

STATE OF NEW YORK
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL

HEALTH PLANNING COMMITTEE

AGENDA

March 28, 2019

*Immediately following the Establishment and Project Review Committee Meeting
(which is scheduled to begin at 10:15 a.m.)*

Empire State Plaza, Concourse Level, Meeting Room 6, Albany

I. COMMITTEE ON HEALTH PLANNING

John Ruge, M.D., Chair of the Health Planning Committee

- A.** Licensed Home Care Service Agency Certificate of Need Review
Public Need Methodology and Financial Feasibility

Mark Kissinger, Special Advisor to the Commissioner of Health

- B.** Primary Care Clinics: Physical Plant Standards

Joan Cleary-Miron, Director, Health Care Facility Transformation Program

Udo Ammon, Director, Bureau of Architecture and Engineering Review

Licensed Home Care Service Agency Certificate of Need Review Public Need Methodology and Financial Feasibility

Effective April 1, 2020, the Public Health and Health Planning Council (PHHPC) will be required to consider the public need for licensed home care service agencies and the financial feasibility of the applicant in its review of applications pursuant to Part B of Chapter 57 of the Laws of 2018 which amended PHL 3605, Subdivision 4. The Department of Health will develop regulations outlining the requirements for the new public need methodology and standards for the review of financial resources pursuant to the statutory changes. The information to be considered for inclusion in the regulations and standards is being presented to the PHHPC Committee on Health Planning in the outline below and in detail in the attached paper.

Applicability of the need methodology

- The law requires public need review and approval by PHHPC for initial licensure applications and change of ownership applications received on or after April 1, 2020.
- The Department may recommend statutory and regulatory changes to include construction provisions for LHCSAs and to exempt change of ownership applications for LHCSAs from public need review.
- In addition, the Department recommends a review of the procedures used to approve construction requests to ensure that the practices align with the intent of the legislation. The Department will halt the approval of such requests until the review is complete.
- Assisted Living Program (ALP) LHCSAs may be exempt from the public need methodology. Agencies seeking to serve patients in the community in addition to the ALP will be subject to the need methodology for the community portion of the application.

Planning area designations

- The Department recommends designating each county as a separate planning area. Alternate planning areas may be allowed when requested by the applicant and when approved by the commissioner, in consultation with PHHPC.
- Applicants may be required to serve the entire planning area they seek licensure in or the Department may allow for exceptions.

Need methodology

- The need methodology may include a calculation using county normative use rates based on population estimates and either the unduplicated patient count or the total number of cases and visits/hours for nursing services and all other service types for LHCSAs in the planning area. Consideration should also be given to using a research-based methodology to include demographics and disease and disability rates.
- Unmet need determinations may include a calculation of each LHCSA's rate of change in patient count or case capacity projected to the target year.
- The Department recommends including a rebuttable presumption that there is no need for additional agencies when a certain case capacity threshold is met in a planning area.

Financial feasibility

- The Department will develop standards to review financial feasibility in the application process, to include, but not be limited to, that the application passes a reasonableness test demonstrating adequate finances and sources of future revenue to properly establish and operate the licensed home care service agency.

Licensed Home Care Service Agency Certificate of Need Review
Public Need Methodology and Financial Feasibility

Public Health and Health Planning Council
Committee Meeting
March 28, 2019

Table of Contents

Introduction 3

Request for Information..... 3

LHCSA Need Methodology 4

 Application of the public need methodology..... 4

 Planning area designations 6

 Need methodology 6

 Additional considerations..... 9

Financial Feasibility.....10

Conclusion10

Appendix A12

Appendix B25

Introduction

Licensed home care service agencies (LHCSAs) provide, directly or through contract arrangement, nursing services, home health aide services, and/or personal care services. LHCSAs providing these services must be issued a license by the Commissioner of Health in order to operate pursuant to Public Health Law (PHL) Section 3605. LHCSAs may also provide physical, occupational, and respiratory therapies, speech language pathology, audiology, nutritional services, medical social services, as well as medical supplies, equipment and appliances or specialty services, such as IV infusion.

Currently, there are approximately 1,100 approved operators with over 1,300 licensed sites statewide.

Applications for licensure are submitted to the Department of Health (Department) and are subject to approval by the Public Health and Health Planning Council (PHHPC). Applications are reviewed to ensure the character, competence, and standing in the community of the applicant's incorporators, directors, sponsors, stockholders, or operators. Applications must be submitted for initial licensure, purchase or mergers, change of stock ownership, or other acquisition or control change.

Effective April 1, 2020, PHHPC will be required to consider public need and financial feasibility during its application review for licensed home care service agencies. Part B of Chapter 57 of the Laws of 2018 amended PHL 3605, Subdivision 4 to require that PHHPC "not approve an application for licensure unless it is satisfied as to: (a) the public need for the existence of the licensed home health care service agency at the time and place and under the circumstances proposed; (b) the character, competence and standing in the community of the applicant's incorporators, directors, sponsors, stockholders, or operators; (c) the financial resources of the proposed licensed home health care service agency and its sources of financial revenues; and (d) such other matters as it shall deem pertinent".

Prior to the effective date, the Department will develop regulations outlining the requirements for the new public need methodology and as well as standards for the review of financial resources and sources of revenue.

The development of a LHCSA public need methodology comes at a time when the State is focusing its efforts on the home care industry to ensure that the appropriate supply of home care agencies is available and accessible, while reigning in the proliferation of licensed agencies. Chapter 57 of the Laws of 2018 included a two-year moratorium on the licensure of new LHCSAs effective through March 31, 2020, the requirement that all LHCSAs be registered with the Department beginning January 1, 2019 to operate and receive reimbursement, and included new LHCSA contracting limits with managed care plans.

Request for Information

In July 2018, the Department issued a Request for Information (RFI) to gather input for the development of the public need methodology for LHCSAs. The RFI was open to responses from the public through October 26, 2018. In that time, the Department received responses from 27 home care agencies, individuals, advocacy groups, insurance companies, and government agencies. The responses are incorporated throughout this paper and will be considered by the

Department in the development of the need methodology. A summary of the relevant RFI responses can be found in Appendix A.

LHCSA Need Methodology

Application of the public need methodology

Under current law and regulation, LHCSA applications must be submitted to PHHPC for initial licensure, purchase or mergers, change of stock ownership, or other acquisition or control change.

The new language of the law effective April 1, 2020 states that the “public health and health planning council shall not approve an application for licensure” unless the application satisfies the conditions of the law, including the demonstration of public need. The law requires public need review and approval by PHHPC for initial licensure applications received on or after April 1, 2020. Change of ownership applications will also require certificate of need approval by PHHPC, to include the new public need assessment, when the methodology becomes effective.

- **Changes of Ownership**

Under PHL §3611-a(1), “Any change in the person who, or any transfer, assignment, or other disposition of an interest or voting rights of ten percent or more, or any transfer, assignment or other disposition which results in the ownership or control of an interest or voting rights of ten percent or more, in a limited liability company of a partnership which is the operator of a licensed home care service agency or a certified home health agency shall be approved by the public health and health planning council...”. Paragraph (2) of this section applies the same language to stock and voting rights transfers for corporations. However, the law continues to state that, with respect to CHHAs, “such change shall not be subject to the public need assessment” as described in law (PHL §3611-a(1)(b)). Similar language does not exist for LHCSAs.

The question of whether or not a public need assessment should cover change of ownership applications was included in the RFI. The majority of stakeholders do not believe a public need review should apply to change of ownership applications. Six stakeholders responded yes, but with justification that better fit the description of a character and competence review rather than a public need review. Under PHL §3611-a(1), a change of ownership application already requires PHHPC approval including a character and competence review of the incoming owners or operators.

- **Construction**

Article 36 of the Public Health Law does not include language regarding construction specific to licensed home care service agencies. Construction is defined as the “addition or deletion of services offered; a change in the agency’s geographic service area; the erection, building, or substantial acquisition or alteration of a physical structure or equipment; or a substantial change in the method of providing services” (PHL §3602(12)). There is no statutory basis to apply the new LHCSA public need methodology to actions that are defined as construction. Instead, established agencies seeking to add or delete services or change their geographic scope of practice follow the administrative procedures in place and managed by the Department.

Under 10 NYCRR 765-2.2(a), LHCSAs seeking to add nursing, home health aide or personal care services are required to submit an application to the Department at least 90 days prior to the anticipated start of service and obtain written approval from the Department prior to commencing the service. However, pursuant to program practice, any request to add or delete a service, change the geographic scope of practice, or change office locations is handled through a written request submitted by the agency to the appropriate home care regional office. Nursing services are required to be included on each license for a home care services agency.

Under subsection (c) of the same section, LHCSAs are required to notify the Department in writing at least 30 days prior to commencing or discontinuing physical therapy, occupational therapy, speech/language pathology, nutrition services, social work, respiratory therapy, physician services, or medical supplies, equipment and appliances.

Under section 765-2.3 of the same title, LHCSAs seeking to discontinue the provision of nursing, home health aide or personal care services must provide 30 days written notice to the Department of its intention to do so.

Construction provisions are included in both the Certified Home Health Agency (CHHA) and hospice laws and regulations and approval from PHHPC is required prior to commencing any of the plans outlined in the construction definition. Because there is no statutory authority to require construction applications to undergo public need review for LHCSAs, the Department will undertake a review of the procedures used to approve such applications to ensure that the practices align with the intent of the legislation. During this time, the Department will halt the review and approval of such applications until the review of procedures is complete.

The RFI asked stakeholders if the need methodology regulations should apply to existing LHCSA operators requesting to expand services into other planning areas. Eleven of the fifteen responses to this question were yes, but with varying degrees of application. See Question 19 in Appendix A for a summary of responses. Some stakeholders also recommended a grandfathering exception for existing agencies looking to add new services in counties where they are already approved to provide services.

Licensure applications for agencies seeking to exclusively serve patients in an Assisted Living Program (ALP) will be exempt from the public need methodology. If the agency is applying to serve patients in the community in addition to the ALP, the community portion of the application will be subject to the new need methodology.

Options for discussion:

- Recommend statutory and regulatory changes to include construction provisions for LHCSAs similar to CHHA and hospice.
- Recommend statutory and regulatory changes to exempt change of ownership applications for LHCSAs from public need review similar to CHHA.
- Review the Department's procedures used to approve requests for service addition or deletion and changes to a LHCSA's service area to ensure that the practices align with the intent of the legislation. Halt the review and approval of such requests until the review of procedures is complete.

- Exempt ALP-affiliated LHCSAs from the public need methodology. Agencies seeking to serve patients in the community in addition to the ALP, will be subject to the need methodology for the community portion of the application.

Planning area designations

Planning areas are the geographic boundaries in which public need estimates are allocated. In both CHHA and hospice need methodology regulations, the planning areas may consist of one county or two or more contiguous counties. Responses to the RFI yielded a variety of perspectives from stakeholders, including recommendations to designate planning areas by county, to designate planning areas to cover geographic regions within counties such that counties contain multiple planning areas, to differentiate between upstate and downstate and rural areas, to determine planning areas by the concentration of the population needing services, among other responses. See responses for Question 2 in Appendix A.

Factors to be considered when designating planning areas in both hospice and CHHA regulations may include provider and patient travel patterns, including driving time and availability of public transportation; the availability of existing home care and services; and other factors.

Given the need to rely on currently available data to determine public need and to allocate need in the designated planning areas, a base planning area by county may be most appropriate in this context. Counties should be treated as starting points, but the regulations should permit flexibility in redefining the planning area for a particular application based on factors such as population density or travel time, among other considerations.

The default requirement for LHCSAs should be to serve the entire planning area unless an exception is granted under special circumstances. The applicant will be required to justify to PHHPC why it cannot serve the entire planning area. Special circumstances may include, but are not limited to, geographic barriers or travel time which impede service delivery, proposals which focus care to a specific underserved area or specialty population, workforce challenges that limit the agency's ability to provide services in the entire planning area, or other factors identified by PHHPC or the Department.

Options for discussion:

- Designate each county as a separate planning area.
- Allow for alternate planning areas when requested by an applicant and upon approval by PHHPC and the Commissioner.
- Require agencies to agree to serve the entire planning area that they seek licensure in unless justification of special circumstances is provided and the application is approved by PHHPC.

Need methodology

The need methodology should function as a guideline for determining need for additional services within a planning area, but is not meant to be an absolute predictor of the number of agencies needed in each planning area. The methodology should include sufficient flexibility to allow for consideration of local factors and to be responsive to the changing environment.

To determine need for LHCSAs, the Department should consider establishing a base year and target planning year that will help to establish future need. The following should be considered:

- The total population estimated by county for the base year and the planning target year using U.S. Census Bureau data.
- The county normative use rates for LHCSAs. Use rates will be based on either the unduplicated patient count for LHCSAs within a planning area or the number of cases and visits/hours for nursing services and the total for all other services, including social work, case management, therapy services, personal care aide services and other services (*See Appendix B*) for each LHCSA in the county. Both can be determined using the most recent LHCSA Statistical Report. In 2018, the Department launched a revised LHCSA statistical report. The revised report included a registration form as mandated by Chapter 57 of the Laws of 2018. All licensed agencies are required to register with the Department on an annual basis to continue operations and collect reimbursement for services. LHCSAs had until November 16, 2018 to register with the Department for 2019. In the first year of the mandate, the Department saw a registration rate of almost 90 percent among all licensed sites. This provides the Department with a new, reliable dataset from which to pull information to inform the need methodology.

The LHCSA statistical report requires agencies to enter the number of unduplicated patients served during the report year for each county that the agency provides services in, as well as the number of cases and visits/hours for all services provided in that county. See Appendix B for an example of the LSR7 Form with instructions. The statistical report captures data from the previous year. For example, the report due on November 16, 2018 includes information from the 2017 calendar year.

The county normative use rate will be determined by dividing the unduplicated patient count or the number of cases and visits/hours for nursing services and all other service types for the county by the population by county in the base year.

- County level estimates of need will be determined by multiplying the county historical normative use rates subject to allowable adjustments up or down based on factors to be outlined in regulation, by the estimated county level population for the planning target year.

The county level projected LHCSA use estimates would constitute the public need for LHCSAs in the planning areas subject to allowable adjustments to the county normative use rate that will be outlined in regulation.

To estimate unmet need for LHCSAs in a planning area, the projected public need will be compared to the patient or case and visits/hours capacity of approved LHCSAs in the planning area projected for the planning target year. Projected capacity will include:

- The number of unduplicated patients or the number of cases and visits/hours for nursing services and all other service types for the two most recent calendar years for which data is available for each LHCSA within a planning area.
- The rate of change for each agency, which will be determined using the difference in unduplicated patient count or the number of cases and visits/hours for each LHCSA from the two most recent calendar years and dividing the difference by the number of

unduplicated patients served or the number of cases and visits/hours serviced in the first year.

- This rate of change will be applied to each LHCSA's patient count or case capacity for the base year to determine the projected capacity at the targeted planning year.
- For agencies that do not have two years of data, an average rate of change will be determined for the LHCSAs in the planning county. The average rate of change will be used to determine the projected capacity for such LHCSAs with less than two years of available data.

There will be a rebuttable presumption that there is no need for any additional agencies in a planning area if the projected capacity for existing LHCSAs in such planning area is equal to or more than 90% of the need based on the most recent available data. It shall be the responsibility of an applicant in such instances to demonstrate that there is a need for additional LHCSAs despite the 90% capacity rate in the applicant's planning area utilizing the factors to be outlined by the Department. Factors to consider may include, but are not limited to:

- Availability and accessibility of workforce
- Transportation infrastructure
- Availability of telehealth and other technologies
- Characteristics of rural, suburban, and urban communities
- Quality of service provision and survey history of existing agencies in the planning area
- Cultural competency of existing agencies in the planning area
- The need to serve high-risk patients or those with a need for specialty services
- The availability of agencies accepting reimbursement through public programs compared to private pay
- Long term care service infrastructure
- A LHCSA's experience with value-based contracting with payers

Stakeholders provided many examples in response to the RFI regarding factors to be included when determining need. See Question 3 of Appendix A.

The Department will explore other data sources to inform the public need methodology in addition to using the annual LHCSA statistical report.

As an alternative to using normative use rates determined by patient count or case capacity, estimates based on demographics could be considered. The Department could undertake a review of the total number of residents in each planning area with a reported disability resulting in a limitation in completing activities of daily living. The information could be broken down by age group and projected to accommodate the expected growth in the older adult population. This method to determine use rates may better reflect the number of residents in need of care, rather than using the patient count or case capacity. However, reporting on disease and disability status and limitations in functional abilities has proven difficult as various definitions of disability exist with multiple reporting methods.

Options for discussion:

- Estimate need by county using population estimates for the base and target planning years, and development of county normative use rates. The county normative use rates could be calculated using the unduplicated patient count for each LHCSA in the county

or using the number of cases and visits/hours for nursing and other services for each LHCSA in the county. Adjustments to normative use rates could be considered based on specific factors defined in regulation.

- Estimate need by county using population estimates for the base and target planning years, demographic information including disease and disability rates resulting in limitations in functional abilities, and county normative use rates derived from these factors.
- Estimate projected LHCSA capacity using the two most recent years of available data from the statistical report and rate of change for each agency. Existing capacity of LHCSAs could be based on either unduplicated patient count or the total number of cases and visits/hours for nursing and other services reported by each LHCSA.
- Explore additional data sources to inform the public need methodology rather than the annual LHCSA statistical report.
- Determine unmet need by comparing the estimated need by county to the estimated projected LHCSA capacity by county.
- Presume that there is no need for additional services when projected capacity is equal to or more than 90% of the projected need in the county unless an agency applying for licensure can demonstrate to the department that there is a need that the agency can accommodate.
- Determine a frequent evaluation schedule for the need methodology leading to the first planning target year and an appropriate schedule thereafter. Determine appropriate changes or adjustments at the end of the target planning year or earlier if evaluations prove that adjustments are appropriate.

Additional considerations

- Exceptions to the need methodology

In considering whether exceptions should be allowed under the need methodology, RFI stakeholders provided recommendations such as excluding agencies that provide home infusion services, excluding agencies that serve participants of the Traumatic Brain Injury waiver and the Nursing Home Transition and Diversion waiver, excluding agencies that serve pediatric clients, excluding agencies that serve the Assisted Living Program, among others. Some stakeholders noted that there should not be exceptions as the need methodology should be flexible enough to ensure that agencies are able to meet all types of need. Full recommendations can be found in Appendix A, Questions 7, 14, and 15.

- Additional requirements for initial licensure

In addition to the new need methodology criteria and financial feasibility review, RFI stakeholders offered additional requirements to consider for initial licensure applications. Some included requiring applicants to have a quality improvement plan, requiring applicants to include a workforce development plan as well as a recruitment and retention plan, and requiring an assessment of the applicant's understanding of community resources. The full recommendations can be found in Appendix A, Question 10.

- Special considerations in application review

The RFI included multiple questions regarding whether or not special considerations should be given to agencies offering specialty services, workforce solutions, or serving public versus private pay patients. Stakeholders offered many responses to these ideas. See Questions 11, 16, and 17 in Appendix A.

Financial Feasibility

In addition to a review of public need, Part B of Chapter 57 of the Laws of 2018 which amended PHL 3605, Subdivision 4 requires that PHHPC consider the financial resources of the proposed licensed home care service agency and its projections of revenues and expenses in applications for licensure. The standards of this review will require, at a minimum, that the application passes a reasonableness test with respect to the financial capability of the LHCSA (or sources of start-up funding) and financial feasibility (projections indicating that the LHCSA's operating revenues will be equal to or greater than projected expenditures over time). The review will include examination of the sources of available working capital that the proposed LHCSA operators have, with a minimum requirement equal to at least two months of estimated operating expenses of the LHCSA.

Conclusion

Effective April 1, 2020, PHHPC will be required to consider the public need for additional licensed home care service agencies and the financial feasibility of the applicant in its review of applications pursuant to Part B of Chapter 57 of the Laws of 2018 which amended PHL 3605, Subdivision 4. Decision points relating to the applicability of the need methodology, planning area designations, calculating the need methodology, and additional considerations to be determined prior to that date and to inform regulation development include:

- Applicability of the need methodology
 - Recommending statutory and regulatory changes to include construction provisions for LHCSAs similar to CHHA and hospice.
 - Recommend statutory and regulatory changes to exempt change of ownership applications for LHCSAs from public need review similar to CHHA.
 - Reviewing the Department's procedures used to approve requests for service addition or deletion and changes to a LHCSA's service area to ensure that the practices align with the intent of the legislation. Halt the review and approval of such requests until the review of procedures is complete.
 - Exempting ALP-affiliated LHCSAs from the public need methodology. Agencies seeking to serve patients in the community in addition to the ALP, will be subject to the need methodology for the community portion of the application.
 - Determining whether other exceptions to the need methodology will be considered and what those exceptions will be.
 - Determining whether there should be additional requirements for initial licensure applications.
- Planning area designations
 - Designating each county as a separate planning area.
 - Allowing alternate planning areas when requested by the applicant.

- Requiring applicants to agree to serve the entire planning area they seek licensure in or if exceptions will be made. Whether the exceptions will be defined in regulation or left open for the applicant to determine.
- Need methodology
 - Defining a need calculation using county normative use rates based on population estimates for the base and target planning years and either the unduplicated patient count or the number of cases and visits/hours for nursing services and all other services for each LHCSA in the planning area projected forward.
 - Defining a need calculation using county normative use rates based on population estimates for the base and target planning years and research-based methodology to include demographics and disease and disability rates projected forward.
 - Determining unmet need by comparing need estimates by county to projected LHCSA capacity in the targeted planning year. Projected LHCSA capacity will be calculated using either the existing LHCSA's rate of change for unduplicated patient count or its total cases and visits/hours for nursing and all other services.
 - Exploring additional data sources to inform the public need methodology in addition to the annual LHCSA statistical report.
 - Presuming there is no need for additional agencies when projected capacity is equal to or more than 90% of the projected need in the county.
 - Determining a frequent evaluation schedule for the need methodology leading to the first planning target year and an appropriate schedule thereafter. Determine appropriate changes or adjustments at the end of the target planning year or earlier if evaluations prove that adjustments are appropriate.
- Financial feasibility
 - Developing standards to review the financial resources of the proposed licensed home care service agency and its sources of financial revenues in applications for licensure.

Appendix A

Summary of responses to LHCSA Public Need Methodology Request for Information

In July 2018, the Department issued a Request for Information (RFI) to gather input for the development of the public need methodology for LHCSAs. The RFI was open to responses from the public through October 26, 2018. The responses are incorporated throughout this paper and will be considered by the Department in the development of the need methodology.

The Department received responses from 27 stakeholders including 15 home care agencies, 6 associations, 4 advocacy groups/consultants, 1 managed care company, and 1 government agency. The associations included Continuing Care Leadership Coalition (CCLC), Empire State Association for Assisted Living (ESAAL), Home Care Association of NY (HCA), LeadingAge NY, NY Association of Health Care Providers (HCP), and Home Care Association of America. The advocacy groups and consultants included Center for Disability Rights, Home Care IPA, Medmal Consultants, and PHI. The Office of Mental Health also provided a response. A summary of responses to questions relevant to the development of the public need methodology are included below.

2. How should planning areas be designated and what factors should be considered?

Recommendations for planning area designations included:

- Designating planning areas by borough or county.
- Planning areas should be more granular than county level to better ascertain whether and where need is being met, especially in rural areas. They should cover a geographic area within a county such that counties contain multiple planning areas.
- In NYC, use counties/boroughs or portions of counties, not the whole city, as the planning area.
- MLTC regions should also apply to LHCSAs as broad planning areas. For smaller planning areas, use existing neighborhoods (for example, United Hospital Fund's neighborhoods in New York City).
- Differentiating between upstate and downstate different regions based on population and need. Rural areas should be different designations with increased rates and reimbursement for travel time and expenses.
- Planning areas should be assessed individually for each county.
- Planning areas should be determined by the concentration of the population needing services. County lines are arbitrary.

Recommendations for factors to be considered included:

- Consider the rural, suburban, and urban dimensions that exist within counties.
- The number of LHCSAs that are already established in the area and how efficiently they are able to satisfy public need, including capacity to serve multiple languages and cultures, compliance with laws and regulations, services agreements with the majority of health plans, and the breadth of home care services offered.
- Consider provider saturation in the geographic area and socioeconomic factors within the community to be served.

Appendix A: Summary of RFI Responses

- Factors to consider include ethnic/cultural backgrounds of the service population and workers residing in the area, number of housing projects/cluster apartment dwellings, cultural/language competency of existing providers in the area, number of current and potential Medicaid/Medicare recipients based on the socio-economic profile of the residents in the area.
- Factors should include demographics, service utilization, socioeconomic factors, urban/rural differences, emerging technology
- Emergence of Naturally Occurring Retirement Communities (NORCs), county to county migration, out of county access from other counties
- Consider utilizing claims/encounter data to identify the specific areas predominantly served by each LHCSA within planning areas and those that lack access to services.
- Survey different demographic areas to consider the number of middle-aged patients and quantities of certified home health aides

Many stakeholders noted that the availability of workforce is necessary to consider in designating planning areas, including the number of aide training programs in the area.

Transportation and infrastructure were mentioned by numerous stakeholders, including driving distances, access to public transportation, availability of ridesharing services, and the variability of transportation services that exists within and among counties.

Two stakeholders recommended that the Department establish a workgroup to contribute to the development of the planning area designations.

3. What factors should be included when determining the need for LHCSAs?

Many stakeholders noted that there needs to be an adequate evaluation of community needs when determining the need for LHCSAs. Recommended factors include:

- Environmental risk factors
- Socioeconomic factors
- Demographic factors
- Prevalence of disease and trends (dementia, TBI, cardiovascular conditions, Rheumatoid arthritis, developmental disability, HIV/AIDS, paralysis, psychiatric conditions, alcohol/substance abuse)
- Percentage of individuals who are elderly, home-bound, or disabled
- Access to ancillary services (meals on wheels, day treatment programs, senior centers, urgent care, etc.)
- The need for specialty services
- The number and capacity of currently operating LHCSAs (provider saturation levels). Determine trends in supply and demand. Supply of LHCSAs should consider capacity. Consider compliance records of existing agencies.
- Workforce availability and accessibility. Consider the impact of adding a new agency on workforce availability for existing providers.
- Consider the projected impact of new market entrants on existing agencies
- Consider differences across urban, suburban, and rural areas
- Quality of services historically delivered by a provider, special competencies for reaching hard to serve populations including language competency, commitment to VBP.
- Providing adequate choice of provider

Appendix A: Summary of RFI Responses

- Use of telehealth and other technology
- Concern over giving majority weight to prevalence of disability as older adults often do not identify as having a disability but are in need of attendant services
- Consider the size of the population that is currently institutionalized as high rates of institutionalization indicate there are issues with serving people at home
- Do not limit to a specific age range as the disability community includes a broad age range with people in need of LHCSA services.
- Consider differences in public payer Medicaid market and private pay market. Private pay need should include a review of agency financing, character competence, and leadership experience. Public/private pay need should include population density, and other needs, such as number of cases.
- Emergence of NORCs in targeted area, cultural competency of providers, expansion of M/WBE, commitment to VBP initiatives focusing on DSRIP goals of reduced hospitalizations and reduced readmission rates, risk-based arrangement understanding, focus on specific diseases such as diabetes, COPD, asthma
- Compare population estimates and demographics in a county to the capacity of existing providers, determine the need to serve high-risk and high needs disease diagnosis (such as dementia), LHCSAs with expertise in these areas should be rated higher.
- Include consumer and workforce demographic trends, migration trends for workers and consumers, cultural/linguistic competence, transportation, ability for existing LHCSAs to provide services to subpopulations, wait times, and current and future need.

One stakeholder recommends a workgroup to provide input into specific factors that should be considered in the need methodology.

7. Should there be exceptions to the need methodology? If so, identify.

For those stakeholders who answered that exceptions to the need methodology are warranted and provided recommendations for those exceptions, the recommendations included:

- Exclude all existing LHCSAs that are operational prior to the effective date of the need methodology and that are compliant with state requirements.
- Exclude private pay LHCSAs that do not contract with Managed Care Organizations and do not receive Medicaid dollars
- Exclude home infusion LHCSAs
- Exclude LHCSAs that service the needs of waiver participants in the Traumatic Brain Injury (TBI) waiver and the Nursing Home Transition and Diversion (NHTD) waiver, and those that serve pediatric clients
- Exclude LHCSAs that serve Assisted Living Programs (ALPs). For changes of ownership, a new operator of an existing LHCSA should be able to serve and accept new clients within the Adult Care Facility (ACF) and in the community if the former operator of the LHCSA was approved to provide services in these settings.
- Exemptions should be considered if there is an increase in conditions that necessitate the urgent establishment of home care, including opioid addiction, HIV/AIDs, drug and alcohol addiction with psychiatric illness co-morbidities.
- When a high rate of institutionalization occurs in any planning area, an exception to the need methodology should be allowed to provide for more access to home care.

Appendix A: Summary of RFI Responses

- Exemptions should be considered for special care cases, those with cultural and linguistic needs.
- Exclude multi-service level long term care providers seeking to establish a LHCSA. For example, Continuing Care Retirement Communities (CCRCs), other campus-based continuum providers, and LHCSAs serving ALPS (if an ALP LHCSA will also serve the community, the application should be subject to a need review for the community services).

Other stakeholders noted that the need methodology should not include exceptions as it should be flexible enough to ensure that LHCSAs are able to meet all types of need, including for populations with special health needs, cultural and linguistic needs, or other specific service needs. The methodology should be dynamic enough to identify when need is not being met and allow for the certification of new, qualified LHCSAs. Base numbers should be adjusted on an annual basis.

8. When would adjustments to the need methodology within a planning area be acceptable?

- Timeframes:
 - Every three to five years or otherwise as the marketplace dictates may be useful
 - Periodically reviewed (e.g. every three years). Could be subject to revisions in cases of major demographic or epidemiological shifts, changes in technology or medical practice
 - Periodically and frequently (e.g. every three years) to determine whether changes in demographics, technology advanced, or other market/health care changes. Consider input from an established workgroup on this topic. Should ensure a dynamic process that can meet changing market needs and demands.
 - Every few years
 - Considered, at a minimum, every 5 years, with the allowance for greater frequency when necessary (shift in utilization rates or unforeseen demographic changes)
 - Two times a year
 - Every three years, when a new benefit is introduced, or when there is a change in regulations
- As needed:
 - When the number of LHCSAs outgrows demand in the community, or there is insufficient number of vendors in one service area
 - Assessed on a requested basis by an agency, client, or MLTC company. There should be a needs assessment appeal process.
 - When client needs are not being met due to changes in the demographics of the area
 - Adjustments should be based on the size of the population being served in institutional settings. High institution utilization rates would mean the methodology should be adjusted to accept more providers. Also consider consistently poor consumer feedback on LHCSA services
 - When they address worker shortages

Appendix A: Summary of RFI Responses

- When there is an increase in population or significant trends in disease prevalence in a specific area. The closing or merging of providers may require reevaluation.
- When there are known transportation issues (fare hikes), access to MLTC/HMO Contracts, increased hospitalization, readmission rates, change in legislation, population changes, lack of performance from existing LHCSA providers, increase in certain diseases

9. How often should need be recalculated?

Four responded that need should be recalculated annually or more often. Six responded that the need should be recalculated every 3-5 years. Others answered that need should be recalculated on as needed basis, either in addition to regularly scheduled recalculations or on its own, due to:

- Appeals to the need methodology
- Changing demographics, disease prevalence rate, and the availability of workforce
- Market indications
- Crisis situations
- When a new benefit is introduced, or when there is a change in regulations

Additional responses included:

- Each region would require difference recalculations due to population numbers. Need continuous census and demographic data.
- Need should rarely be recalculated as the number of agencies isn't the issue, but the workforce. If required, the need for recalculations should be initiated by the LGOs.
- Recalculated every 18-24 months. Frequency should account for aging of the population, number of people who qualify for services, and the implementation of CFCO.
- Recalculate as determined by a workgroup or as factors change (model changes, demographic or epidemiological changes, technology)

10. What additional requirements, if any, should be included for LHCSA applications for initial licensure?

- Requesting LHCSA applicant to complete a plan of action describing how the services will be managed and supervised in the event of license approval (compliance tracking/maintenance, admissions and discharge, care planning, mandating electronic time attendance verification, potential to exceed the minimum set of requirements, etc.)
- There should be a needs assessment form created that a new LHCSA to provide the data proving that additional services are required in a certain area based in part on the number of cases turned down by other agencies due to lack of staffing to fulfill cases.
- Prospective LHCSA's computer technology, billing capabilities, policies; relationships with managed care networks, ability to work within a value based payment system and a strong workforce capability.
- Historic practice of a LHCSA and any parent corporation should be undertaken, demonstrated focus on compliance.
- Licensure requirements should include that the LHCSA be disability-led.
- Criteria should be contingent upon the services the LHCSA will provide

Appendix A: Summary of RFI Responses

- Additional requirements: Availability of up to six weeks of working capital; identification of an office location that is accessible 24/7 and handicap accessible; established emergency preparedness MOU with community health providers, public and government EMR entities in and around proposed service communities/catchment areas
- A requirement that applicants submit a workforce development plan. This might spur innovative ways to build the home care workforce and minimize the churn in workers.
- M/WBE and technology infrastructure
- Basic mental health training may be considered, as well as a method to assess the agencies understanding of the various community resources for collaborative purposes.
- Character and competence review of the owners, operators, and management team, inclusive of NYS OMIG and US Dept. of Health and Human Services Office of Inspector General lists.
- Applicants should be required to have a workforce development plan to include:
 - the variety of roles and occupations required to meet need, including entry-level and advanced roles, and any specialty roles, as needed – as well as a plan for training and properly compensating workers. It should also include any additional workplace supports it plans to offer workers, such as peer mentors or a case manager that helps address barriers to employment.
- Applicants should have a recruitment and retention plan that outlines:
 - strategies for recruiting and hiring new workers, reducing turnover, promoting workers within the agency, and maximizing retention
- New LHCSAs should have a quality improvement plan, in addition to a quality improvement committee. LHCSAs that are renewing their license should be required to have similar plans that draw upon their quality measures for the past three years and outline how they will improve.
- Evidence of significant experience in the home care industry, proof of financial sustainability, credentials that meet the new minimum criteria to be established by the DOH, historical familiarity with the needs of the communities to be served, and character attestations from a variety of community leaders or LGOs.

Three stakeholders replied that no additional requirements should be included for initial licensure.

One stakeholder provided that the public need application should include the following domain, applicable to all applicants, regardless of geographic region: *Demonstration of Commitment to Providing Culturally Competent Care to Individuals Living with Mental Illness.*

- To reinforce individuals living with mental illness as a priority population for LHCSAs statewide, the public need application should state that the need methodology related to commitment of providing culturally competent services must be addressed by all applicants. While this population is a priority for Medicaid Redesign, DSRIP and the Olmstead mandate, most LHCSAs will likely not have staff immediately trained to serve individuals living with mental illness. In recognition of this reality, LHCSAs can demonstrate a commitment to providing culturally competent care to this population by submitting letters of support from OMH housing providers across the continuum who have agreed to collaborate to serve their residents/clients: Licensed OMH Housing programs seeking to transition residents to the community who have home care needs

(state-operated congregate residences, congregate/treatment, apartment/treatment) and Unlicensed housing program seeking to maintain individuals in the community through provision of personal care and home health aide services (Supported Single Room Occupancy, Scattered Site Supported Housing). LHCSAs should also have the option of submitting letters of support from care management agencies affiliated with OMH Housing providers. These agencies are employed by DOH Health Homes and are responsible for referring clients to needed home care services, coordinating transitions of care and ensuring appropriate community-based services are engaged to maintain individuals in the community.

11. What special considerations, if any, should be prioritized when reviewing LHCSA applications for initial licensure?

Stakeholders had many different answers for what should be prioritized for initial licensure applications:

- Availability to render specialty services in the community (private duty nursing, IV therapy, peritoneal dialysis in the home); working with clients with disabilities, severe conditions, visual/hearing impairments, mental health illnesses
- The applicant's ability to continuously review its programs by evaluating and reevaluating outcomes so as to improve the delivery of client care
- Any efforts by the LHCSA to provide employee training on the independent living philosophy, and any efforts to promote community among the personal care attendant staff. Reviewers should also give special consideration to LHCSAs that provide additional certifications of PCAs. Finally, special considerations should be given to experience providing culturally competent care to specific cultures and language groups. The Deaf population should be considered a specific culture of language group for purposes of these special considerations.
- Stipulate requirements for agencies accepting public funding, but allow agencies only serving a private pay population to determine how to conduct business.
- Those that will provide Medicaid services, not just private pay.
- Those that provide evidence of an unmet need in an underserved and vulnerable populations at risk of hospitalization, prolonged hospitalization, or long term care facility placement.
- Evidence of the agency's plan for meeting priority public health or social determinants of health needs.
- Evidence that the agency completes a component of a community or systemic project intended to achieve state policy goals
- A strategic plan for utilizing new technology to reach and serve a patient population and/or assist workers
- A strategic plan for transportation alternatives for workers
- Existing established partnerships and/or experience in long term care or senior/disability services
- A strategic plan for optimizing performance on quality measures relevant to LHCSA services.
- Cultural competence, M/WBE ownership, employee development programs, those that provide educational incentives to personal care aides, Wage Parity compliance and

design beyond transportation (Metro Card) and healthcare, Strong VBP program understanding

- Agencies serving those with TBIs should be considered
- Special consideration should be given to applicants that: Are worker-owned or worker-centered (i.e. have clear policies and protocols where workers have a distinct voice in informing and/or shaping the decisions of the agency); Are non-profit; Provide their own, high-quality training programs or partner with a high-quality training provider; Serve distinct populations that have historically struggled to access care; Provide culturally and linguistically competent services to specific subpopulation(s); Provide more than the minimum amount of required training; Outline a clear career advancement plan for direct care workers; Utilize advanced home health aides or another advanced role for direct care workers; Have a workforce development plan that includes training for supervisors, as well as direct care workers; Provide workers with higher than average compensation (including wages and/or benefits); and/or Provide supports to workers that help to minimize barriers to employment.
- New home infusion applications should be given priority status since there are so few agencies, especially in rural areas.
- A workgroup should determine the feasibility and practicality of special considerations. determine prioritization of special considerations is problematic due to myriad factors, including regional variances, demographics, population density in rural and urban areas, and availability of alternative health care services.

Seven stakeholders answered that agencies with a training program should be given special consideration. For example, special consideration should be given to agencies that provide a comprehensive training program and culturally diverse set of aides; ability/training to support individuals with complex healthcare and support needs; and, ability/training to provide valuable input on individual conditions to help avoid preventable and/or unnecessary hospitalizations.

In contrast, one agency noted that initial licensure should not be tied to operating a training program. LHCSAs with training programs make it a condition to receive free HHA certification to work only with their affiliated, commonly owned agencies. This creates a shortage of workers for other agencies who do not run their own training programs. Initial licensure must be granted to those meeting administrative and contract oversight capabilities/qualifications and not an affiliation with a training school.

One answered that said no special considerations should be given.

14. Should a need methodology consider services to specialty populations such as pediatrics or specialty services such as IV infusion services or flu shot immunizations?

- Ten stakeholders answered yes:
 - Specialty services are to be considered, because certain populations and age groups are underserved (e.g. children). Vendors that are competent to service those populations must be encouraged to extend their competency and standard of practice to challenging groups of clients.
 - Generally, yes, although flu shots may not reach the threshold of a specialty service.
 - Working with children necessarily requires working for the entire family as a unit. The uniqueness of providing services to a family unit should be considered.

Appendix A: Summary of RFI Responses

- This must be based on respective community health profile reports based on trend – current year and the year prior.
- Any need methodology should ensure that all subpopulations have access to quality LHCSA services, including specialty populations or specialty services.
- Home infusion services should be exempt.
- Five responded no:
 - If a new LHCSA is seeking to provide services to specialty populations, it can demonstrate that there is a need for these services in their service area, but it should not be part of a need methodology or exceptions process. Creating specific populations to service, or requiring need to be demonstrated for specialty populations, creates a need to establish a need methodology for each population that is presented, which would be entirely unwieldy and unnecessary. LHCSAs should apply for the specific services that they would like to be included on their license and deliver them to the populations needing such services. Existing LHCSAs seeking to expand services to specialty populations should not be subject to a need methodology review because they are already approved to deliver services.
- Flu shot services should not qualify as a specialty service.

15. Should a need methodology consider or eliminate from its calculation those agencies that are proposing to provide personal care services only and license those organizations discreetly?

- Fifteen stakeholders answered that agencies that are proposing to provide personal care services only should not be licensed discreetly:
 - Those agencies should be part of the new need methodology, otherwise unneeded agencies will continue to proliferate in the service area, exceeding the community demand for that type of service.
 - Narrowing the licensure may affect the ability of a LHCSA to take on dynamic VBP arrangements.
 - Licensing should be granted through an RFP process which allows equal opportunities for all interested and qualified applicants to compete and demonstrate their capabilities to be awarded an operating license.
 - Agencies may also choose to add additional services to their LHCSA in the future, so only licensing specific organizations for personal care may cause more work in the future.
 - Any need methodology should ensure access to all LHCSA services. This should include personal care services, for which there is a higher level of need than home health services.
 - The need methodology should consider all agencies in its calculation, but should also recognize that an agency proposing limited services may be taking the place of full-services agencies that are more capable of taking on risk.
- Seven answered that these agencies should be licensed discreetly:
 - Given the limitation on the number of LHCSA contracts in Medicaid managed care, discreetly providing licensure to agencies that only provide PCA services

Appendix A: Summary of RFI Responses

would be a positive development as it would minimize barriers to entry for agencies in planning areas. However, agencies offering only PCA services should not have an advantage over more robust LHCSAs if the need methodology is not applied. a weighted system that gives additional points to more robust LHCSAs that offer more types of services serve more populations, are disability-led, and educate their staff on independent living philosophy should be used in licensing any new LHCSAs in a planning region.

- The methodology should exclude those applicants that only seek to provide private pay, in-home personal care services. It is not efficient use of the state's resources to include providers that deliver only personal care services among the entities subject to a needs methodology calculation.
- This seems to be the intent of the moratorium
- One stakeholder offered a separate comment that relates to this Question 15 – LHCSA currently represents two service levels: Personal Care and Skilled Services. In order to best address and support Consumer Choice and the rising need for the senior population to be able to have access to both of these services independently, an ideal solution would be to establish an independent in-home personal care level licensure/certification, and move the other services to the CHHA license and not apply any need methodology to the “Personal Care License”. This is how other successfully regulated states are structured and allow for more efficient oversight and process opportunities for the home care providers within the state.

16. Should the availability of appropriate staffing for a LHCSA planning region be considered in public need?

- Nine stakeholders answered yes:
 - The LHCSA who is applying should provide data to show where the staffing is being pulled from.
 - This is important, but caution against a specified or fixed approach to staffing patterns. Demonstrated investment in workforce growth is critical.
 - Yes, but by the provider or owner/operator, not the state.
 - Yes, applicants should be required to include a plan for developing new home care workers for their agencies in their service area. Applications should not be denied based on the existence of workforce shortages
 - Yes and should include contingencies to obtain staffing from other areas using transportation
 - Yes, although this is hard to estimate as staffing is unpredictable
 - Yes, but staffing is not predictable or measurable
- Four responded no:
 - No, the need for services should be paramount in the consideration of public need
 - No, workforce concerns vary by region and are impossible to predict. Input on an on-going basis from the workgroup/advisory group would be helpful in examining workforce needs.
 - There are so many variables that are largely dependent on the patient population that any additional regulation may not be sufficient to address.

Appendix A: Summary of RFI Responses

- Staffing should not be an exclusion for LHCSA licensing. However, a recruitment/retention plan and a workforce development plan should be required in applications.

17. Should the Department consider whether a LHCSA will service public payment (Medicare/Medicaid) beneficiaries in determining LHCSA need?

- Six responded yes:
 - All prospective LHCSAs must be held to the same standards of participation.
 - Yes, but not if this is elevated to an exclusionary factor.
 - LHCSA need should be determined with the goal of ensuring availability of community-based services to all, including those are institutionalized.
 - Only those LHCSAs that serve Medicaid beneficiaries should be subject to the public need analysis. LHCSA applicants that serve exclusively private pay individuals should not be included in a public need analysis
- Five responded no:
 - Priority in processing or selecting applicants should not be given to applicants seeking to serve public payment beneficiaries over private payment beneficiaries. There should be an equal opportunity for providers that wish to enter the private market to do so
- Four responded that only those LHCSAs that serve Medicaid beneficiaries should subject to the public need analysis. LHCSA applicants that serve exclusively private pay individuals should not be included in a public need analysis.

Others responded that the workgroup should consider this issue; that any need methodology should include all subpopulations, including those with different payment sources; and that the willingness to accept public payment beneficiaries should be a condition of licensure.

18. Should the need methodology regulations cover change of ownership applications?

Those who answered yes to this question tended to answer in relation to the new operator's experience or character and competence review, rather than a public need review.

- Six responded yes:
 - Should cover CHOW to ensure that the new owner will envision running operations with adequate knowledge of the industry and sense of responsibility.
 - This will create an opportunity to be disability-led, promote the philosophy of independent living, and provide continuity of care to its consumers.
 - The new owner has to demonstrate equal if not better capabilities to assume oversight and management from exiting operator.
 - Any need methodology for change of ownership applications should consider quality measures. If the LHCSA's performance on workforce and care quality measures fall below average, then the new owner should be required to submit a revised quality improvement plan and workforce development plan to remedy the issue(s) before being considered.
- Ten answered no:
 - Should not cover CHOW as long as the LHCSA is in good standing
 - This should not supersede the focus on readiness for VBP or extant demonstration of quality performance.

Appendix A: Summary of RFI Responses

- For a change in ALP/LHCSA operator: The new operator of an existing LHCSA should be able to continue to serve and accept new clients both within the ACF building and in the outer community if the former operator of the LHCSA were serving individuals prior to transfer of the operation. This is critical because many ALP-based, ACF and ALR LHCSAs serve a limited number of individuals within the four walls of the building. Not allowing them to continue to serve in the outer community will create problems of scale and financial challenges.
- Applying the public need analysis to CHOWs would place an unnecessary administrative burden on transactions that do not seek new licensure, but rather, involve changes in the operator or ownership of existing LHCSAs. CHOW transactions are consistent with the goal of avoiding the proliferation of unneeded agencies and even facilitate consolidation. Subjecting a CHOW transaction to the public need analysis may force an applicant to reveal commercially sensitive information for a limited public benefit and thus, should be outside the scope of the public need analysis
- Change of ownership or change of corporate status (proprietary to voluntary, or vice versa) should be an administrative review to both expedite review and action, and to eliminate the burden on PHHPC. Such actions have nothing to do with need, but simply a leadership change. The Department already has a process for reviewing this type of action and should continue with this practice.
- There should be no requirement to apply the need methodology to changes of ownership applications. In fact, the process for changes of ownership and/or corporate structure should be streamlined and expedited. The Workgroup should provide input into the development of an expedited process that could consider leadership abilities, compliance with State Cost Reports, Statistical Reports, and DOH Surveys and plans of correction, and participation in programs such as value-based purchasing DSRIP, etc.

19. Should the need methodology regulations apply to existing LHCSA operators requesting to expand services into other planning areas (counties and/or regions)?

- Eleven responded yes:
 - Expansion should be considered only after the LHCSA has demonstrated its capability of complying with standard conditions of participation to achieve improved health outcomes in their existing planning areas.
 - This should not be outweighed by the priority position of the role for quality and VBS Readiness.
 - This should assist in ensuring that consumers in all planning areas have choice of provider, and have access to services provided under the waiver programs.
 - Every region/catchment area has different challenges and needs that the operator must be able to address.
 - It should narrowly apply
 - Existing LHCSAs should be fully exempt from the need methodology for adding new services or branches to their license in their approved service areas.
 - A relaxed review process should allow existing LHCSAs to expand into adjacent counties or planning areas, notwithstanding the results of the need methodology, for reasons including but not limited to, if the

Appendix A: Summary of RFI Responses

expansion is part of a multi-county program, a collaborative initiative with another provider, or a response to a demonstrated need in the region.

The relaxed review process should consider the impact on current providers in the proposed planning area.

- Relaxed review should apply to both existing traditional LHCSAs and ALP LHCSAs already licensed to serve the broader community.
- In these situations, the planning council should carefully consider the LHCSA's current quality performance, workforce development plan, recruitment and retention plan, and other relevant indicators of quality and business capability.
- Four responded no:
 - Not if they have been established for a predetermined period of time
 - There should be a streamlined process for this type of expansion of services that considers a demonstrated need for services in that area, collaborative initiatives with other providers or participation in VBP or DSRIP initiatives. The Workgroup should provide input into this process.

Others responded that there should be a grandfathered process for agencies looking to add new services in existing counties and a grandfathering exception for those agencies that provide primarily home infusion services already in existence.

Appendix B

LSR7 – Services by County Form - collects data on services provided by county. There is a sheet for each county in New York State, in alphabetic order. The LSR7 worksheets were put at the end of the list of worksheets on the left hand side of the screen.

LSR7 Albany - Services By County												
LSR7 Services By County-Albany		Unduplicated Ct/New Admissions	Cases Under Age 21	Visits/Hours Under Age 21	Cases Age 21-64	Visits/Hours Age 21-64	Cases Male Age 64+	Visits/Hours Male Age 64+	Cases Female Age 64+	Visits/Hours Female Age 64+	Nurse Family Partnership Cases	Nurse Family Partnership Visits
70000	70001	70002	70003	70004	70005	70006	70007	70008	70009	70010	70011	70012
Albany County												
Unduplicated Patient Count	01001											
Number of new admissions during the reporting year	01002											
Enter Cases, Visits, and Hours for each service type			Cases Under 21	Visits Under 21	Cases 21-64	Visits 21-64	Cases Male 64+	Visits Male 64+	Cases Female 64+	Visits Female 64+	Cases NFP	Visits NFP
Nursing Services	01003											
			Cases Under 21	Hours Under 21	Cases 21-64	Hours 21-64	Cases Male 64+	Hours Male 64+	Cases Female 64+	Hours Female 64+	Total Cases	Total Hours
Private Duty Nursing Services	01004											
Community Health Work Services	01005											
Medical Social Work Services	01006											
Case Management/Care Management Services	01007											
Physician Services	01008											
Audiology, Nutrition, and Therapy Services	01009											
Home Health Aide Services	01010											
Personal Care Aide Services	01011											
Homemaker and Housekeeper Services	01012											
IV Infusion Therapy Services	01013											
Waiver Services	01014											
Telehealth Monitoring	01015											
Assistive Technology	01016											
Durable Medical Equipment	01017											
Other	01018											
Total for County (excludes Nurses)	01030											

Some of the totals on this form are automatically calculated – they are the lavender fields.

Enter the total number of unduplicated patients, and the number of new admissions during the report year for each county that your agency provides services.

An **unduplicated patient** is an individual who has received at least one episode of care and may have received more than one. Regardless of the number of episodes in the reporting year, the individual is only counted once.

New admissions are patients that have been admitted to the agency during the reporting year. Patients that were admitted at a previous time during the report year (or in prior years) and discharged and were admitted again during the report year should count as a new admission at the time of admission, with the following exceptions:

DO NOT count a patient as a new admission if any of the following conditions apply:

- The patient's age category was changed during the report year
- The patient was discharged to a hospital or RHCF and readmitted to the agency within 30 days with the same illness or diagnosis. In this instance the discharge should not be counted.
- The patient was admitted with an unspecified diagnosis and a definite diagnosis was subsequently established.

Nursing services captures data about nursing services provided to patients in the selected county. The data is then broken out by **cases and visits**, age, and gender (for ages 64+). If your agency records Nursing Services in hours, please count 2.5 hours as 1 visit. In addition, if your agency is part of the Nurse Family Partnership – the number of nursing service **cases and visits** should be recorded in the selected county. The **Nurse Family Partnership** is a program in which nurse home visitors work with low-income young women who are pregnant with their first child, helping these vulnerable young clients achieve healthier pregnancies and births, stronger child development, and a path toward economic self-sufficiency.

All other services provided to patients in the selected county must be recorded below the Nursing Services row. The data is then broken out by **cases and hours**, age, and gender (for ages 64+).

A **case** is an episode of service with a start date (admission) and an end date (discharge). Multiple services may be provided during an episode of service. For an episode of service to count as a case for this report the admission date must be in this reporting year or prior year(s), and the discharge date must be in this reporting year or the patient must still be receiving services at the end of the reporting year. A patient who has been seen only to be assessed for personal care services should not be counted as a case and these visits should not be reported.

A patient sometimes represents more than one case. However, DO NOT count a patient as a new case if any of the following conditions apply:

- The patient's age category was changed during the report year
- The patient was discharged to a hospital or RHCF and readmitted to the agency within 30 days with the same illness or diagnosis. In this instance the discharge should not be counted.
- The patient was admitted with an unspecified diagnosis and a definite diagnosis was subsequently established.