STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
100 NORTH UNION STREET, SUITE 870
MONTGOMERY, ALABAMA 36104

NOTICE

DATE: February 27, 2020

TO: Applicant and Interested Parties

FROM: Emily T. Marsal
Executive Director

SUBJ: Proposed State Health Plan Adjustment submitted by Alabama Home Health, LLC
PA 2020-001

A Plan Adjustment, designated PA2020-001, has been accepted as complete on February 27, 2020. Persons other than the applicant have thirty (30) days from February 27, 2020, to electronically file statements in opposition to or in support of the application, as well as any other documentation they wish to be considered by the Statewide Health Coordinating Council (SHCC). Pursuant to SHPDA ALA. ADMIN. CODE r. 410-1-3-.09, all such statements and documentation must be filed at shpda.online@shpda.alabama.gov, together with a certification that the filing has been served on the applicant and/or any other persons that have filed notices of support for or opposition to the application.

This Plan Adjustment can be viewed in its entirety at www.shpda.alabama.gov, under Announcements/SHP/Proposed Adjustments & Amendments /PA2020-001 – 410-2-4-.07 Home Health – Alabama Home Health, LLC.

Interested parties may address the proposed Plan Adjustment at the SHCC meeting, subject to such time limits and notice requirements as may be imposed by the SHCC Chairman. If the SHCC approves the Plan Adjustment in whole or in part, the adjustment, along with the SHCC's favorable recommendation, will be sent to the Governor for consideration and approval/disapproval. A Plan Adjustment shall be deemed disapproved by the Governor if not acted upon within fifteen (15) days.

SHPDA Rule 410-2-5-.04 – Plan Revision Procedures, may be viewed in its entirety on the Agency's website at www.shpda.alabama.gov, under Announcements/SHP/Approved Adjustments & Amendments/410-2-5-.04 Plan Revision Procedures (Effective 03/23/2018).

Detailed information regarding the applicable deadlines for the proposed Plan Adjustment is listed on the following page.

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REVIEW SCHEDULE

TO:
1. Plan Adjustment Applicant
2. All Providers of Similar Services in the Proposed County
3. All Providers of Similar Services in Adjacent Counties
4. Interested Persons

NOTICE: An application for Plan Adjustment has been submitted for review under the provisions of Sections 22-21-260(13), Code of Alabama, 1975. A brief description of the proposal and of the Review Schedule is set forth below:

Emily T. Marsal
Executive Director

February 27, 2020
Date

DESCRIPTION OF PROPOSED FACILITY AND/OR SERVICE		
1. Plan Adjustment No.: PA2020-001	2. TYPE FACILITY: HOME HEALTH	3. COUNTY: Montgomery
4. NAME OF APPLICANT: Alabama Home Health, LLC		
5. BRIEF DESCRIPTION OF ADJUSTMENT (Change in bed capacity, service, equipment, units proposed, etc.): The applicant proposes the need for the addition of one (1) Home Health Provider in Montgomery County, Alabama.		

REVIEW SCHEDULE
6. REVIEW PERIOD BEGINS (DAY 1): February 27, 2020
7. DEADLINE FOR PERSONS WISHING TO SUBMIT INFORMATION IN OPPOSITION TO OR SUPPORT OF THE PROPOSED PROJECT (DAY 30): March 30, 2020
8. PROPOSED DATE OF PUBLIC HEARING: June 9, 2020

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Application for an Adjustment to the Alabama SHP
Submitted By Alabama Home Health, LLC

One Additional Home Healthcare Provider in Montgomery County, Alabama

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LIST OF EXHIBITS

A. **Exhibit 1**: Ala. Admin. Code § 4-10-2-4-.07 Home Health.

B. **Exhibit 2**: Statistical Update to the Home Health Section 410-2-4-.07 of the Alabama State Health Plan.

C. **Exhibit 3**: Map of Home Health Providers in Montgomery County, Alabama.

D. **Exhibit 4**: Map of Home Health Providers in Counties Contiguous to Montgomery County, Alabama.

E. **Exhibit 5**: Letters of Support.

   a. Montgomery City Councilmember Arch Lee, District 7.

   b. Hon. Kirk Hatcher, Alabama House of Representatives, District 78.

   c. Hon. Steven L. Reed, Judge of Probate, Montgomery County, Alabama.

   d. Thomas Rutherford Sellers, MD.

   e. Ted Bridges, COO of Prehab Diabetes Services, Inc.

F. **Exhibit 6**: Expert Report on the Current and Projected Need for Additional Home Health Operators in Montgomery County, Alabama.

G. **Exhibit 7:** Amendment to the Expert Report on SHPDA Current and Projected Need for Additional Home Health Operators in Montgomery County, Alabama using SHPDA Methodology

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I. APPLICANT IDENTIFICATION

Applicant: Alabama Home Health, LLC.
184 Commerce Street
Montgomery, Alabama 36104

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Proof of Publication: Not required following the amendment to Section 410-2-5-04.(4)

Fee: $3500 payable to the State Health Planning and Development Agency, delivery under separate cover.

II. PROJECT DESCRIPTION

a. Goal

The goal of this proposed adjustment is to have the **State Health Plan (SHP)** recognize the need for one additional **Home Health Care Provider (HHCP)** in Montgomery County, Alabama.

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Under the SHP policy, the need for HHCP is underestimated. It is based on outmoded data, and a methodology that understates the need for HHCP in areas with populations that are older, and have disproportionally high numbers of African-Americans, as is the case with Montgomery and its contiguous counties. The goal of this adjustment is to remedy these deficiencies and meet the need for HHCP in Montgomery County.

b. Proposed Adjustment

An adjustment to the SHP is appropriate "to address circumstances and meet the identified needs of a specific county." Ala. Admin. Code § 410-2-5-.04(2)(a). Because of the needs of Montgomery County, Applicant asks the Statewide Health Coordinating Council ("SHCC") to adopt the following adjustment to the SHP: "SHCC has recognized the need for additional Home Healthcare Providers in Montgomery County."'

The current provisions of the SHP applicable to HHCP, are attached as **Exhibit 1.** In addition, a copy of the Statistical Update to the Home Health Section 410-2-4-.07 of the SHP has been attached as **Exhibit 2**.

III. Service Area

Under the SHP, the planning area for HHCP is designated by county. This adjustment, as proposed, is for Montgomery County. However, under the SHP, HHCP operators can move into a contiguous county after a year of operation. Ala. Admin. Code § 4-10-2-4-.07(1)(d); Section 22-21-265, Code of Ala. 1975.

In addition, this proposal also considers the surrounding counties of Crenshaw, Autauga, Elmore, Macon, Bullock, and Pike, which would be eligible service areas after a year of operation.

A map of Montgomery County showing relevant existing providers is attached as **Exhibit 2**. A map showing the surrounding counties and their existing providers is attached as **Exhibit 3.**

IV. Population Projections

Montgomery and its contiguous counties have two major demographic trends that demonstrate they require more HHCP than the average county in Alabama. One, the area shows a disproportionally high number of African-American residents. According to the latest census update, just over 26% of Alabama residents are African-American.[1] Montgomery County's African-American population is 58.1%, over double the State average. The adjoining counties of Bullock, Lowndes and Macon have African-American populations almost three times the State

[1] The U.S. Census Bureau, "Alabama: 2010," Table 4, (Dec. 2012) *available at* https://www.census.gov/prod/cen2010/cph-1-2.pdf,

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average. Two, 13.8% of Alabama residents are over the age of 65.[2] Moreover, Montgomery and its contiguous counties have a higher number of seniors than the State average. The following section will explain why these two groups require a greater need for HHCP.

Montgomery and Surrounding Counties' Demographics[3]

County	Total Population (2016)	% Male	% Female	% Black	% 65+	Projected Population (2020)
Montgomery	226,349	47.3%	52.7%	58.1%	14.0%	226,832
Autauga	55,416	48.7%	51.2%	19.3%	14.7%	56,705
Bullock	10,362	54.0%	46.0%	70.4%	16.3%	10,637
Crenshaw	13,913	48.8%	51.2%	23.6%	18.6%	14,017
Elmore	81,799	48.5%	51.5%	21.2%	14.8%	83,991
Lowndes	10,358	47.3%	57.8%	73.4%	18.9%	9,667
Macon	18,963	45.6%	54.4%	82.9%	18.2%	17,617
Pike	33,286	47.8%	52.2%	37.7%	14.8%	33,231

Percentage of the Population Projected to be 65+[4]

County	2016	2020	2025	2030	2035	2040	Δ 2016-2040
Montgomery	14.0%	14.9%	16.8%	18.2%	18.6%	18.9%	+4.9%
Autauga	14.7%	14.9%	17.0%	19.0%	20.1%	21.4%	+6.5%
Bullock	16.3%	17.8%	20.2%	21.5%	20.7%	20.0%	+3.7%
Crenshaw	18.6%	19.0%	21.0%	22.8%	23.0%	24.0%	+5.4%
Elmore	14.8%	16.2%	18.8%	21.1%	22.2%	23.2%	+8.4%
Lowndes	18.9%	20.0%	23.5%	26.4%	26.8%	25.5%	+6.6%
Macon	18.2%	19.0%	21.4%	23.0%	23.0%	22.7%	+4.5%
Pike	14.8%	15.6%	17.1%	17.8%	17.8%	17.2%	+2.4%

V. NEED FOR THE PROPOSED ADJUSTMENT

The United States has one of the best and unique health care systems in the world. Considering that, the US also spends 17.9% of its Gross Domestic Product (GDP) on health care.[5] Which breaks down to a colossal $3.5 trillion or $10,739 per person.[6] This is nearly double the amount of other civilized countries.[7] As a result, the United States healthcare system has strived

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[2] *Id.* at Table 1.

[3] Data made available at http://www.shpda.state.al.us/documents/CBER%20Population/CBERPopulation.aspx. Data taken from the Center for Business and Economic Research ("CBER") at the University of Alabama, County "Population Estimates by Race/Age/Sex, 2016," *available at* https://cber.cba.ua.edu/edata/est_prj/AL%20County%20population%20by%20RaceAgeSex2016.xls.

[4] CBER's "Alabama County Population Aged 65 and Over 2000-2010 and Projections 2020-2040," *available at* https://cber.cba.ua.edu/edata/est_prj/AL_copop_age65+2000-2040_2018mid-series.xls.

[5] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf

[6] *Id.*

[7] https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#item-start

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to drive down costs and promote efficiency.[8] One of the ways identified has been to shift patients from the more expensive inpatient care, to the less costly outpatient care.[9] To better understand this shift from inpatient to outpatient care, it is helpful to give a brief overview of the continuum of care and the costs associated with each stage.

On one end of this continuum of care you have acute hospital care. This provides serves inpatient from doctors, nurses and other hospital staff. Consequently, it is the most expensive stage in the US healthcare system. The next on that expense continuum would be Long Term Care Hospitals (LTCH). These are certified inpatient hospitals that concentrate on patients with an average stay of over 25 days.[10] Their focus is on patients with serious conditions, such as respiratory or head trauma, that could improve over time and return home.[11]

The next level would be Inpatient Rehabilitation Facilities (Rehab). These can either be free standing or located within an acute care center, but offer inpatient services.[12] They provide rigorous rehabilitative plans, but a patient must be able to complete three hours of intensive rehabilitative services in order to be released.[13] Just below Rehab on this expense continuum is a Skilled Nursing Facility (SNF) or what is colloquially known as a Nursing Home. SNFs are essentially an inpatient service for those who require indefinite supervised care. This includes more medical services like medication monitoring and mobility aid, but also non-medical services like bathing and grooming. Traditionally in Alabama, about 82% of SNFs patients are covered by Medicaid.[14] A high percentage of those who come out of hospitals at 65 or above require some type of rehabilitation services.[15] The two inpatient rehabilitation are more expensive than Home Health Rehabilitation,(described below).

The next group on this continuum of care would be the Specialty Care Assisted Living Facilities (SCALF). This type of facility is specifically licensed to serve "residents with a degree of cognitive impairment that would ordinarily make them ineligible for admission or continued stay in an assisted living facility"[16] (ALF).These are sometimes referred to as memory care units because they deal more specifically with those suffering from Alzheimer's or other forms of dementia. Just below SCALF on the continuum of healthcare would be a standard ALF. ALFs provide residence and care to those who need basic assistance with routine activities.[17] ALF residents must meet basic requirements. Once ALF residents exceed these protocols, they must be moved into higher form of care, in this case a SCALF or SNF. Below these services sits

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[8] https://members.elevatinghome.org/files/Education-Quality/VNAA%20CSfinal.pdf at 1
[9] *Id.*
[10] https://www.medicare.gov/pubs/pdf/11347-Long-Term-Care-Hospitals.pdf
[11] *Id.*
[12] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/InpatientRehab.html
[13] *Id.*
[14] https://www.medicare.gov/coverage/skilled-nursing-facility-snf-care
[15] Effectiveness and feasibility of early physical rehabilitation programs for geriatric hospitalized patients: a systematic review
Nienke M Kosse, Alisa L Dutmer, Lena Dasenbrock, Jürgen M Bauer, Claudine JC Lamoth
BMC Geriatr. 2013; 13: 107. Published online 2013 Oct 10. doi: 10.1186/1471-2318-13-107
[16] Alabama Department of Public Health; Rules, Chapters 420-5-20-.1 (2) Definitions (2) (r) "Specialty Care Assisted Living Facility".
[17] https://www.alabamapublichealth.gov/providerstandards/descriptions.html

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Independent Living Facilities, which serves residents who do not require daily care and assistance. None of the categories in this group are covered by Medicaid or Medicare.

On the far end of this continuum of care is Home Healthcare followed by Hospice services. These are the least expensive because, with some exceptions, they are outpatient services provided in the patient's home. Hospice care includes services for patients and families experience during the final stages of illness and death.[18] Home Healthcare provides the patient with care in the home, as opposed to another inpatient or outpatient facility.[19] This allows patients to be comfortable, providing better outcomes and sometimes ending or postponing the need for hospitalization or SNFs.[20]

Home Healthcare is unique in that it offers an array of different services in the home. These services are performed by professionals such as registered nurses, licensed nurses, home health aides, social workers, and therapists.[21] The services provided include, but are not limited to, the following:

- Diabetic Care
- Skilled Nursing
- Intravenous Therapy
- Post Hospital Assessment and Teaching
- Cardiovascular Care
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Medical and Social Work Services[22]

As discussed above, one of the goals of the Patient Protection and Affordable Care Act (ACA) was to reform the healthcare industry by bringing it in line with national trends. This included providing higher quality care while also reducing costs.[23] Preventing primary hospitalizations and readmissions were both identified as means to meet these goals.[24] HHCPs are best suited to facilitate these goals because they work with families in the home, and can identify issues before they become complications. By identifying these issues in the home, they prevent costly initial hospitalizations or readmissions. In addition, this will both reduce the amount of patients in a hospital as well as driving down the costs associated with those hospital visits.

[18] Alabama Department of Public Health; Rules, Chapters 420-5-17-.01 (1) Definitions (h) "Hospice Care Program".
[19] http://www.alabamapublichealth.gov/homehealth/
[20] *Id.*
[21] *Id.*
[22] *Id.*
[23] https://members.elevatinghome.org/files/Education-Quality/VNAA%20CSfinal.pdf at 1.
[24] *Id.*

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Therefore, this coordination by HHCPs is crucial in achieving the policy goals, because it extends care outside of many inpatient healthcare facilities.[25]

The reduction in healthcare costs by utilizing HHCPs can be seen in a variety of ways. For instance someone recovering from surgery with home healthcare for a month will receive a bill around $1,200 but someone who recovers in a facility (such as a nursing home) would be billed around $12,000.[26] From a bird's eye perspective, the Medicare Payment Advisory Commission (MedPAC) reports that 3.4 million, or 17 percent, of traditional fee-for-service Medicare beneficiaries used home health in 2016.[27] Center for Disease Control (CDC) data shows that approximately 81.9 percent of home health users are age 65 or older, 55.1 percent are 75 or older, and nearly 25.2 percent are 85 or older.[28]

Of the patients who received home health care in 2011, 83.2 percent have three or more chronic conditions. According to MedPAC, in 2016, 44 percent of beneficiaries who had a prior hospitalization received Medicare home health while 66 percent were community referral admissions.[29] Community referral admissions reference those patients that came from non profits, families, churches etc. It encompasses any patients who did not come from a prior hospitalization. Of the 66 percent of community referral admissions, 19 percent were first episodes and 46 percent were physician certifications.[30]

Finally, a study conducted by the Alliance for Home Health Quality and Innovation, demonstrated that HHCPs and SNFs serve patients of a similar acuity. This suggests that patients could be appropriately placed in high quality, lower cost settings.[31]

In addition, the Alliance study notes that home health care is the least costly post-acute setting, representing 38.7 percent of all Medicare episodes using post-acute care first settings, but comprising only 27.8 percent of payments.[32] In summary, research and historic utilization patterns demonstrate that access to home health care provide, not only a cost savings to the payor, but also improved health outcomes for the recipient. As a result, they should be expanded as part of a more cost effective and efficient health care delivery system.

As the numbers decline in the hospital readmissions costs go down due to shorter stays. HHCPs provide an excellent way to facilitate this shift. It achieves the same readmission rates as hospitals. Moreover, it provides critical procedures like depression treatment, fall risk and instructions to families.

As shown above, Alabama, like the rest of the nation, is getting older. The landscape and scope of home healthcare services are being propelled by those population trends. For instance, 65% of those enrolled in Medicare have three or more chronic conditions. In addition, half of this

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[25] *Id.*
[26] https://www.usnews.com/news/articles/2014/09/30/is-home-health-a-solution-to-rising-health-costs
[27] http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch9_sec.pdf?sfvrsn=0 at 251.
[28] https://www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf at 20. Figure 20.
[29] http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch9_sec.pdf?sfvrsn=0 at 253.
[30] *Id.*
[31] http://www.ahhqi.org/images/pdf/cacep-wp1-highlights.pdf
[32] Id.

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number live below the poverty line.[33] It is estimated that by 2040, 80 million Americans will be 65 and older. Moreover, the number Americans 85 and older will be about 14.1 million. As individuals age, not only does their health tend to decline, but their healthcare costs increase.[34] As stated above, in 2011, 83.2 percent of HHCP patients have three or more chronic conditions requiring a higher level of care.[35]

Because of its growth as a cost effective alternative, and its propensity to reduce readmission rates, home health care is a facet of the industry that is becoming a more critical part of the American healthcare system. As America's population ages, we are starting to see more people over the age of 65 than at any time in our nation's history. As a result, home healthcare will become crucial in serving that population effectively. Nowhere is this more true than in Alabama, in which roughly 16% of residents are over the age of 65.[36] As seen above, Montgomery and its surrounding counties are disproportionately older than the State's average. As a result, the SHP underestimates the need for HHCPs in the area because it fails to adequately factor in the growth of the senior and African-American populations.

VI. FACTS & FIGURES ABOUT HOME HEALTH CARE PROVIDERS

In 2016, there were over 12,181 Medicare certified home health agencies throughout the United States. In 2016, 3,507,659 beneficiaries were served, and 110,277,728 visits made.[37]

The Department of Health and Human Services (DHHS) and the Centers for Medicare & Medicaid Services (CMS) consider quality healthcare a priority. In that respect, they have adopted the Institute of Medicine's (IOM) definition of quality care as the following:

- **Effectiveness** Relates to providing care processes and achieving outcomes as supported by scientific evidence.
- **Efficiency** Relates to maximizing the quality of a comparable unit of health care delivered or unit of health benefit achieved for a given unit of health care resources used.
- **Equity** Relates to providing health care of equal quality to those who may differ in personal characteristics other than their clinical condition or preferences for care.
- **Patient Centeredness** Relates to meeting patients' needs and preferences and providing education and support.
- **Safety** Relates to actual or potential bodily harm.
- **Timeliness** Relates to obtaining needed care while minimizing delays.

[33] Kaiser Family Foundation. Medicare at a glance. 2014. [December 31, 2014]. http://kff.org/medicare/fact-sheet/medicare-at-a-glance-fact-sheet. [Reference list]
[34] https://www.usnews.com/news/articles/2014/09/30/is-home-health-a-solution-to-rising-health-costs
[35] https://members.elevatinghome.org/files/Education-Quality/VNAA%20CSfinal.pdf via CMS.
[36] https://www.census.gov/library/visualizations/interactive/population-65-years.html
[37] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html

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VII. CURRENT AND PROJECTED UTILIZATION (2018)[38]

Name of Facility	County	Number of Visits	Number of Patients Served
Kindred at Home	Montgomery (Prattville)	16,155	539
Associates Home Health Services	Montgomery (Union Springs)	0	0
Kindred at Home	Montgomery (Enterprise)	2,689	50
Hospital Home Health	Montgomery (Luverne)	50	3
Amedisys Home Health of Selma	Montgomery (Selma)	0	0
Ivy Creek Home Health of Elmore	Montgomery (Wetumpka)	5,482	213
Kindred at Home	Montgomery (Geneva)	0	0
Alabama Dep. Of Public Health Home Care	Montgomery	4,674	154
Baptist Home Health	Montgomery	24,026	949
Kindred at Home	Montgomery	32,187	1,138
Intrepid USA Healthcare Services	Montgomery	2,125	287
Amedisys Home Health of Montgomery	Montgomery	21,458	671
Alacare Home Health and Hospice	Montgomery (Troy)	17,635	910
Troy Regional Medical Center of Home Health	Montgomery (Troy)	1,535	45
Totals:		**128,016**	**4,959**

38 file:///Users/williamblount/Desktop/CONs/Home%20Health%20/Application%20for%20Adjustment%20/ADPH/HH-2%20DRAFT%20REPORT%20MONTGOMERY%20COUNTY%2010-03-2019.pdf

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Note: For Projected Utilization and "Need" Assessment, please refer to the report listed as "Exhibit 6" as well as its amendment listed as "Exhibit 7"

VIII. STAFFING

The staffing required for an additional HHCP in Montgomery County would need to meet the Alabama Department of Public Health's regulatory standards, as well as the operational standards of the entity awarded a Certification of Need under this adjustment.

In regards to available staffing in the area, there are several nursing schools and technical schools in the area that train professionals and paraprofessionals in the home health industry. Additionally

Alabama Home Health, LLC, like all affiliates of the Carpenter Health Network, will require all employees to take the monthly online RELIAS education. This includes all professional staff.

IX. IMPACT ON OTHER FACILITIES

The Applicant does not expect this adjustment to effect existing facilities for the following reasons:

a) **The aging population.** As shown above, Montgomery County is above the State average in citizens over 65 years of age. As the county and the country ages, and people live longer, HHCPs will be critical providing quality healthcare. Due to this increase, it is not expected to have an effect on existing providers. If a CON were granted under this adjustment, the majority of patients at any new facility would be new patients.
b) **The County's demographics show an underserved population**. Montgomery County has a higher than average African American population that continues to grow and age. This demographic is already underserved in the area and the demand will only increase.

X. COMMUNITY SUPPORT

Letters of Support for the proposed adjustment are presented as **Exhibit 4**. As these letters show, this proposed adjustment has wide support in the medical community.

XI. OTHER INFORMATION

About Alabama Home Health, LLC

Alabama Home Health, LLC is affiliated and shares common ownership with the Carpenter Health Network, LLC, located in Baton Rouge, LA. Carpenter has been providing home healthcare, rehabilitation and hospice services for twenty years. They have locations in Alabama and other Gulf Coast states such as Texas, Louisiana, Florida, and Mississippi. In that time they focused on bringing new models of healthcare to meet patient's needs.

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Pat Mitchell, CEO of the Carpenter Health Network, LLC was named the 2019 Public Citizen of the Year by the National Association of Social Workers, Louisiana Chapter (NASW-LA). Mitchell was honored at the NASW-LA Annual Conference at the Baton Rouge Hilton on March 20, 2019.

Submitted by:

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EXHIBIT
1
exhibitsticker.com

(h) Religious Organizations

(i) The Department of Human Resources

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: **New Rule:** Filed June 19, 1996; effective July 25, 1996. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended (SHP Year Only):** Filed December 2 2014; effective January 6, 2015.

410-2-4-.07 **Home Health.**

(1) Definitions

(a) Home Health Agency. A home health agency is an organization that is primarily engaged in providing skilled nursing services and other therapeutic services. Services are provided on an intermittent basis. Each visit must be less than four hours in duration. Any visit made to or procedures performed on a patient at their home must only be made upon a physician's written order. Home health providers shall provide at least the following services, including, but not limited to, skilled nursing care, personal care, physical therapy, occupational therapy, speech therapy, medical social services, and medical supplies services.

(b) Home Health Care. Home health care is that component of a continuum of comprehensive health care whereby intermittent health services are provided to individuals and families in their places of residence for the purpose of promoting, maintaining or restoring health, or of maximizing the level of independence, while minimizing the effects of disability and illness, including terminal illness. Services appropriate to the needs of the individual patient and family are planned, coordinated, and made available by providers organized for the delivery of home health care through the use of employed staff, contractual arrangements, or a combination of employed staff and contractual arrangements. There is no licensure requirement for home health agencies in Alabama.

(c) Home Health Services. Home health services are made available based upon patient care needs as determined by an objective patient assessment administered by a multidisciplinary team or a single health professional. Centralized professional coordination and case management are included. These services are provided under a plan of treatment certified by a physician that may include, but are not limited to, appropriate service

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components, such as medical, nursing, social work, respiratory therapy, physical therapy, occupational therapy, speech therapy, nutrition, homemaker home health aide service, and provision of medical equipment and supplies.

(d) Section 22-21-265, Code of Ala. 1975, allows an existing home health agency to accept referrals from a county which is contiguous to the county where the CON is held (see the referenced section above for restrictions as provided in the section with regards to contiguous counties; also this information is posted on the SHPDA website at http://www.shpda.alabama.gov.)

(2) Inventory of Existing Resources. The State Health Planning and Development Agency annually compiles several home health agency reports and identifies counties which are in need of an additional agency. These publications are available for a fee upon request. A current listing of home health agencies is located at http://www.shpda.alabama.gov or http://www.adph.org.

(3) Planning Policy - (Availability). Home health visits are scheduled on an intermittent basis and must be available seven days a week at such times as may be ordered by referring physicians. While availability must include provision for weekend and evening services, emergency services are not within the scope or purpose of home health providers.

(4) Accessibility

(a) Home health services must be obtainable by the general public in every county in the state.

(b) Because physicians and other referral sources are sometimes unfamiliar with the total scope of services offered by home health providers, patients' accessibility is also limited by failure to refer appropriately to home health services. Every agency should provide an active community information program to educate consumers and professionals to the availability, nature, and extent of home health services.

(c) Because services are provided in patients' own homes, accessibility to services is not dependent upon physical or geographic accessibility to the home health provider's offices. The essential characteristics are location of home health visiting staff in proximity to patients' places of residence and telephone accessibility of the provider to patients, physicians, and other referral sources.

(5) Acceptability and Continuity

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(a) Acceptability is the willingness of consumers, physicians, discharge planners, and others to use home health services as a distinct component of the health care continuum.

(b) Continuity reflects a case management approach that allows patient entry into the health care continuum at the point that ensures delivery of appropriate services. Home health care provides a balanced program of clinical and social services, and may serve as a transitional level of care between inpatient treatment and infrequent physician office visits. Home health also extends certain intensive, specialized treatments into the home setting.

(c) Planning Guides and Policies

1. Planning Guide. Home health providers shall maintain referral contacts with appropriate community providers of health and social services, to facilitate continuity of care and to coordinate services not provided directly by the home health provider.

2. Planning Policy. Home health providers must furnish discharge-planning services for all patients.

(6) Quality

(a) Quality is that characteristic, which reflects professionally appropriate and technically adequate patient services.

(b) The state home health industry, through development of ethical standards and a peer review process, can foster provision of quality home health care services. Each provider must establish mechanisms for quality assurance, including procedures for resolving concerns identified by patients, physicians, families or others involved in patient referral or patient care.

(c) Planning Policies

1. Planning Policy. The county will be the geographic unit for need determination, based upon population.

2. Planning Policy - (New Providers). When a new provider is approved for a county, that provider will have eighteen months from the date of the Certificate of Need to meet the identified need in the county before a new provider may apply for a Certificate of Need to serve a county.

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3. Planning Policy - (Existing Providers). If an existing provider ceases to operate in a county, once the Certificate of Need is deemed null and void then a provider can apply under the current published statistical need.

4. Planning Policy - Favorable Consideration. Home health agencies that achieve or agree to achieve Charity Care plus Self Pay at the statewide average percent for all home health providers shall be given favorable CON consideration over home health applicants that do not achieve or agree to achieve the statewide average for Charity Care plus Self Pay, but not less than one (1) percent. The latest published SHPDA data report HH-11 shall be used to determine the statewide average percent for Charity Care plus Self Pay, which was 1.3 percent for 2005. Donations of assets to governmental and non-profit organizations at the individual county level may be considered. See section 410-2-2-.06 for the definition of charity care.

5. Planning Policy - CON Intervention/Opposition.

(i) Any CON application filed by a health care facility shall not be deemed complete until, and unless:

(I) The applicant has submitted all survey information requested by SHPDA prior to the application date; and

(II) The SHPDA Executive Director determines that the survey information is substantially complete.

(ii) No Home Health Agency or Hospice Agency filing an intervention notice or statement in opposition in any CON proceeding may cite or otherwise seek consideration by SHPDA of such facility's utilization data until, and unless:

(I) the intervenor or opponent has submitted all survey information requested by SHPDA prior to the application date; and

(II) the SHPDA Executive Director determines that the survey information is substantially complete.

6. Home Health Need Methodology

(i) Purpose. The purpose of this home health need methodology is to identify, by county, the number of home health agencies needed to assure the continued availability, accessibility, and affordability of quality home health care for residents of Alabama.

(ii) Basic Methodology.

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The SHCC finds that the current home health methodology, set forth below, is in need of review prior to the grant or consideration of new home health agencies. Consequently, no new home health applications shall be accepted until the earlier of (1) January 1, 2016; or (2) the adoption of a revised home health need methodology.

In order to perform the calculations for this methodology, population data from the Center for Business and Economic Research (CBER) was used. All time frames are based on the year of the latest reported data.

Step 1:

1. Data required to perform the calculations in this methodology are: population data for the current reporting year, the two reporting years immediately prior to the current reporting year, and the projected data for three years immediately following the current reporting year.

2. Persons served data for the current reporting year, and the two reporting years immediately prior to the current reporting year, are required to perform the calculations in this methodology. This information can be gathered off of the HH-2 report as generated by SHPDA.

3. The ratio for the change in population for two age cohorts, Population under 65 and Population age 65 and over, needs to be determined per county. The ratio for the change will be for a three year period. Therefore, the current reporting year will be compared to the year three years following the current reporting year. The year immediately prior to the current reporting year will be compared to the year two years following the current reporting year. The year two years prior to the current reporting year will be compared to the year immediately following the current reporting year. To show this another way:

Current Reporting Year	--	Current Reporting Year + 3
Current Reporting Year -1	--	Current Reporting Year + 2
Current Reporting Year -2	--	Current Reporting Year + 1

4. Projected patients served under the age of 65 for future reporting years are calculated on a county basis by: multiplying the year's total persons served by 25% (0.25) to determine the approximate number of persons served under the age of 65. This number is divided by the county population under the age of 65 to determine a utilization rate. To determine the

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projected patients served under the age of 65, this total is then multiplied by the total projected population for the target year for each county.

5. Projected patients served age 65 and older for future reporting years are calculated on a county basis by: multiplying the year's total persons served by 75% (0.75) to determine the approximate number of persons served age 65 and older. This number is divided by the county population age 65 and older to determine a utilization rate. To determine the *projected patients served age 65 and older*, this total is then multiplied by the total projected population for the target year for each county.

6. To determine the *total number of projected persons served per county*, add the totals from steps 4 and 5.

7. Add the total number of *projected persons served*, by county, to determine the *statewide projected total persons served*.

8. Multiply the target year's *projected total persons served* for the target year by 25% (0.25) to reflect the *projected statewide total persons served* under the age of 65.

9. Divide the total statewide population under the age of 65 for the target year by 1000.

10. Divide the numeric result from step 8 by the numeric result in step 9.

11. Multiply the target year's *projected total persons served* by 75% (0.75) to reflect the projected statewide total persons served ages 65 and over.

12. Divide the total statewide population age 65 and over for the target year by 1000.

13. Divide the numeric result from step 11 by the numeric result in step 12.

14. Add the results from steps 10 and 13. This is the *projected average statewide persons served per 1000 population*, by county, for the target year.

15. Repeat steps 4 through 14 for the second target year.

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16. Repeat steps 4 through 14 for the third target year.

17. To determine the *projected weighted statewide average persons served*, perform the following calculation: multiply the *projected statewide average persons served per 1000 population* for 3 years after the current reporting year by 3; multiply the *projected statewide average persons served per 1000 population* for 2 years after the current reporting year by 2; and multiply the *projected statewide average persons served per 1000 population* for 1 year after the current reporting year by 1.

18. Add the three results determined in step 17 and divide the total by 6 for the *projected statewide average persons served per 1000 population*.

19. To determine the *Current Home Health Comparative Value*, multiply the number derived in step 18 by 85% (0.85). This is the value that will be utilized in the comparisons in step 2.

Step 2:

1. Using the data created above for the target year (the year three years after the current reporting year), follow the steps below to determine the future projected need for Home Health Services by county.

2. Multiply the target year's total persons served by 25% (0.25) to reflect the *county wide total persons served under the age of 65*.

3. Divide the total county wide population under the age of 65 by 1000.

4. Divide the numeric result from step 2 by the numeric result in step 3.

5. Multiply the current year's total persons served by 75% (0.75) to reflect the *county wide total persons served ages 65 and over*.

6. Divide the total county wide population age 65 and over by 1000.

7. Divide the numeric result from step 5 by the numeric result in step 6.

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8. Add the results from steps 4 and 7. This is the *projected total persons served per 1000 population* used to determine need for Home Health Services in a county.

9. Subtract the result from step 8, by county, from the *Current Home Health Comparative Value*. If this number is negative, there is no need for a new Home Health provider in a county. If the number is positive, continue to step 10.

10. This number is then divided by the SUM of 0.75 (75%) times 1000 divided by the county population aged 65 and over AND 0.25 (25%) times 1000 divided by the county population under the age of 65. This number is the number of new persons required to be served in a county to bring the county persons served per 1000 value up to the statewide comparative value.

11. A threshold level of 100 new patients needed to be served is required for a determination of need in a county. If the number of new patients needed to be served is less than 100, there is no need for a new Home Health provider in a county. If the number is equal to or greater than 100, there is a need for a new Home Health Care provider in a county.

Step 1:
For each target year by county:

(reported year persons served * 0.25) / (reported year population under 65)

= utilization rate population under 65

Utilization rate * target year population under 65 = projected persons served under 65

(reported year persons served * 0.75) / (reported year population age 65 and over)

= utilization rate population age 65 and over

Utilization rate * target year population age 65 and over = projected persons served age 65 and over

Projected persons served under 65 + projected persons served age 65 and over

= Target year projected persons served by county

For each target year:

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Sum of all Target year projected persons served by county = Target year projected total persons served

(Target year projected total persons served * 0.25)/(Projected population under 65 /1000) + (Target year projected total persons served * 0.75) / (Projected population age 65 and over /1000)

= Projected Statewide Average Persons Served per 1000 Population

To Determine Current Home Health Comparative Value for Step 2:

$$\frac{\text{((3 Years after Current Reporting Year Projected Average Persons Served * 3) + (2 Years after Current Reporting Year Projected Average Persons Served * 2) + (1 Year after Current Reporting Year Projected Average Persons Served *1))}}{6}$$

= Projected Weighted Average Persons Served per 1000 Population

Projected Weighted Average Persons Served per 1000 Population * 0.85

= Current Home Health Comparative Value

Step 2: *(Using population and persons served projections for 3 years after current reporting year)*

$$\frac{\text{(countywide total persons served * 0.25)}}{\text{(county population under 65/1000)}} + \frac{\text{(countywide total persons served * 0.75)}}{\text{(county population 65 and over/1000)}}$$

= County Persons Served per 1000 Population

Current Home Health Comparative Value - County Persons Served per 1000 Population

= County Projected Persons Per 1000 Population in Need of Home Health Services.

$$\frac{\text{County Projected Persons Per 1000 Population in need of Home Health Services}}{\text{(0.75*1000/Population age 65 and over) + (0.25*1000/Population under 65)}}$$

= New persons required to be served in county to equal Current Home Health Comparative Value

If number is negative, there is no need in a county.
If number is less than 100, there is no need in a county.
If number is 100 or more, there is a need for a new Home Health provider in a county.

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For a listing of Home Health Agencies or the most current statistical need projections in Alabama you may contact the Data Division as follows:

MAILING ADDRESS
(U.S. Postal Service)

PO BOX 303025
MONTGOMERY AL 36130-3025

STREET ADDRESS
(Commercial Carrier)

100 NORTH UNION STREET
STE 870
MONTGOMERY AL 36104

TELEPHONE:
(334) 242-4103

FAX:
(334) 242-4113

E-Mail:
info@shpda.alabama.gov

Website:
http://www.shpda.alabama.gov

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: Effective 8, 1993. **Amended:** Filed June 19, 1996; effective July 25, 1996. **Amended:** Filed January 8, 1997; effective February 12, 1997. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Repealed and New Rule:** Filed December 12, 2006; effective January 16, 2008. **Amended (SHP Year Only):** Filed December 2, 2014; effective January 6, 2015. **Amended:** Filed February 10, 2015; effective March 17, 2015.

Note: Statistically updated September 30, 1993. Rule No. 410-2-4-.02 through 410-2-4-.09, inclusive, have been revised to reflect more current inventories, population, and utilization statistics, effective September 30, 1993. Statistically updated August 3, 1994. These updates reflect changes in inventories, utilization, populations, and need projections; effective August 3, 1994. Statistically updated August 21, 1995.

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COUNTY ASSESSMENT OF NEED FOR HOME HEALTH AGENCIES

	VISITS	PERS SERV	POP 65 + 2003	VISIT PER 1,000 65 +	PERS SERV/ 1,000 65 +	PERS NEEDED TO = 138	METHODOLOGY CONCLUSION
AUTAUGA	30,298	860	5,007	6,051	172		
BALDWIN	66,015	2,532	24,392	2,706	104	829	Possibly Underserved
*BARBOUR	24,984	797	3,928	6,360	203		
*BIBB	9,424	380	2,593	3,634	147		
BLOUNT	20,796	704	7,183	2,895	98	287	Possibly Underserved
*BULLOCK	5,937	200	1,525	3,893	131	21	**
*BUTLER	16,709	599	3,481	4,800	172		
CALHOUN	52,671	1,719	16,169	3,258	106	517	Possibly Underserved
*CHAMBERS	12,589	653	5,874	2,143	111	188	Possibly Underserved
*CHEROKEE	6,645	323	4,225	1,573	76	262	Possibly Underserved
*CHILTON	31,257	861	5,435	5,751	158		
*CHOCTAW	24,677	640	2,449	10,076	261		
*CLARKE	16,463	521	3,939	4,179	132	24	**
*CLAY	20,292	531	2,467	8,225	215		
*CLEBURNE	2,536	125	2,045	1,240	61	27	**
*COFFEE	26,980	859	6,470	4,170	133	52	**
COLBERT	53,686	1,404	8,711	6,163	161		
*CONECUH	27,740	621	2,213	12,535	281		
*COOSA	3,152	142	1,824	1,728	78	109	Possibly Underserved
*COVINGTON	28,479	906	6,871	4,145	132	41	**
*CRENSHAW	9,755	282	2,308	4,227	122	95	**
*CULLMAN	56,261	1,586	11,920	4,720	133	60	**
DALE	17,995	665	6,260	2,875	106	232	Possibly Underserved
*DALLAS	37,655	1,188	6,445	5,843	184		
*DEKALB	34,977	1,195	9,238	3,786	129	83	**
ELMORE	24,232	1,367	7,665	3,161	178		
*ESCAMBIA	20,281	696	5,428	3,736	128	54	**
ETOWAH	64,290	1,784	16,549	3,885	108	496	Possibly Underserved
*FAYETTE	9,901	431	3,084	3,210	140		
*FRANKLIN	40,091	944	4,786	8,377	197		
*GENEVA	18,784	627	4,358	4,310	144		
*GREENE	11,019	276	1,465	7,522	188		
*HALE	21,480	450	2,324	9,243	194		
*HENRY	5,215	226	2,710	1,924	83	149	Possibly Underserved
HOUSTON	44,638	1,531	12,630	3,534	121	215	Possibly Underserved
*JACKSON	39,214	1,123	7,720	5,080	145		
JEFFERSON	286,078	12,400	88,407	3,236	140		
*LAMAR	22,473	539	2,617	8,587	206		
LAUDERDALE	30,957	1,414	13,785	2,246	103	620	Possibly Underserved
LAWRENCE	34,648	861	4,436	7,811	194		
LEE	27,481	1,188	10,037	2,738	118	351	Possibly Underserved
LIMESTONE	39,301	1,140	7,771	5,057	147		
*LOWNDES	6,392	209	1,745	3,663	120	58	**

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COUNTY ASSESSMENT OF NEED FOR HOME HEALTH AGENCIES

	VISITS	PERS SERV	POP 65 + 2003	VISIT PER 1,000 65 +	PERS SERV/ 1,000 65 +	PERS NEEDED TO = 138	METHODOLOGY CONCLUSION
*MACON	13,279	596	3,303	4,020	180		
MADISON	82,481	3,537	32,677	2,524	108	980	Possibly Underserved
*MARENGO	15,882	480	3,319	4,785	145		
*MARION	35,104	1,022	5,171	6,789	198		
*MARSHALL	62,023	1,916	12,290	5,047	156		
MOBILE	492,952	7,142	48,819	10,098	146		
*MONROE	33,695	608	3,446	9,778	176		
MONTGOMERY	93,382	3,734	26,553	3,517	141		
MORGAN	57,857	1,884	14,305	4,045	132	86	**
*PERRY	6,477	195	1,762	3,676	111	48	**
*PICKENS	21,370	637	3,316	6,445	192		
*PIKE	28,289	945	3,805	7,435	248		
*RANDOLPH	19,512	607	3,674	5,311	165		
RUSSELL	32,406	1,145	6,658	4,867	172		
ST. CLAIR	25,025	771	8,293	3,018	93	373	Possibly Underserved
SHELBY	26,537	1,270	14,140	1,877	90	679	Possibly Underserved
*SUMTER	17,090	478	2,006	8,519	238		
*TALLADEGA	66,798	1,993	10,985	6,081	181		
*TALLAPOOSA	18,785	857	6,973	2,694	123	300	Possibly Underserved
TUSCALOOSA	101,008	3,589	18,783	5,378	191		
*WALKER	72,028	1,839	10,828	6,652	170		
*WASHINGTON	16,668	462	2,349	7,096	197		
*WILCOX	5,950	171	1,791	3,322	95	77	**
*WINSTON	31,169	869	3,744	8,325	232		
TOTALS	2,760,215	84,246	599,479	4,604	141		

*Designated as Rural by the Health Care Financing Administration.

**Under Section 410-2-4-.07(8) a county will be considered for an additional agency only when the number required to bring the county up to the set number of persons served per 1,000 population 65 and older equals, at a minimum, 100 new person.

Note: Counties below 138 persons served per 1,000 population 65 and older are possibly underserved, utilizing the three year weighted average methodology.

Note: Methodology per *Alabama State Health Plan* 2004-2007 Section 410-2-4-.07.

Source: SHPDA HH-2 report for period ending September 30, 2003

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ALABAMA
Home Health Care Agencies

Facility Name		City		
BALDWIN *County*				
AMEDISYS HOME HEALTH INC. OF ALABAMA		FAIRHOPE		
MERCY MEDICAL HOME HEALTH		FAIRHOPE		
MID SOUTH HOME HEALTH AGENCIES, INC.		DAPHNE		
SOUTH BALDWIN HOSP HOME HEALTH AGENCY		FOLEY		
THOMAS HOSPITAL HOME HEALTH		DAPHNE		
	BALDWIN County Totals:	Number Of Facilities:		5
BARBOUR *County*				
LAKEVIEW COMMUNITY HOSPITAL HOME HEALTH		EUFAULA		
	BARBOUR County Totals:	Number Of Facilities:		1
BIBB *County*				
BIBB MEDICAL CENTER HOME HEALTH		CENTREVILLE		
	BIBB County Totals:	Number Of Facilities:		1
BLOUNT *County*				
MEDICAL CENTER BLOUNT HOME HEALTH		ONEONTA		
	BLOUNT County Totals:	Number Of Facilities:		1
BULLOCK *County*				
ASSOCIATES HOME HEALTH		UNION SPRINGS		
	BULLOCK County Totals:	Number Of Facilities:		1
BUTLER *County*				
LVSMH HOME HEALTH AGENCY		GREENVILLE		
RELIABLE HOME HEALTH SERVICES, INC.		GEORGIANA		
	BUTLER County Totals:	Number Of Facilities:		2
CALHOUN *County*				
AMEDISYS HOME HEALTH OF ANNISTON		ANNISTON		
GENTIVA HEALTH SERVICES Calhoun		ANNISTON		
NORTHEAST AL REG MEDICAL CENTER HOME HEALTH		ANNISTON		
	CALHOUN County Totals:	Number Of Facilities:		3
CHAMBERS *County*				
LANIER HOME HEALTH SERVICES		VALLEY		
	CHAMBERS County Totals:	Number Of Facilities:		1
CHEROKEE *County*				
CHEROKEE BMC HOME HEALTH		CENTRE		
	CHEROKEE County Totals:	Number Of Facilities:		1
CHILTON *County*				
CHILTON MEDICAL CENTER HOME HEALTH		CLANTON		
	CHILTON County Totals:	Number Of Facilities:		1
CHOCTAW *County*				
PRIMARY HOME CARE		GILBERTOWN		
	CHOCTAW County Totals:	Number Of Facilities:		1
CLARKE *County*				
INFIRMARY HOME HEALTH AGENCY		GROVE HILL		
JACKSON HOME HEALTH		JACKSON		
	CLARKE County Totals:	Number Of Facilities:		2
CLAY *County*				
CLAY COUNTY HOSPITAL HOME HEALTH		ASHLAND		
	CLAY County Totals:	Number Of Facilities:		1
COLBERT *County*				
TRI-COUNTY HOME HEALTH CARE AGENCIES		SHEFFIELD		
	COLBERT County Totals:	Number Of Facilities:		1

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ALABAMA
Home Health Care Agencies

Facility Name		City		
CONECUH *County*				
EVERGREEN HOME CARE		EVERGREEN		
	CONECUH County Totals:	Number Of Facilities:	1	
COVINGTON *County*				
GENTIVA HEALTH SERVICES Covington		ANDALUSIA		
HOME CARE SERVICE OF OPP		OPP		
MIZELL MEMORIAL HOSPITAL HOME HEALTH CARE AGENCIES		OPP		
	COVINGTON County Totals:	Number Of Facilities:	3	
CRENSHAW *County*				
CRENSHAW BAPTIST HOME HEALTH SERVICES		LUVERNE		
	CRENSHAW County Totals:	Number Of Facilities:	1	
CULLMAN *County*				
CULLMAN REG MEDICAL CENTER HOME CARESERVICES		CULLMAN		
WOODLAND MEDICAL HOSPITAL HOME HEALTH		CULLMAN		
	CULLMAN County Totals:	Number Of Facilities:	2	
DALE *County*				
DALE MEDICAL CENTER HOME HEALTH		OZARK		
	DALE County Totals:	Number Of Facilities:	1	
DALLAS *County*				
AMEDISYS HOME HEALTH, INC. OF SELMA		SELMA		
MID SOUTH HOME HEALTH		SELMA		
	DALLAS County Totals:	Number Of Facilities:	2	
DEKALB *County*				
BAPTIST DEKALB HOME CARE		COLLINSVILLE		
	DEKALB County Totals:	Number Of Facilities:	1	
ELMORE *County*				
COMMUNITY HOME CARE		TALLASSEE		
IVY CREEK HOME HEALTH OF ELMORE		WETUMPKA		
	ELMORE County Totals:	Number Of Facilities:	2	
ESCAMBIA *County*				
ATMORE COMMUNITY HOSPITAL HOME HEALTH		ATMORE		
D. W. MCMILLAN HOME HEALTH		BREWTON		
	ESCAMBIA County Totals:	Number Of Facilities:	2	
ETOWAH *County*				
GADSDEN REGIONAL MEDICAL CENTER (HH)		ATTALLA		
RIVERVIEW REGIONAL MED CTR HOME HEALTH		GADSDEN		
	ETOWAH County Totals:	Number Of Facilities:	2	
FAYETTE *County*				
FAYETTE MEDICAL CENTER HOME HEALTH AGENCY		FAYETTE		
	FAYETTE County Totals:	Number Of Facilities:	1	
FRANKLIN *County*				
COMMUNITY HOME HEALTH (Franklin)		RED BAY		
NORTHWEST HOME HEALTH		RUSSELLVILLE		
SOUTHERN RURAL HEALTH CARE CONSORTIUM (Franklin)		RUSSELLVILLE		
	FRANKLIN County Totals:	Number Of Facilities:	3	
GREENE *County*				
GREENE COUNTY HOSPITAL HOME HEALTH		EUTAW		
	GREENE County Totals:	Number Of Facilities:	1	
HALE *County*				
HALE COUNTY HOSPITAL HOME HEALTH		GREENSBORO		
	HALE County Totals:	Number Of Facilities:	1	
HOUSTON *County*				
CARESOUTH-DOTHAN		DOTHAN		
HORIZON HOME CARE OF DOTHAN		DOTHAN		
MEDICAL CENTER HH SERVICES II		DOTHAN		

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ALABAMA
Home Health Care Agencies

Facility Name		City	
MEDICAL CENTER HH SERVICES, I		DOTHAN	
	HOUSTON County Totals:	Number Of Facilities:	4
JACKSON *County*			
HOSPITAL HOME HEALTH		SCOTTSBORO	
	JACKSON County Totals:	Number Of Facilities:	1
JEFFERSON *County*			
ABLE HOME HEALTH INC		BESSEMER	
ALACARE HOME HEALTH SERVICES, INC.		BIRMINGHAM	
Alacare Home Health Services, Inc. (Troy)		BIRMINGHAM	
AMEDISYS HOME HEALTH OF BIRMINGHAM		BIRMINGHAM	
BAPTIST HOME CARE SERVICES			
BROOKWOOD HOME HEALTH AGENCY		BIRMINGHAM	
CARE FIRST, INC.		BIRMINGHAM	
GENTIVA HEALTH SERVICES		BIRMINGHAM	
HEALTH SERVICES EAST, INC.		BIRMINGHAM	
HOME CARE PLUS, INC.		BIRMINGHAM	
JEFFERSON COUNTY HEALTH DEPARTMENT		BIRMINGHAM	
MIDSOUTH HOME HEALTH - SHELBY		PELHAM	
SOLEUS HC SERVICE OF NC AL, INC.		BIRMINGHAM	
ST MARTINS HOME HEALTH, INC.		BIRMINGHAM	
	JEFFERSON County Totals:	Number Of Facilities:	14
LAMAR *County*			
LAMAR HOME CARE, INC.		VERNON	
	LAMAR County Totals:	Number Of Facilities:	1
LAWRENCE *County*			
LAWRENCE BAPTIST MEDICAL CENTER HOME HEALTH		MOULTON	
MID SOUTH HOME HEALTH AGENCY INC.		MOULTON	
	LAWRENCE County Totals:	Number Of Facilities:	2
LEE *County*			
EAST AL MEDICAL CENTER HOME CARE		OPELIKA	
SOUTHERN HOME HEALTH SERVICES		OPELIKA	
	LEE County Totals:	Number Of Facilities:	2
LIMESTONE *County*			
ATHENS LIMESTONE HOSPITAL HOME HEALTH		ATHENS	
	LIMESTONE County Totals:	Number Of Facilities:	1
MADISON *County*			
AMEDISYS HOME HEALTH OF HUNTSVILLE		HUNTSVILLE	
HGA - HOME HEALTH GROUP - HUNTSVILLE		HUNTSVILLE	
SPECTRUM HOME HEALTH AGENCY		HUNTSVILLE	
	MADISON County Totals:	Number Of Facilities:	3
MARENGO *County*			
B. W. WHITFIELD MEM HOME HEALTH CARE AGENCIES		DEMOPOLIS	
	MARENGO County Totals:	Number Of Facilities:	1
MARION *County*			
MARION REGIONAL HOME HEALTH SERVICES		HAMILTON	
NORTHWEST HOME HEALTH-WINFIELD		WINFIELD	
	MARION County Totals:	Number Of Facilities:	2
MARSHALL *County*			
MEDICAL CENTER HOME HEALTH (Marshall)		ALBERTVILLE	
	MARSHALL County Totals:	Number Of Facilities:	1
MOBILE *County*			
AMEDISYS HOME HEALTH INC. OF AL MOBILE		MOBILE	
GENTIVA HEALTH SERVICES		MOBILE	

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ALABAMA
Home Health Care Agencies

Facility Name		City	
INFIRMARY HOME HEALTH AGENCY		MOBILE	
KARE IN HOME HEALTH SERVICES OF ALA, INC		MOBILE	
SAAD'S HEALTH CARE SERVICES		MOBILE	
SPRINGHILL HOME HEALTH AGENCY		MOBILE	
VANGUARD HOME HEALTH OF MOBILE		MOBILE	
	MOBILE County Totals:	Number Of Facilities:	7
MONROE ***County***			
MONROE COUNTY HOSPITAL PROGRESSIVE HOME CARE		MONROEVILLE	
VANGUARD HOME HEALTH OF MONROEVILLE		MONROEVILLE	
	MONROE County Totals:	Number Of Facilities:	2
MONTGOMERY ***County***			
AMEDISYS HOME HEALTH		MONTGOMERY	
BAPTIST HOME HEALTH SERVICES MONTGOMERY		MONTGOMERY	
GENTIVA HEALTH SERVICES MONTGOMERY		MONTGOMERY	
MID SOUTH HOME HEALTH AGENCY		MONTGOMERY	
MONTGOMERY HOME CARE		MONTGOMERY	
	MONTGOMERY County Totals:	Number Of Facilities:	5
MORGAN ***County***			
ALACARE HOME HEALTH & HOSPICE		DECATUR	
HEALTH GROUP-HOME HEALTH GROUP-DECATUR		DECATUR	
	MORGAN County Totals:	Number Of Facilities:	2
PICKENS ***County***			
AMEDISYS HOME HEALTH INC. OF AL PICKENS		REFORM	
MEDICAL CENTER HOME HEALTH (Pickens)		CARROLLTON	
	PICKENS County Totals:	Number Of Facilities:	2
PIKE ***County***			
TROY REGIONAL MEDICAL CENTER (HH)		TROY	
	PIKE County Totals:	Number Of Facilities:	1
RUSSELL ***County***			
CHATTAHOOCHEE VALLEY HHC, INC.		PHENIX CITY	
	RUSSELL County Totals:	Number Of Facilities:	1
SHELBY ***County***			
COMFORT CARE HOME HEALTH SERVICES		ALABASTER	
	SHELBY County Totals:	Number Of Facilities:	1
ST. CLAIR ***County***			
ST CLAIR REGIONAL HOME HEALTH		PELL CITY	
	ST. CLAIR County Totals:	Number Of Facilities:	1
SUMTER ***County***			
HILL HOSPITAL HOME HEALTH		YORK	
	SUMTER County Totals:	Number Of Facilities:	1
TALLADEGA ***County***			
COOSA VALLEY BMC HOME HEALTH		SYLACAUGA	
GENTIVIA HEALTH SERVICES		SYLACAUGA	
	TALLADEGA County Totals:	Number Of Facilities:	2
TALLAPOOSA ***County***			
COMMUNITY HOME CARE (Tallapoosa)		DADEVILLE	
	TALLAPOOSA County Totals:	Number Of Facilities:	1
TUSCALOOSA ***County***			
AMEDISYS HOME HEALTH OF TUSCALOOSA		TUSCALOOSA	
COMMUNITY HOME HEALTH (Tuscaloosa)		TUSCALOOSA	
DCH HOME HEALTH CARE AGENCIES AGENCY		TUSCALOOSA	
	TUSCALOOSA County Totals:	Number Of Facilities:	3

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STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ALABAMA
Home Health Care Agencies

Facility Name		City	
WALKER ***County***			
WALKER BMC HOME CARE SERVICES		JASPER	
	WALKER County Totals:	Number Of Facilities:	1
WILCOX ***County***			
J PAUL JONES HOME HEALTH AGENCY		CAMDEN	
	WILCOX County Totals:	Number Of Facilities:	1
WINSTON ***County***			
NORTHWEST HOME HEALTH - HALEYVILLE		HALEYVILLE	
	WINSTON County Totals:	Number Of Facilities:	1
	State Totals:	Number Of Facilities:	109

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STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ALABAMA
ALABAMA HEALTH DEPARTMENT COUNTY HOME HEALTH AGENCIES

Facility	City
AUTAUGA COUNTY HEALTH DEPARTMENT	PRATTVILLE
BARBOUR COUNTY HEALTH DEPARTMENT	CLAYTON
CHOCTAW COUNTY HEALTH DEPARTMENT	LINDEN
CLAY COUNTY HEALTH DEPARTMENT	LINEVILLE
COFFEE COUNTY HEALTH DEPARTMENT	ENTERPRISE
NORTHWEST AL REGION HOME HEALTH DEPT	TUSCUMBIA
CONECUH COUNTY HEALTH DEPARTMENT	EVERGREEN
CULLMAN COUNTY HEALTH DEPARTMENT	CULLMAN
DALLAS COUNTY HEALTH DEPARTMENT	SELMA
DEKALB COUNTY HEALTH DEPARTMENT	FORT PAYNE
ETOWAH COUNTY HEALTH DEPARTMENT	GADSDEN
GENEVA COUNTY HEALTH DEPARTMENT	GENEVA
HOUSTON COUNTY HEALTH DEPARTMENT	DOTHAN
JACKSON COUNTY HEALTH DEPARTMENT	SCOTTSBORO
LAMAR COUNTY HEALTH DEPARTMENT	VERNON
LAWRENCE COUNTY HEALTH DEPARTMENT	MOULTON
LIMESTONE COUNTY HEALTH DEPARTMENT	ATHENS
MARION COUNTY HEALTH DEPARTMENT	HAMILTON
MARSHALL COUNTY HEALTH DEPARTMENT	GUNTERSVILLE
MOBILE COUNTY HEALTH DEPARTMENT	MOBILE
MONROE COUNTY HEALTH DEPARTMENT	MONROEVILLE
MONTGOMERY COUNTY HEALTH DEPARTMENT	MONTGOMERY
MORGAN COUNTY HEALTH DEPARTMENT	DECATUR
PIKE COUNTY HEALTH DEPARTMENT	TROY
RANDOLPH COUNTY HEALTH DEPARTMENT	ROANOKE
RUSSELL COUNTY HEALTH DEPARTMENT	PHENIX CITY
SUMTER COUNTY HEALTH DEPARTMENT	LIVINGSTON
TALLEDEGA/COOSA COUNTY HEALTH DEPARTMENT	SYLACAUGA
TUSCALOOSA COUNTY HEALTH DEPARTMENT	TUSCALOOSA
WASHINGTON COUNTY HEALTH DEPARTMENT	CHATOM
WINSTON COUNTY HEALTH DEPARTMENT	HAMILTON

State Totals: Number Of Facilities: 31

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STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
100 NORTH UNION STREET, SUITE 870
MONTGOMERY, ALABAMA 36104

November 16, 2012

MEMORANDUM

TO: Recipients of the 2004-2007 *Alabama State Health Plan*

FROM: Alva M. Lambert
Executive Director

SUBJECT: Statistical Update to the 2004-2007 *Alabama State Health Plan*

Enclosed is a statistical update to the Home Health Section 410-2-4-.07 of the *Alabama State Health Plan*.

Please replace pages 146-147

AML/blw

Enclosure: As stated

MAILING ADDRESS: P.O. BOX 303025, MONTGOMERY, ALABAMA 36130-3025
PHONE: (334) 242-4103 FAX: (334) 242-4113

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County	Total Projected Patients Served, 2012	Total Projected Population Under 65, 2012	Total Projected Population Over 65, 2012	Projected Patients Served <65, 2012	Projected Patients Served >65, 2012	Projected Total Patients Served, 2012	Projected Statewide Weighted Average	For Statewide Average - 15%	Rounded Avg -15%	Difference to meet	Patients to Meet Total	Threshold	Reflects Need
Autauga	1,120	48,183	7,201	6	117	122	136	115.6	116	(6)	(59)	100	
Baldwin	5,007	157,378	35,732	8	105	113	136	115.6	116	3	131	100	Need
Barbour	760	27,684	4,696	7	121	128	136	115.6	116	(12)	(72)	100	
Bibb	799	22,233	3,505	9	171	180	136	115.6	116	(64)	(284)	100	
Blount	1,271	56,468	9,756	6	98	103	136	115.6	116	13	156	100	Need
Bullock	216	10,525	1,698	5	95	100	136	115.6	116	16	34	100	**
Butler	905	16,951	3,785	13	179	193	136	115.6	116	(77)	(360)	100	
Calhoun	3,779	94,159	18,096	10	157	167	136	115.6	116	(51)	(1,149)	100	
Chambers	1,026	29,898	6,479	9	119	127	136	115.6	116	(11)	(91)	100	
Cherokee	733	23,255	5,896	8	93	101	136	115.6	116	15	108	100	Need
Chilton	1,579	41,883	7,093	9	167	176	136	115.6	116	(60)	(541)	100	
Choctaw	414	12,757	3,033	8	102	110	136	115.6	116	6	21	100	**
Clarke	1,109	23,843	4,727	12	176	188	136	115.6	116	(72)	(423)	100	
Clay	452	12,519	2,939	9	115	124	136	115.6	116	(8)	(30)	100	
Cleburne	438	12,986	2,650	8	124	132	136	115.6	116	(16)	(54)	100	
Coffee	1,167	39,259	7,794	7	112	120	136	115.6	116	(4)	(36)	100	
Colbert	2,282	47,696	9,964	12	172	184	136	115.6	116	(68)	(842)	100	
Conecuh	557	11,669	2,470	12	169	181	136	115.6	116	(65)	(201)	100	
Coosa	291	11,113	2,152	7	101	108	136	115.6	116	8	22	100	**
Covington	1,352	30,659	7,530	11	135	146	136	115.6	116	(30)	(275)	100	
Crenshaw	462	11,260	2,462	10	141	151	136	115.6	116	(35)	(107)	100	
Cullman	2,230	74,264	14,454	8	116	123	136	115.6	116	(7)	(130)	100	
Dale	1,384	42,917	7,940	8	131	139	136	115.6	116	(23)	(228)	100	
Dallas	1,298	38,186	6,802	9	143	152	136	115.6	116	(36)	(305)	100	
DeKalb	1,770	66,439	11,166	7	119	126	136	115.6	116	(10)	(134)	100	
Elmore	1,796	74,800	10,342	6	130	136	136	115.6	116	(20)	(267)	100	
Escambia	1,350	34,514	6,333	10	160	170	136	115.6	116	(54)	(427)	100	
Etowah	3,614	88,600	17,713	10	153	163	136	115.6	116	(47)	(1,045)	100	
Fayette	569	15,220	3,597	9	119	128	136	115.6	116	(12)	(53)	100	
Franklin	1,319	29,742	5,372	11	184	195	136	115.6	116	(79)	(535)	100	
Geneva	873	22,506	5,139	10	127	137	136	115.6	116	(21)	(134)	100	
Greene	388	8,083	1,562	12	186	198	136	115.6	116	(82)	(161)	100	
Hale	565	16,609	2,614	9	162	171	136	115.6	116	(55)	(181)	100	
Henry	457	13,885	3,188	8	107	116	136	115.6	116	0	1	100	**
Houston	2,128	79,921	15,163	7	105	112	136	115.6	116	4	78	100	**
Jackson	1,622	50,196	9,759	8	125	133	136	115.6	116	(17)	(204)	100	
Jefferson	16,426	586,023	91,112	7	135	142	136	115.6	116	(26)	(3,028)	100	
Lamar	499	13,196	2,934	9	128	137	136	115.6	116	(21)	(77)	100	
Lauderdale	2,550	79,960	16,224	8	118	126	136	115.6	116	(10)	(200)	100	
Lawrence	988	32,086	5,674	8	131	138	136	115.6	116	(22)	(160)	100	
Lee	2,504	133,007	13,549	5	139	143	136	115.6	116	(27)	(477)	100	
Limestone	1,986	68,603	10,073	7	148	155	136	115.6	116	(39)	(501)	100	
Lowndes	369	12,012	2,152	8	128	136	136	115.6	116	(20)	(55)	100	

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Macon	576	19,636	3,630	7	119	126	136	115.6	116	(10)	(48)	100		
Madison	***5,340***	***273,508***	***41,894***	***5***	***96***	***100***	***136***	***115.6***	***116***	***16***	***825***	***100***	***Need***	***(1)***
Marengo	828	18,053	3,602	11	172	184	136	115.6	116	(68)	(305)	100		
Marion	1,058	26,247	6,162	10	129	139	136	115.6	116	(23)	(174)	100		
Marshall	2,592	81,968	14,738	8	132	140	136	115.6	116	(24)	(441)	100		
Mobile	10,597	365,218	55,768	7	143	150	136	115.6	116	(34)	(2,389)	100		
Monroe	818	20,473	3,971	10	154	164	136	115.6	116	(48)	(241)	100		
Montgomery	4,894	210,727	29,619	6	124	130	136	115.6	116	(14)	(518)	100		
Morgan	2,751	104,642	17,308	7	119	126	136	115.6	116	(10)	(214)	100		
Perry	366	9,410	1,804	10	152	162	136	115.6	116	(46)	(104)	100		
Pickens	912	17,836	3,492	13	196	209	136	115.6	116	(93)	(405)	100		
Pike	1,085	27,804	4,494	10	181	191	136	115.6	116	(75)	(426)	100		
Randolph	625	21,048	4,242	7	110	118	136	115.6	116	(2)	(10)	100		
Russell	1,130	45,187	7,309	6	116	122	136	115.6	116	(6)	(57)	100		
Saint Clair	1,230	71,249	11,792	4	78	83	136	115.6	116	33	498	100	**Need**	
Shelby	3,253	177,411	23,979	5	102	106	136	115.6	116	10	295	100	**Need**	
Sumter	456	11,741	1,989	10	172	182	136	115.6	116	(66)	(165)	100		
Talladega	2,126	73,299	13,016	7	123	130	136	115.6	116	(14)	(225)	100		
Tallapoosa	1,159	35,422	8,085	8	108	116	136	115.6	116	0	3	100	**	
Tuscaloosa	4,890	156,324	21,300	8	172	180	136	115.6	116	(64)	(1,738)	100		
Walker	2,643	60,543	12,594	11	157	168	136	115.6	116	(52)	(821)	100		
Washington	624	16,388	2,902	10	161	171	136	115.6	116	(55)	(200)	100		
Wilcox	330	11,097	1,890	7	131	138	136	115.6	116	(22)	(53)	100		
Winston	929	23,317	4,713	10	148	158	136	115.6	116	(42)	(246)	100		
Totals	**123,613**	**4,201,695**	**712,813**								(19,436)		**6**	
Weighted Average						**136**								

**Under Section 410-2-4-.07 a county will be considered for an additional agency only when the number required to bring the county up to the set number of persons served per 1,000 population 65 and older equals, at a minimum, 100 new persons.

Note: Counties below 136 persons served per 1,000 population are defined as underserved, utilizing the three year weighted average methodology.

Note: Methodology per *Alabama State Health Plan* 2004-2007
Section 410-2-4-.07.

Source: SHPDA HH-2 report for period ending September 30, 2009

(1) - On February 13, 2012, a batching cycle was created to allow applications to address the need shown in Madison County. An application filed pursuant to this batching cycle is scheduled to be heard by the CON Review Board on December 12, 2012. Since this batching cycle has expired, no applications will be accepted to address this need pending issuance of a final Order by SHPDA in regard to the pending application. If the application is granted, this statistical update will be revised to show no need in Madison County for 36 months following the issuance of the Certificate of Need.

16-Nov-12

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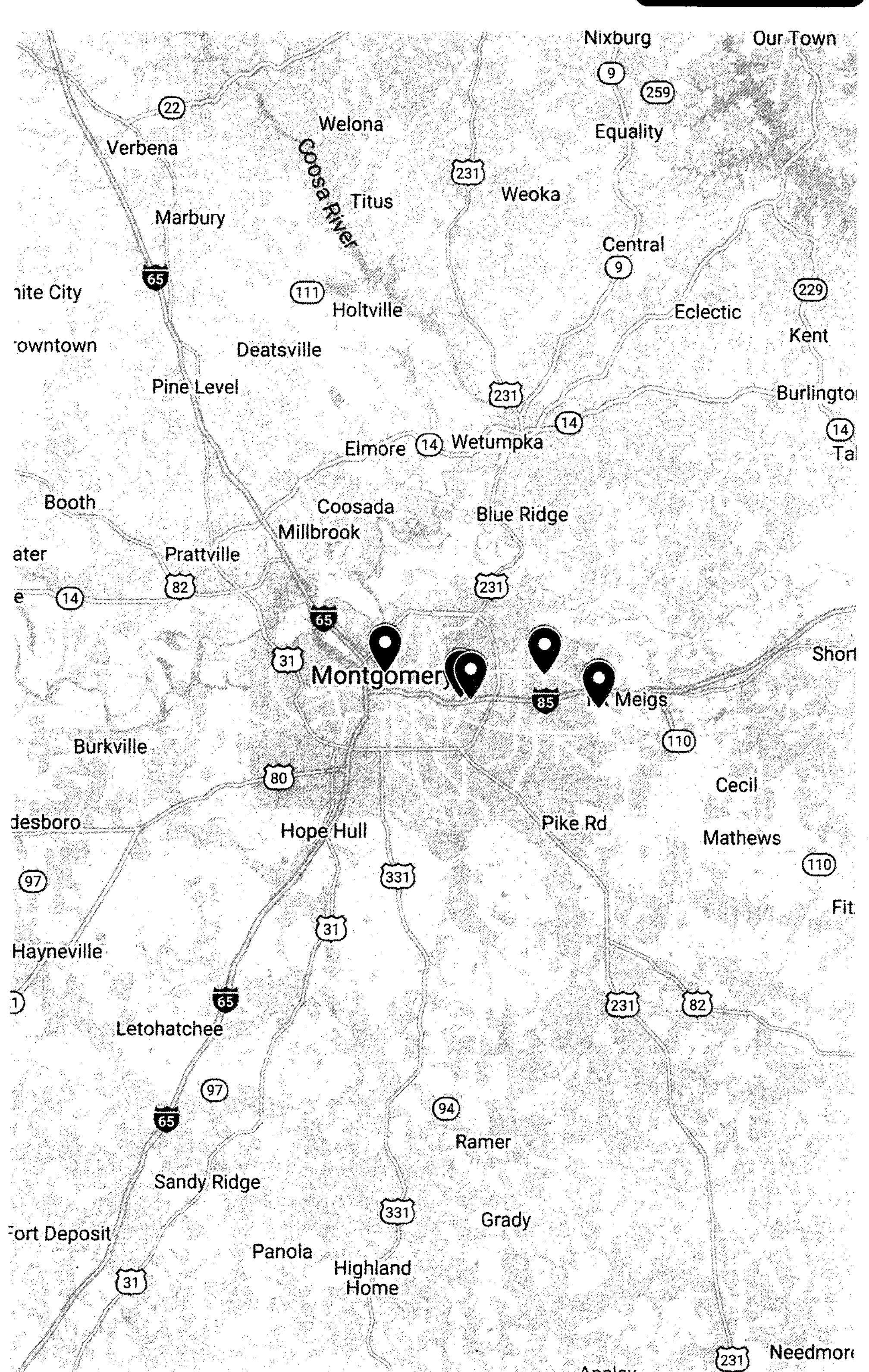
MTG County Home Health Operators

ReportDirectoryExcelExport-2019-11-14-1351425638423.xls

- Alabama Department of Public Health Home Care
- Amedisys Home Health of Montgomery
- Baptist Home Health
- Intrepid USA Healthcare Services
- Kindred at Home

ADPH Operators Directory (MTG County)



MTG Surrounding Counties Home Health Facilities

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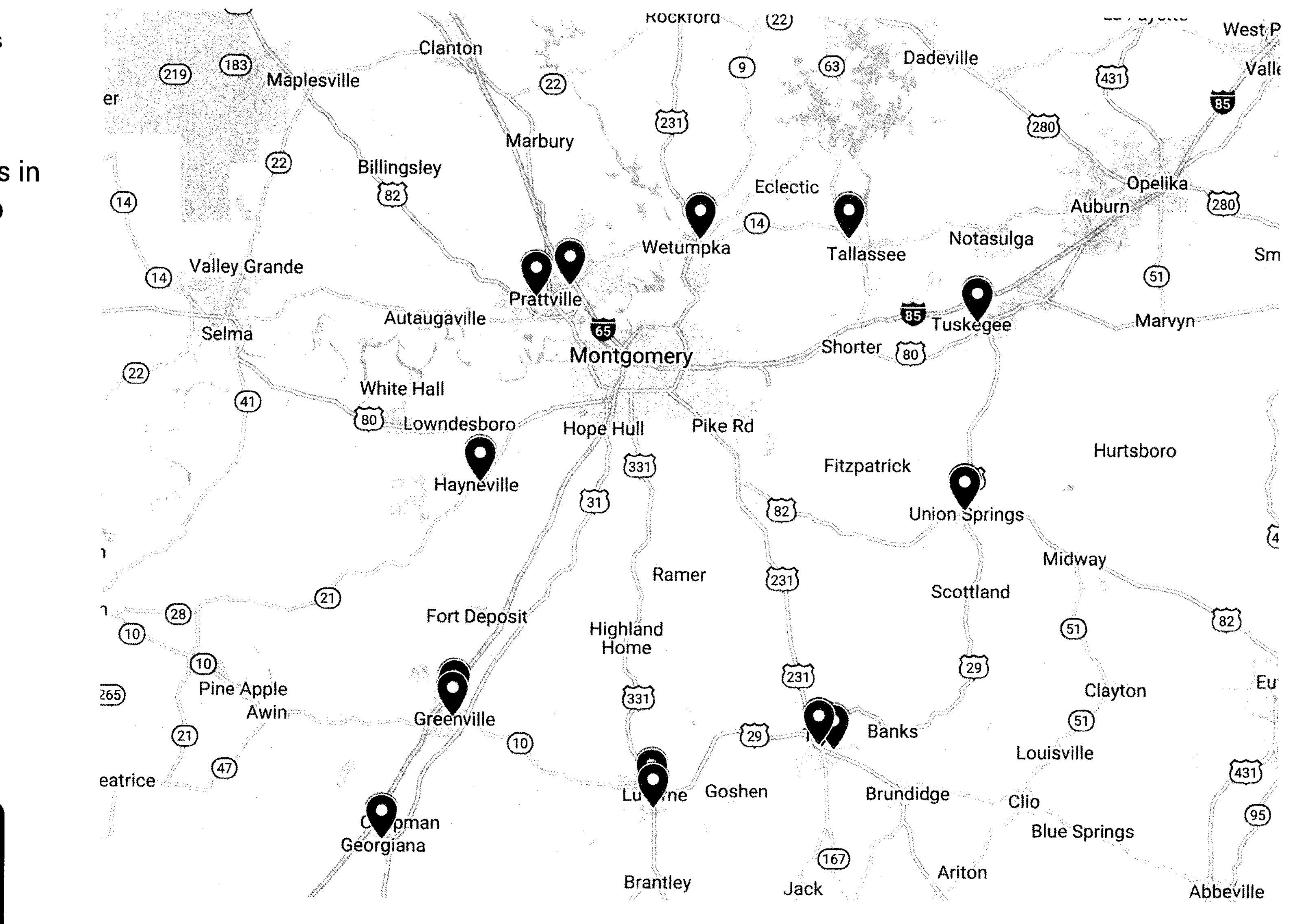
MTG Contiguous Counties Map_HH.xlsx

All items

Home Health Operators in counties contiguous to Montgomery County



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4

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Feb 21 2020
STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

To: Ms. Emily T. Marsal, Executive Director
From:
Date:
In re: Application for Adjustment by the Carpenter Health Network

Dear Ms. Marsal,

I am writing to express my support for Carpenter Health Network's application for adjustment to the Home Healthcare of the State Health Plan. As you know, both Montgomery County's African American and Senior citizen populations are over the state and national average. They are also growing. As a result, the current plan home healthcare in Montgomery County does not adequately address this growing need.

Home healthcare has been identified by CMS and others a cost effective way to prevent hospital stays, readmissions and overrun. This aspect of the American healthcare system is mostly utilized by seniors and minorities. As this populations grows in Montgomery County and the nation, it would be advantageous for Alabama to prepare itself accordingly. As a result, the outdated State Health Plan should be adjusted to reflect that growing need and concern in our community.

In addition to being preventative, cost effective and proactive, home health provides a great educational opportunity. The authors of this application, The Carpenter Health Network, utilize the unique AIM program in their operation. This program seeks to break the pyscho-social barriers in some communities associated with palliative care. They train each member of their staff that goes into the home to educate patients and family members about overall healthcare and the options available. In conclusion, I heartily endorse Carpenter's application for adjustment.

Sincerely,

Ted Bridges
COO

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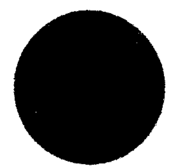
PreHab, Inc., 8355 Crossland Loop Montgomery, Alabama 36117
Phone: 334.270.1630 Fax: 877.877.8383



Steven L. Reed

PROBATE JUDGE

Montgomery County

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STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

September 6, 2019

Dear Ms. Marshal:

I am writing to express my support for Carpenter Health Network's application for adjustment to the Home Healthcare of the State Health Plan. As you know, both Montgomery County's African American and Senior citizen populations are over the state and national average. They are also growing. As a result, the current plan home healthcare in Montgomery County does not adequately address this growing need.

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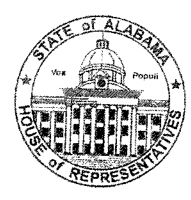
Respectfully submitted,

Steven L. Reed

P.O. BOX 223 • MONTGOMERY, AL 36101-0223 • TELEPHONE 334-832-1240 • FAX 334-832-7776



ALABAMA HOUSE OF REPRESENTATIVES

11 SOUTH UNION STREET, MONTGOMERY, ALABAMA 36130

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STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

REP. KIRK HATCHER
DISTRICT 78
POST OFFICE BOX 6213
MONTGOMERY, ALABAMA 36106

STATE HOUSE: 334-261-0506
DISTRICT PHONE: 334-450-8023
EMAIL: kirk.hatcher@alhouse.gov

July 17, 2019

Dear Ms. Marsal,

I am writing to express my support for Carpenter Health Network's application for adjustment to the Home Healthcare of the State Health Plan. As you know, both Montgomery County's African American and Senior citizen populations are over the state and national average. They are also growing. As a result, the current plan for home healthcare in Montgomery County does not adequately address this growing need.

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Sincerely,

Kirk Hatcher

City of **Montgomery**, Alabama

Office of the
CITY COUNCIL

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Todd Strange, Mayor

City Council Members
Charles W. Jinright, President
Tracy Larkin – Pres. Pro Tem
Fred F. Bell
Richard N. Bollinger
Audrey Graham
William A. Green, Jr.
Arch M. Lee
Brantley W. Lyons
Glen O. Pruitt, Jr.

To: Ms. Emily T. Marsal, Executive Director
From: Arch M. Lee
Date: July, 17, 2019
In re: Application for Adjustment by the Carpenter Health Network

Dear Ms. Marsal,

I am writing to express my support for Carpenter Health Network's application for adjustment to the Home Healthcare of the State Health Plan. As you know, both Montgomery County's African American and Senior citizen populations are over the state and national average. They are also growing. As a result, the current plan for home healthcare in Montgomery County does not adequately address this growing need.

Home healthcare has been identified by CMS and others a cost-effective way to prevent hospital stays, readmissions and overrun. This aspect of the American healthcare system is mostly utilized by seniors and minorities. As this populations grows in Montgomery County and the nation, it would be advantageous for Alabama to prepare itself accordingly. As a result, the outdated State Health Plan should be adjusted to reflect that growing need and concern in our community.

In addition to being preventative, cost effective and proactive, home health provides a great educational opportunity. The authors of this application, The Carpenter Health Network, utilize the unique AIM program in their operation.

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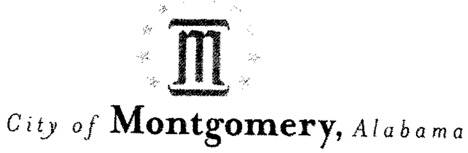

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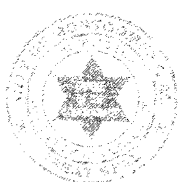
This program seeks to break the pyscho-social barriers in some communities associated with palliative care. They train each member of their staff that goes into the home to educate patients and family members about overall healthcare and the options available. In conclusion, I heartily endorse Carpenter's application for adjustment.

Sincerely,

Arch M. Lee
District 7
Montgomery City Council



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To: Ms. Emily T. Marsal, Executive Director
From: Thomas Sellers, MD
Date: July 14, 2019

In re: Application for Adjustment by the Carpenter Health Network

Dear Ms. Marsal,

I am writing to express my support for Carpenter Health Network's application for adjustment to the Home Healthcare of the State Health Plan. As you know, the population of Montgomery County, as well as the entire state of Alabama, is aging, with the senior citizen population projected to continue to increase for the foreseeable future. As a result, the current plan for home healthcare in Montgomery County does not adequately address this growing problem.

Home healthcare has been identified by CMS and others as a cost-effective way to limit hospital stays and help prevent readmissions and overrun. This aspect of the American healthcare system is primarily utilized by seniors and minorities. As the population continues to age in Montgomery County and the nation, it would be advantageous for Alabama to prepare itself accordingly.

In addition to being preventative and proactive, home health provides a great educational opportunity. The authors of this application, The Carpenter Health Network, utilize the unique AIM Palliative Home Health program, which not only offers a needed service to patients facing life-limiting illness, but also seeks to break the pyscho-social barriers in some communities associated with palliative care. They train each member of their staff that goes into the home to educate patients and family members about overall healthcare and the options available.

I feel strongly that home health is an extremely valuable resource, and increasing its availability and access for the aging patient population can have a considerable economic and health benefit for the state of Alabama. In conclusion, I heartily endorse Carpenter's application for adjustment.

Sincerely,

Thomas Sellers, MD

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Here comes Applied Economic Studies, G. Dennis Nabors, Esq., and Wm. Wilson Blount, Esq., on behalf of Alabama Home Health, LLC, (**AHH**). In response to requests from the State Health Planning and Development Agency (**SHPDA**), in particular, to submit "current and projected calculations" in regards to the need additional for home health providers in Montgomery County, Alabama;[1] George S. Ford, PhD. and R. Alan Seals, PhD. Prepared the following report:

A health care provider who wishes to offer home health services in an Alabama county must obtain a Certification of Need ("CON") from SHPDA. These CON regulations limit free entry into health care services based on the belief that redundant healthcare facilities lead to higher cost and lower quality health care.[2] To obtain a CON, therefore, an applicant must demonstrate, among other things, that the consumption of home health services is today—or is expected to be in the future—large enough to support additional providers.

We were asked by AHH to evaluate the need for additional home health providers in Montgomery County, Alabama. Based on our projections of need for home health services, we conclude that the increased need for home health care in Montgomery County is sufficiently large to support additional providers of such services. Our recommendation is based on the forecasted growth of home health patients in Montgomery County between 2017 and 2022. Under conservative assumptions, we estimate the increase in home health patients in Montgomery County to be greater than 2,000 persons. With the median number of patients served by a home health provider in the state at 600 persons, the increased need for home health services in Montgomery County is more than adequate to permit an additional provider of home health services without redundancy.

In determining the need for additional providers in Montgomery County, we developed a method rooted in the underlying logic of CON regulation. That is, the supply of services should be enhanced when the demand side of the market grows enough to support additional providers. In developing our method, we reviewed the procedures for determining need outlined in SHPDA's Draft 2020-2012 Alabama State Health Plan at §410-2-4-.07. We concluded, however, that SHPDA's methodology is inconsistent with the purpose of CON regulation. SHPDA's proposed method finds "need" to be greatest in counties where the consumption of home health services is relatively small and, contrariwise, that "need" is least in counties where the consumption of home health services is large. This illogical approach unnecessarily restricts the supply of services in counties that need it most. The method for home health is also inconsistent with the methods used for other health care services where the supply is adjusted to meet growing demand.

SHPDA's method for determining "need" perhaps explains why, as we show below, Alabama lags in the per capita consumption of home health services. Employment in the home health sector in Alabama's counties is, on average, 24% below the national average. The state's CON regulations appear to be curtailing the consumption of home health services in the state; a reduction that is deepening over time. Reducing the use of home health services worsens health outcomes, raises the cost of health care by substituting patients' homes for scarce hospital beds, and inconveniences the most vulnerable of Alabama's citizens.

Our analysis is outlined as follows. First, as CON regulations restrict the flow of labor and capital into the home health sector, we employ data on the size of the home health sector in U.S. counties to quantify the impact of the state's regulations. Our statistical analysis reveals that Alabama counties are well below

[1] SHPA Letter Dated October, 21, 2019. RE: PA2020-001 to Alabama Home Health, LLC.

[2] Empirical evidence does not support these claims and fifteen states have abandoned CON regulations since federal support for such regulations ended in 1986. *See, e.g.*, Mercatus Center, *How State Certificate-of-Need (CON) Laws Affect Access to Health Care*, MEDIUM (May 12, 2016) (available at: https://medium.com/concentrated-benefits/how-state-certificate-of-need-con-laws-impact-access-to-health-care-b8d3ec84242f).

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average in the size of the home health sector: home health employment in Alabama is about 24% below the natural average. Second, we determine whether a CON should be granted for Montgomery County by constructing a model of future demand for home health services. We conclude that the need for home health services in Montgomery County is large enough to support an additional home health provider. Third, we demonstrate why SHPDA's methodology for determining "need" is inconsistent with the underlying basis of CON regulations.

I. Home Health Services in Alabama

In forecasting the "need" for additional home health providers in Montgomery County we rely, in part, on data measuring the utilization of home health services in recent years for the county and the state. Using utilization rates in this manner presumes that the observed utilization rates, presently or in the past, are in some sense "optimal." Yet, CON regulations restrict the number of firms that can provide service, so such regulations may lead to the under-consumption of home health care. To evaluate whether the use of home health care in Alabama counties is under- or over-supplied, we look to county-level employment data for home health services.

County-level data on home health workers is obtained from the Bureau of Labor Statistics ("BLS") for years 2001 through 2018.[3] Data on home health employment is available for 590 counties including fourteen of Alabama largest counties.[4] County-level data on per-capita income data is obtained from the Bureau of Economic Analysis ("BEA"). Five-year averages (reported in 2017) of persons 65 years and older and the share of African American population for each county is obtained from the Census Bureau's Factfinder; this data is based on the American Community Survey ("ACS"). A dummy variable is set equal to 1.0 for all Alabama counties (0 otherwise).

Our analysis aims to determine how employment and establishments in the home health sector in Alabama differs, if at all, from other states. The observed use of home health services likely will vary among counties for a variety of reasons including population levels and demographic mix, so we employ multiple regression analysis. We limit our attention to the last five years of data for a sample size of 2,950 observations. The regression model is:

$$\ln JOBS_{i,t} = \beta_0 + \beta_1 \ln POP_{i,t} + \beta_2 SINGLE_i + \beta_3 \ln INC_{i,t} + \beta_4 BLACK_i + \beta_5 AGE65_i + \delta AL_i + \lambda_t + \varepsilon_{i,t} \tag{1}$$

where $JOBS_{it}$ is home health employment in county i in year t, POP in county population in year t, INC is county per-capita income in year t, $BLACK$ is the share of population in the county that is AFRICAN AMERICAN, $AGE65$ is the share of county population that is age 65 years or older, AL is a dummy variable for Alabama counties, λ_t is a year fixed effect, ε is the econometric disturbance term, and "ln" indicates the natural log transformation. The δ coefficient indicates how employment in the Home Health sector differs in Alabama counties from other counties.[5] Equation (1) is estimated by Ordinary Least Squares ("OLS") and hypothesis tests are conducted using robust standard errors.

The R^2 for the regression is 0.72, so the model explains 72% of the variation in the dependent variable. Of the six variables in the model (ignoring the fixed effects, λ_t), all are statistically significant at the 10% level or better. The number of home health workers in a county is nearly proportional to population

[3] Home Health Services are listed under SIC 621610 (available at: https://www.bls.gov/ppi/ppinaictosic16.htm#LINK3).

[4] The Alabama counties are: Baldwin, Calhoun, Cullman, Etowah, Houston, Jefferson, Lauderdale, Madison, Marengo, Mobile, Montgomery, Morgan, Tuscaloosa, and Walker.

[5] It is important to note that multiple regression implies that the effect on the Alabama coefficient is net of all the effects of the other regressors in the model, including population. *See, e.g.*, W.H. Greene. ECONOMETRIC ANALYSIS (2003).

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($\beta_1 = 0.94$) and the t-statistic is very large. Population is the dominant determinant of home health employment. The share of homes with a single resident is positively related to the number of home health workers ($\beta_2 = 1.7$). Workers are negatively related to income ($\beta_3 = -0.13$), but the coefficient is small; a 10% increase in per-capita income reduces the number of workers only by about 1%. The number of home health workers is positively related to the share of Black population ($\beta_4 = 0.45$) and a 10-percentage point increase in Black population increases home health employment by nearly 5%. As expected, home health employment is positively related to persons age 65 or older ($\beta^5 = 0.76$), with a 10-percentage point increase in older population increasing such workers by nearly 8%.

Alabama counties, on average, have far fewer home health workers than other counties in the nation, to the tune of about a 24% lower employment level ($\delta = -0.27$).[6] This effect is sizable. In this sample, the number of home health workers in the Alabama in 2018 is 21,724, so the underemployment in the state equals about 5,200 jobs.[7] Alabama has some catching up to do.

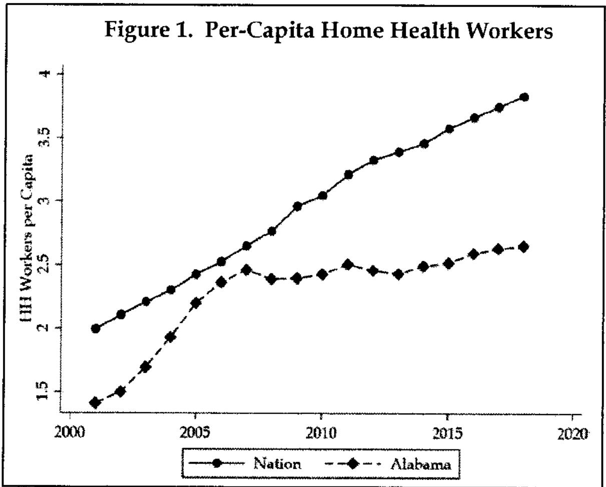

Figure 1. Per-Capita Home Health Workers

While our statistical analysis documents that Alabama falls below the per capita national average, a simple figure of per-capita (per 1000 persons) home health workers over the 2001-2018 period illustrates the under-provision of such services in the state, relative to the rest of the nation. Such services are under-provided in all years, but the under-provision of services has become increasingly worse since 2006.

Table 1. Demographic Comparisons

Demographic Indicator	Rest of Nation	AL
Per-Capita Income	49,951	41,836
Single Resident Homes	28.0%	29.9%
Black Population Share	12.7%	24.8%
Share Age 65 or Older	15.8%	16.4%

Alabama's counties, relative to the nation, have lower incomes, much higher proportions of African Americans, higher proportions of persons living alone, and a more aged population—all factors that point to a greater need for home health services in the state relative to the nation. As such, we conclude that

6 With the dependent variable in natural log form, the marginal effect of a dummy variable is $\exp(\delta) - 1$.

7 Additional analysis suggests that Montgomery County's under-employment equals the state's average under-employment. To evaluate Montgomery County specifically, a dummy variable is added to the model for the county.

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home health care is substantially underprovided in Alabama. Also, observed utilization rates of home health services in Alabama are thus inaccurate indicators of the true need for home health services in Alabama.

II. Forecast Need for Montgomery County

Certificate of Need regulations attempt to sync the supply of to the demand for health care services to avoid redundancy of costly health facilities. In unregulated markets, the balancing of supply and demand happens without government interference. In health care, however, some states, including Alabama, regulate the entry of health care providers. As a consequence, the state must devise some method that determines the "need" for additional supply. To avoid redundancy, supply is augmented when expected demand is sufficiently high to support additional firms.

As we see it, the determination of "need" is a two-step process. First, we require a forecast for future demand (i.e., patients) for home health care services. Second, we must compare the change in the need for home health services—that is, the forecast less current consumption—to a meaningful threshold. If the "new" demand exceeds this threshold, then a CON should be granted.

Our method is outlined as follows. There are two periods: the current period (*t*) and the future (or forecast) period ($t + 1$). The number of home health patients in county *i* at time *t* is, by definition,

$$S_{i,t} \equiv u_{i,t} \cdot N_{i,t} \qquad (2)$$

where $S_{i,t}$ is the number of persons served in county *i* at time *t*, $N_{i,t}$ is the population in county *i* at time *t*, and $u_{i,t}$ is the utilization rate in county *i* at time *t* (which equals $S_{i,t}/N_{i,t}$). Likewise, the number of persons served in the forecast period in the future is:

$$S_{t+1} \equiv u_{t+1} \cdot N_{t+1}, \qquad (3)$$

where S_{t+1}, u_{t+1} and N_{t+1} cannot be observed; these values must be forecasted. Independent forecasts of population are readily available, but forecasts of the utilization rates are not. Using what information is available, we rewrite Equation (3) as:

$$\hat{S}_{t+1} = u_t(1+g_i)\hat{N}_{t+1}, \qquad (4)$$

where g_i is the growth in utilization between periods and $\hat{S}$ and $\hat{N}$ are forecast values. Given the information available to us at this time, we forecast the number of persons requiring home health services in 2022 based on utilization rates from 2017, the last year for which we have data. (We have requested more data from SHPDA, but as of yet, we have not received it). We do not have data on the growth in home health utilization directly, but we do know that employment in the sector is growing 3.5% annually and expenditures on home health are expected to grow by 6.8% in the future.[8]

Additional providers should be granted a CON when the following expression is satisfied:

$$\hat{S}_{i,t+1} - S_{i,t} \geq T, \qquad (5)$$

where *T* is the threshold. This threshold should have some economic meaning. We set the threshold *T* equal the median number of home health patients served per provider across the counties, since this figure

[8] Employment growth is estimated by the authors using regression and the BLS data. R. Holly, *Home Health Spending Rate Projected to Surpass All Other Care Categories*, HOME HEALTH CARE NEWS (February 20, 2019) (available at: https://homehealthcarenews.com/2019/02/home-health-spending-rate-projected-to-surpass-all-other-care-categories/).

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represents the typical size of a home health provider in the state. In satisfying Expression (5), the median number of patients served by existing providers today is not diminished by additional entry in the future. In 2017, the median sized provider served 600 patients, so we set $T = 600$.

In constructing our forecasts, we divide the utilization rate and population variables into persons below age 65 and those 65 or older. For Montgomery County, the 2017 utilization rates were 0.0285 for younger and 0.195 for older persons.[9] These values are used in Equation (4) to forecast future consumption.

Table 2. Projections of Need for Montgomery County

Scenario	Annual g	2017 Patients	2022 Patients	Patient Growth
A	3.5%	12,117	14,733	2,616
B	6.8%	12,117	15,971	3,854
C	5.2%	12,117	17,333	5,216

In calculating Equation (4), we consider three scenarios for the growth rate g: (1) the growth in home health employment; (2) the growth in home health expenditures; and (3) the average of the two growth rates. Table 2 shows that the number of forecast new patients in Montgomery County exceeds the threshold (600 patients) by a large amount.[10] Even for the smallest growth rate (3.5%), the number of new patients in 2022 is 2,616 persons. Consequently, a request for a CON in Montgomery County should be granted to satisfy the future demand for Home Health services.

In this analysis, we use the population forecasts from the Center for Business and Economic Research ("CBER") at the University of Alabama. These forecasts are used likewise by SHPDA. We note, however, that the CBER's forecast method does not adequately account for temporal changes in the composition of the population. A recent study in the journal *Nature*, the world's pre-eminent publication for scientific research, offers a method that combines the standard Census Bureau's method (which the CBER uses) with procedures that account for the changing demographic composition of the population.

Table 3. Improved Forecast of Over-65 Population for Montgomery County

	2020	2025	2030	2035	2040
CBER Projections	14.95%	16.84%	18.21%	18.57%	18.91%
Improved Forecast	15.60%	18.10%	20.50%	22.00%	23.70%
Difference	-0.65%	-1.26%	-2.29%	-3.43%	-4.79%

For these richer forecasts, the share of the older population in Montgomery County grows faster than in the CBER's projections. As shown in Table 3, by 2040 the CBER's forecasts understate the share of the county's older population by nearly five-percentage points. As such, our forecasts of need are conservative. Going forward, we believe SHPDA should consider using these alternative forecasts when analyzing need.

We note also that these forecasts do not account for the fact that Alabama is rated high among states as a best place to retire.[11] Alabama has a relatively low cost of living, relatively low taxes, and does not tax Social Security Benefits. As the American population ages, it seems likely that the number of older persons, many of whom are in need of home health services, will rise faster in some Alabama counties over the next decade than forecasted (since such forecasts rely largely on observed history). The lower cost of home

[9] These data obtained from forms HH-2 and HH-14. We use patient counts and population data for each age group.

[10] The threshold is met for $g > 0.6\%$ annually, which is a growth rate well below current expectations.

[11] S. Rapacon, *Alabama: #6 Best State to Retire in 2018*, KIPLINGER (June 4, 2018) (available at: https://www.kiplinger.com/article/retirement/T006-C000-S001-alabama-6-best-state-to-retire-in-2018.html.

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health services makes such services particularly attractive to the older population and could materially cut the costs of both public and private health care providers. In light of the growing demand for and lower costs of home health, the expansion of home health care services in Alabama should be encouraged—not restricted—by state health officials.

III. A Review of SHPDA's Method

SHPDA's draft of the 2020-2012 Alabama State Health Plan at §410-2-4-.07 outlines its procedure for determining "need" for home health services. We conclude this method is incompatible with the logic underlying CON regulations and inappropriately restricts entry in larger, faster growing counties.

Minimizing mathematical expression, we may write the SHPDA method's final step as

$$0.85\overline{s}_{t+1}\gamma_{i,t+1} - \hat{S}_{i,t+1} \geq 100, \qquad (7)$$

where $\overline{s}_{t+1}$ is the statewide *per-capita* number of predicted home health patients, $\gamma_{i,t+1}$ is a factor that adjusts the per-capita figure to a *comparable count* of patients for county *i,* and $\hat{S}_{i,t+1}$ is the predicted count of patients in county *i.*[12] (See the Technical Appendix for more detailed expressions). SHPDA marks down the statewide average by the factor 0.85, thereby making the expression more difficult to satisfy. The SHPDA provides no explanation for this markdown or the threshold of 100.

The flaw in SHPDA's method is immediately apparent. In the standard method for evaluating a CON application, parties must demonstrate that expected demand is sufficiently large to justify more supply. In Expression (7), however, an increase in expected demand ($\hat{S}_{i,t+1}$) reduces need. That is, the greater the expected use of home health services in county *i*, the less likely SHPDA will conclude there is "need" in that county. SHPDA's method finds "need" to be low in high-use counties and "need" to be high in low-use counties. SHPDA's method for determining "need" offers conclusions that are precisely backwards. We recommend SHPDA revisit its method for determining need in the home health sector.

IV. Conclusion

Under conservative assumptions, we estimate the increase in home health patients in Montgomery County between 2017 and 2022 to be greater than 2,000 persons. With the median number of patients served by a home health provider in the state at 600 persons, the increased need for home health services in Montgomery County is more than adequate to permit an additional provider of home health services without redundancy.

[12] This factor equals the sum of 0.25 divided by the statewide number of persons under 65 years and 0.75 divided by statewide number of persons 65 years or more divided by the sum of 0.25 divided by the county number of persons under 65 years and 0.75 divided by the county number of persons 65 years or older.

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Technical Appendix

Let N be population (divided by 1,000), S be persons served, and u the utilization rate. Population is divided into those below 65 ("Y") and those 65 and older ("A"). Time is divided into two period: t and $t+1$. The SHPDA method employs three periods for some calculations but condensing the analysis to two periods does not impact the interpretation of the formulas. Counties are indexed by i.

In Step 1, the utilization rates for the two age groups in the base year t are:

$$u_t^Y = 0.25 S_{i,t} / N_{i,t}^Y ; \tag{A1}$$

$$u_t^A = 0.75 S_{i,t} / N_{i,t}^A . \tag{A2}$$

Using population forecasts, the predicted number of future patients in county i by age group are:

$$S_{i,t+1}^Y = u_{i,t}^Y N_{i,t+1}^Y ; \tag{A3}$$

$$S_{i,t+1}^A = u_{i,t}^A N_{i,t+1}^A ; \tag{A4}$$

and the total predicted served for county i is:

$$S_{i,t+1} = S_{i,t+1}^Y + S_{i,t+1}^A . \tag{A5}$$

The statewide average number of patients in t + 1 equals:

$$\overline{S}_{t+1} = \sum_i \left(S_{i,t+1}^Y + S_{i,t+1}^A \right). \tag{A6}$$

Converting the statewide average patients to per-capita terms, we have:

$$\overline{s}_{t+1} = \overline{S}_{t+1} \left(\frac{0.25}{\overline{N}_{t+1}^Y} + \frac{0.75}{\overline{N}_{t+1}^A} \right). \tag{A7}$$

The Current Home Health Comparative Value ("CV") is calculated using:

$$CV = 0.85 \overline{s}_{t+1} . \tag{A8}$$

The county projected patients per-capita is:

$$s_{i,t+1} = S_{i,t+1} \left(\frac{0.25}{N_{i,t+1}^Y} + \frac{0.75}{N_{i,t+1}^A} \right). \tag{A9}$$

Expanding terms, the determination of need is computed using:

$$0.85 \overline{s}_{t+1} - s_{i,t+1} = \frac{0.85 \overline{S}_{t+1} \left(\frac{0.25}{\overline{N}_{t+1}^Y} + \frac{0.75}{\overline{N}_{t+1}^A} \right) - S_{i,t+1} \left(\frac{0.25}{N_{i,t+1}^Y} + \frac{0.75}{N_{i,t+1}^A} \right)}{\left(\frac{0.25}{N_{i,t+1}^Y} + \frac{0.75}{N_{i,t+1}^A} \right)}, \tag{A10}$$

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which simplifies to:

$$0.85\overline{s}_{t+1} - s_{i,t+1} = 0.85\overline{S}_{t+1} \frac{\left(\frac{0.25}{\overline{N}_{t+1}^{Y}} + \frac{0.75}{\overline{N}_{t+1}^{A}} \right)}{\left(\frac{0.25}{N_{i,t+1}^{Y}} + \frac{0.75}{N_{i,t+1}^{A}} \right)} - S_{i,t+1}. \qquad \text{(A11)}$$

A simplified version of Expression (A11) is Equation (5) in the main document.

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Here comes Applied Economic Studies, G. Dennis Nabors, Esq., and Wm. Wilson Blount, Esq., on behalf of Alabama Home Health, LLC, (**AHH**). An amendment to the report filed in response to requests from the State Health Planning and Development Agency (**SHPDA**), in particular, to submit "current and projected calculations" in regards to the need additional for home health providers in Montgomery County, Alabama;[1] George S. Ford, PhD. and R. Alan Seals, PhD. Prepared the following:

Since our original filing of analysis in this case, we obtained additional data from SHPDA that permits the calculation of "need" detailed in SHPDA's Draft 2020-2012 Alabama State Health Plan at §410-2-4-.07. While we continue to believe SHPDA's method is improper, we believe it is reasonable to provide the results from the method for comparison purposes.

As the method requires, we use data from years 2016-2018 to estimate "need" for years 2019-2021. Population forecasts are obtained from the SHPDA website and population for years 2016-2018 are obtained from the Census Bureau's Factfinder.[2] We provided a mathematical summary of the calculations in our initial filing, so we do not repeat it here. SHPDA states that additional home health providers are needed when the "New persons required to be served in a county" exceeds 100. Implementing the SHPDA method indicates that the "new persons required to be served" in Montgomery County is 204 persons.[3] Thus, the threshold for "need" in the county is satisfied.

This data also permits us to calculate the growth in utilization rates for home health services. As we noted in our initial filing, SHPDA's method only accounts for population changes, a limitation that may understate the future number of patients. Across the state, the average growth in the utilization rates of home health services between 2015 and 2018 is 3.74% annually. This figure is very close to one of our assumed growth rates of 3.5%. So, while population changes may affect the number of home health patients, the use of home health services is, on average, growing over time as more patients take advantage of home health services. We conclude that a reasonable forecast of future home health patients must account for both the growth in population and growth in utilization.

Finally, in our initial filing, we stated that the average number of patients served by home health providers in the state was about 600 patients. Using more complete data, we find that our initial estimate overstates the number of patients. In fact, the average provider serves only about 175 patients, a much lower threshold to satisfy. Based on our own method of forecasting need, it remains true that Montgomery County can accept more home health providers without redundancy.

Whether using our forecast of need or SHPDA's method, we conclude that a Certificate of Need is justified for Montgomery County, Alabama.

[1] SHPA Letter Dated October, 21, 2019. RE: PA2020-001 to Alabama Home Health, LLC.

[2] http://www.shpda.state.al.us/documents/CBER%20Population/CBERPopulation.aspx; https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml.

[3] Calculations are conducted using Stata 16.

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Sincerely,

George S. Ford, PhD

R. Alan Seals, PhD