Authority 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.

   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 <u>to meet</u> 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. _____

For Applicants that are a new provider to the State of West Virginia. There must be a threshold of 75 residents that would benefit from home health services in each county within the proposed service area. For those Applicants who were approved during the previous 12 months, a placeholder of 75 will be added to the Need Methodology.

For existing Home Health Providers, the Authority will allow expansion into contiguous counties as long as there is a need for the additional provider(s).

IV. QUALITY AND ACCESSIBILITY

All applicants shall document that they will be in compliance with all current applicable Medicare and Medicaid requirements.

V. 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 “the submission of all required financial disclosure information to the Authority as set forth in W. Va. Code St. R. § 65-13-1, et seq. and W. Va. Code § 26-29B-24.

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.