Home Health Services

Certificate of Need Standards and Criteria

STATE OF TENNESSEE

STATE HEALTH PLAN

PROPOSED CERTIFICATE OF NEED STANDARDS AND CRITERIA

FOR

HOME HEALTH SERVICES

The Health Services and Development Agency (HSDA) may consider the following standards and criteria for applications seeking to provide home health services. Rationale statements for each standard are provided following the standard. Existing providers of home health services are not affected by these standards and criteria unless they take an action that requires a new certificate of need (CON) for such services.

These proposed standards and criteria will become effective immediately upon approval and adoption by the Governor. However, applications for certificates of need to provide home health services that are deemed complete by HSDA prior to the approval and adoption of these standards and criteria by the Governor shall be considered under the Guidelines for Growth, 2000 Edition.

Definitions

Home Health Service: "Home health service" is defined by Tennessee Code Annotated § 68-11-201. This definition is included in HSDA Rule 0720-9-.01. As set out in the statute, home health services include skilled nursing care; physical, occupational, or speech therapy; medical social services; home health aid services; and the provision of certain medical supplies and medical appliances. For the purposes of these standards and criteria, a "home health service" shall be performed by a "home care organization." Please see Note 1 for information regarding Professional Support Services and Personal Support Services.

Home Care Organization: "Home care organization" is defined by Tennessee Code Annotated § 68-11-201 and includes an entity that provides home health services.

Service Area: Refers to the county or contiguous counties in which the applicant intends to provide home health services.

Joint Annual Reports (JARs): The JARs prepared and submitted by home care organizations shall be identified by the Health Services and Development Agency (HSDA) as the primary source of data regarding home health services performed in Tennessee. The Tennessee Department of Health (TDH) maintains the JARs and is responsible for generating reports utilizing TDH data as required by the Certificate of Need program.

Private Duty Services: Refers to those skilled nursing and CNT services under physician orders provided in the home or community setting.

Intermittent Care Services: Refers to those nursing services provided by an RN or an LPN, therapist, social worker, or aide under physician orders that are normally no more than one visit per day of a maximum duration of two hours.

Standards and Criteria

1. **Determination of Need:** In a given county, 1.5 percent of the total population will be considered as the need estimate for home health services in that county. This 1.5 percent formula will be applied as a general guideline, as a means of comparison within the proposed Service Area.

   Rationale: After much effort, the Division has determined that limitations of the data obtained from the current JAR form do not permit a revision of the Need formula, and that there are no more accurate data sources available. Consequently, it has at this time decided to retain the current Need formula from the Guidelines for Growth, and has repeated it herein. The Division commits to working with stakeholders to assess the data needs of the HSDA, the TDH, and stakeholders and to revise the JAR form accordingly. Once sufficient data are collected, a review of the Need formula will be undertaken.

   The existing Need formula is admittedly a conservative one. The Division's research regarding Medicare-Medicaid fraud and abuse in the home health services industry supports a conservative Need formula. In 2012, the Government Accountability Office reported that 40% of all fraud convictions initiated by a group of Medicaid fraud-control units were for home health services — the biggest category of providers convicted through the Medicaid units' efforts. The Centers for Medicare and Medicaid Services (CMS) states that home health agencies offer services and supplies "vulnerable to fraud."

2. The need for home health services should be projected three years from the latest available year of final JAR data.

Note: The Division recognizes that a home care organization can be established within a 12-15 month period of time, and that ideally a one year planning horizon would be used. However, in this instance a three-year planning horizon is used because final JAR data lag significantly behind the current date. Final 2012 JAR data became available in May 2014, thus providing data for need to be projected in 2015 but not for any other future full calendar year. Should a change occur that enables TDH to provide final JAR data significantly earlier, the Division would propose a change in the planning horizon.

3. The use rate of existing home health agencies in each county of the Service Area will be determined by examining the latest utilization rate as calculated from the JARs of existing home health agencies in the Service Area. Based on the number of patients served by home health agencies in the Service Area, an estimation will be made as to how many patients could be served in the future.

   Rationale: This Standard is carried over from the Guidelines for Growth.

4. **County Need Standard:** The applicant should demonstrate that there is a need for home health services in each county in the proposed Service Area by providing documentation (e.g., letters) where: a) health care providers had difficulty or were unable successfully to refer a patient to a home care organization and/or were dissatisfied with the quality of services provided by existing home care organizations based on Medicare's system Home Health Compare and/or similar data; b) potential patients or providers in the proposed Service Area attempted to find appropriate home health services but were not able to secure such services; c) providers supply an estimate of the potential number of patients that they might refer to the applicant.

   Rationale: This Standard seeks to promote State Health Plan Principle 2 concerning Access to Care. The Division believes that if the Need formula is not met, a pattern of problems with referring patients successfully to home care organizations should be demonstrated by the applicant. If no such pattern can be established, there is likely not a need for a new home care organization.

5. **Current Service Area Utilization:** The applicant should document by county: a) all existing providers of home health services within the proposed Service Area; and b) the number of patients served during the most recent 12-month period for which data are available. To characterize existing providers located within Tennessee, the applicant should use final data provided by the JARs maintained by the Tennessee Department of Health. In each county of the proposed Service Area, the applicant should identify home health agencies that have reported serving 5 or fewer patients for each of the

last three years based on final and available JAR data. If an agency in the proposed Service Area who serves few or no patients is opposing the application, that opponent agency should provide evidence as to why it does not serve a larger number of patients.

Rationale: From comments expressed by many stakeholders, the Division is aware that a home care organization may be licensed to provide services in a county/Service Area but may serve few or no patients there. The Division believes this situation may unreasonably impede the expansion of home health services in a county/Service Area and that any such home care organization that is opposing an application should provide evidence that supports its low market penetration.

6. **Adequate Staffing:** Using TDH Licensure data, the applicant should document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application and document that such personnel are available to work in the proposed Service Area. The applicant should state the percentage of qualified personnel directly employed or employed through a third party staffing agency.

   Rationale: This Standard seeks to promote State Health Plan Principle 5 concerning a sufficient and quality health care work force. Home care organization workers do not necessarily need to live in the county in which they work. However, in the short-term, the number of possible workers in a general area is unlikely to change quickly. In order to promote economic efficiencies and access to health care through reduced personnel cost, applicants should demonstrate that they have a plan to recruit sufficient workforce in the general area within reasonable commuting distance of the proposed Service Area. Moreover, the applicant should present its long-term plans to ensure an adequate supply of quality home care workers is available to meet future needs.

7. **Community Linkage Plan:** The applicant should provide a community linkage plan that demonstrates factors such as, but not limited to, referral arrangements with appropriate health care system providers/services (that comply with CMS patient choice protections) and working agreements with other related community services assuring continuity of care focusing on coordinated, integrated systems. A new provider may submit a proposed community linkage plan.

   Rationale: This Standard seeks to promote State Health Plan Principles 3 and 4 concerning Economic Efficiencies and Quality of Care, respectively. In order to promote economic efficiencies and the quality of health care provided in Tennessee, applicants should demonstrate that they have

established relationships with other health care providers that will ensure a continuity of care for their patients.

8. **TennCare Managed Care Organizations (MCOs) and Financial Viability:** Given the time frame required to obtain Medicare certification, an applicant proposing to contract with the Bureau of TennCare's MCOs should provide evidence of financial viability during the time period necessary to receive such certification. Applicants should be aware that MCOs are under no obligation to contract with home care organizations, even if Medicare certification is obtained, and that Private Duty Services are not Medicare certifiable services. Applicants who believe there is a need to serve TennCare patients should contact the TennCare MCOs in the region of the proposed Service Area and inquire whether their panels are open for home health services, as advised in the notice posted on the HSDA website, to determine whether at any given point there is a need for a provider in a particular area of the state; letters from the TennCare MCOs should be provided to document such need. See Note 2 for additional information.

   Applicants should also provide information on projected revenue sources, including non-TennCare revenue sources.

   Rationale: This Standard seeks to promote State Health Plan Principle 3 concerning Economic Efficiencies. This Standard further seeks to promote the orderly development of the health care system by bringing to the forefront issues concerning Medicaid/Medicare certification.

9. **Proposed Charges:** The applicant's proposed charges should be reasonable in comparison with those of other similar agencies in the Service Area or in adjoining service areas. The applicant should list:

   a. The average charge per visit and/or episode of care by service category, if available in the JAR data.
   b. The average charge per patient based upon the projected number of visits and/or episodes of care and/or hours per patient, if available in the JAR data.

   Rationale: This Standard seeks to promote State Health Plan Principle 3 concerning Economic Efficiencies through greater marketplace transparency.

10. **Access:** In concert with the factors set forth in HSDA Rule 0720-11-.01(1) (which lists those factors concerning need on which an application may be evaluated), the HSDA may choose to give special consideration to an applicant that is able to show that there is limited access in the proposed Service Area for groups with special medical needs such as, but not limited to, medically fragile children, newborns and their mothers, and HIV/AIDS

patients. Pediatrics is a special medical needs population, and therefore any provider applying to provide these services should demonstrate documentation of adequately trained staff specific to this population's needs with a plan to provide ongoing best practice education. For purposes of this Standard, an applicant should document need using population, service, special needs, and/or disease incidence rates. If granted, the Certificate of Need should be restricted on condition, and thus in its licensure, to serving the special group or groups identified in the application. The restricting language should be as follows: CONDITION: Home health agency services are limited to (*identified specialty service group*); the expansion of service beyond (*identified specialty service group*) will require the filing of a new Certificate of Need application. Please see Note 3 regarding federal law prohibitions on discrimination in the provision of health care services.

Rationale: This Standard seeks to promote State Health Plan Principle 2 concerning Access to Care.

11. **Quality Control and Monitoring:** The applicant should identify and document its existing or proposed plan for data reporting (including data on patient re-admission to hospitals), quality improvement, and an outcome and process monitoring system (including continuum of care and transitions of care from acute care facilities). If applicable, the applicant should provide documentation that it is, or that it intends to be, fully accredited by the Joint Commission, the Community Health Accreditation Program, Inc., the Accreditation Commission for Health Care, and/or other accrediting body with deeming authority for home health services from CMS.

    Rationale: This Standard seeks to promote the State Health Plan Principle 4 concerning Quality of Care. The Division recognizes that certain home care organizations are certified by CMS but are not necessarily accredited by the entities listed above.

12. **Data Requirements:** Applicants should agree to provide the Department of Health and/or the Health Services and Development Agency with all reasonably requested information and statistical data related to the operation and provision of services and to report that data in the time and format requested. As a standard of practice, existing data reporting streams will be relied upon and adapted over time to collect all needed information.

    Rationale: This Standard seeks to promote accurate health planning through the availability of accurate and timely data.

Notes

1. Professional Support Services and Personal Support Services: It should be noted that an entity providing either "professional support services," as defined by TCA § 68-11-201 (regarding nursing and occupational, physical, or speech therapy services provided to individuals with mental retardation or developmental disabilities pursuant to a contract with the state agency financially responsible for such services), or "personal support services," as set forth in the Rules of the Department of Mental Health and Substance Abuse Services Office of Licensure Chapter 0940-05-38 (regarding self-care assistance, household assistance, personal assistance to access community activities, and education services), does not require a Certificate of Need in order to be licensed by the appropriate department to perform its services.

2. TennCare Medicare Certification: As of the effective date of these standards and criteria, the Rules of the Bureau of TennCare ("TennCare"), the state of Tennessee's Medicaid program, require that any applicant for a Certificate of Need to provide home health services that desires to contract with TennCare's MCOs become Medicare-certified. The process of becoming Medicare-certified can take several months if an agency does not meet Medicare "deemed certified" status through accreditation by national accrediting organizations.

It should be noted that as of the effective date of these standards and criteria, Private Duty Services do not qualify as a Medicare reimbursable service. Thus, an entity that applies for a Certificate of Need should not apply to provide only Private Duty Services if it intends to try to contract with the MCOs as it will not be able to receive Medicare certification. Additionally, applicants should contact TennCare for specific information regarding the ability to contract with MCOs. On the Health Services and Development Agency website (http://www.tn.gov/hsda/) an informational letter is available entitled "Are you thinking about applying for a CON to provide Home Health or Private Duty Nursing Services in Tennessee?"

3. Services not to be Discriminatory in Nature: Some past applications have endeavored to provide home health services to specific populations. It should be noted that federal law prohibits health care providers from providing health care services that discriminate against any population in the areas of race, color, national origin, disability, or age. This prohibition is enforced by the Office for Civil Rights to ensure that eligible persons have equal access to quality health care regardless of race, color, national origin, disability, or age.