GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2022 HOME HEALTH AGENCY SERVICES SURVEY (HHSS)

January 1, 2022 through December 31, 2022

– IMPORTANT NOTICE ABOUT SURVEY ACCURACY AND COMPLIANCE –

The information and data collected through this survey are used for state regulatory and planning purposes and are made available to public officials, advocacy groups, health care purchasers, and consumers. This survey is required under Department of Community Health Rule 111-2-2-.04 and other regulations. The failure to properly submit and/or fully complete all required surveys may result in adverse regulatory action pursuant to DCH Rules 111-2-2-.05, .09 and other regulations or statutes.

The chief executive officer or principal administrator of the facility (who shall attest to the accuracy and completeness of the information provided) and your organization are responsible for ensuring the accuracy of the information and data reported in this survey. The sole responsibility for accuracy resides with the organization and the officials filing the survey. Accuracy at time of submission is particularly important. See Rule 111-2-2-.04(e) prohibiting survey revisions unless approved by the Department at its sole discretion.

Providing false or inaccurate information may result in adverse regulatory action pursuant to DCH Rules 111-2-2-.04(1)(b), 111-2-2-.05(1)(a)1, and 111-2-2-.05(1)(a)7, other regulations and statutes, and may constitute a crime under O.C.G.A. §§ 16-10-20 and 16-14-1.

Pursuant to O.C.G.A. § 31-6-70 (h) all health care facilities, ambulatory surgical centers, and imaging centers required to submit an annual report pursuant to O.C.G.A. § 31-6-70(a) shall make such annual reports publicly available on their websites.

2022 HOME HEALTH AGENCY SERVICES SURVEY FORM

The 2022 Home Health Agency Services Survey (HHSS) can be completed using an online interface. Providers of home health agency services may access the online survey by pointing their web browser to http://www.georgiahealthdata.info/. Notification letters were mailed to agency administrators regarding the 2022 HHSS which included a unique agency identification number (UID) and agency password. Both the UID and password will be needed to access and complete your survey. Instructions for accessing and completing the web-based survey are provided at the Health Planning Surveys web interface (http://www.georgiahealthdata.info/).

The deadline for filing the completed webform for your agency is March 3, 2023.

Survey Completion Status – Typically, a survey will be considered complete when a signed, completed version is received by the Office of Health Planning. All requested data elements must be provided; edit check, error messages, and validation rules must be addressed or in balance; and the survey must be signed in the appropriate location and manner. Once received and determined to be complete by the Office, the survey is considered a public record. Generally, the survey will be deemed complete on the day it is received by DCH. The completion status of all surveys for each facility will be published on the DCH website on or after the survey due date**.**

Copy of Completed Survey – The webform allows for printing (or saving) at completed copy of the survey. It is extremely important that you retain a copy of your completed survey. You must have your browser's pop-up blocker turned off for our website for the save and print feature to function properly.

Revising or Amending the Survey – Pursuant to Rule 111-2-2-.04(1)(g), surveys that are received and determined to be complete by the Office of Health Planning may not be revised after the survey due date without approval by DCH. Requests to revise must be submitted in writing to the Office of Health Planning with a detailed explanation of the revisions and any necessary documentation. The Office of Health Planning will consider revisions on a case-by-case basis and reserves the right to deny a request to revise. The Office may also determine that additional data, information, or documentation is needed to support the proposed revisions.

Data Validation Requirements – Once you are ready to submit the survey, you should determine if the required survey totals are in balance and that all required items are complete by clicking the "View Error Messages" button on the Signature Page. This button produces a message containing a description of any out of balance totals and any required data items that are missing. If there are no errors or validation issues, you can sign and then submit the

survey.

PART A: GENERAL AGENCY INFORMATION

Agency Name and Address - Please provide your agency's current name and the main office address as requested.

Medicaid and Medicare Provider Numbers - Please provide both the home health agency's Medicaid and Medicare provider numbers. Enter numbers and no dashes or alpha characters.

Report Period - January 1, 2022 through December 31, 2022 is the required report period. If the agency was in operation for a full year you must report data for a full year. If the ownership, operation or management of the facility changed during the report period, it is the responsibility of the current owner or operating entity to obtain the necessary data from the prior owner or operator.

PART B: SURVEY CONTACT INFORMATION

Please provide contact information for the individual authorized to respond to questions regarding your agency's survey submission.

PART C: AGENCY OWNERSHIP, OPERATION AND MANAGEMENT INFORMATION

Please provide the following information as applicable to your facility. If certain fields do not apply the form will allow you to enter only "Not Applicable" in the Full Legal Name column.

Agency Owner - The person or entity that owns the building and grounds. Include the appropriate organizational code and the effective date by month, day and year.

Agency Operator - The owner of the business entity who is accountable for the profits and losses of the agency. Include the appropriate organizational code and the effective date by month, day and year.

Management Contractor - A specific entity with whom the Owner or Operator has contracted to manage the routine business of the agency. Include the appropriate organizational code and the effective date by month, day and year.

Branch Office – For the purposes of this survey, branch office is defined as any other office location(s) within the approved service area in addition to the headquarters office from which home health care services are also provided.

PART D: AGENCY UTILIZATION AND PATIENT CASELOAD INFORMATION

Home Health Visit – A home health visit occurs when a patient receives a health-related service from your agency by agency staff at the patient's home, in an outpatient setting, or other residential setting and for which a chargeable or reimbursable cost is incurred. Please be aware that all visit totals must balance throughout the survey.

Home and Community-Based Services and Waiver Programs – Care provided by programs such as the Community Care Services Program (CCSP), Georgia Pediatric Program (GAPP) Medical Day Care and other waiver programs which do not provide health-related services or that provide care that is not provided in the place of residence should not be reported on the HHSS.

Total Visits and Per Visit Charge by Service Discipline – Provide the total number of visits made for home health services by each of the service disciplines listed as appropriate. Also, please provide the per visit rate your agency charges for providing each of the services indicated.

Total Agency Caseload – Caseload is defined as the number of patients. This is determined by taking the number of patients at the beginning of the report period on January 1, 2022, adding the number of new patients (admissions) and subtracting the number of discharges during the year ending on December 31, 2022.

Medicare Periods of Care – Provide the total number of Medicare periods of care that were completed during the report period. A Medicare period is no more than 30 days in length and is the unit of payment for the home health Patient-Driven Groupings Model. The period payment is specific to an individual patient, and the 30-day period begins with the first Medicare billable visit as day one and ends on and includes the 30th day from the start-of-care date. Include completed periods that were less than 30-days such as Medicare Low Utilization Payments Adjustments (LUPA).

Patient Race/Ethnicity (as defined by the U.S. Census Bureau) – Please report the number of unduplicated health-related patients using the following categories. Please note that total patient counts should balance throughout the HHSS.

American Indian or Alaska Native - A person having racial origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian - A person having racial origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, but not limited to, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American – A person having racial origins in any of the Black racial groups of Africa.

Hispanic or Latino – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish Origin" can be used in addition to "Hispanic" or "Latino."

Native Hawaiian or Other Pacific Islander – A person having racial origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White – A person having racial origins in any of the original peoples of Europe, the Middle East, or North Africa. Include people who indicate their race as "White" or report entries such as Irish, German, Lebanese, Near Easterner, Arab, or Polish.

Multi-Racial – A person having racial origins from two or more of the above definitions.

Patient Gender – Please report the total patients by gender. Note that the total patients by gender should balance to total patients reported by race/ethnicity and must balance to total patient counts by patient origin.

Payer Source – Please report the total unduplicated patients, total visits, and revenue by the patient's primary payer source. Other Third-Party Insurance should be for patients covered by a private carrier, but not covered under a managed care plan (a fee-for-service or indemnity plan). Managed Care should be for patients covered by a private, third-party carrier, but covered under a managed care plan such as an HMO or PPO where a rate has been negotiated. Other Non-Government should be used for patients covered by any other type of insurance, but not a government program.

PART E: AGENCY FINANCIAL SUMMARY, INDIGENT AND CHARITY CARE PROVIDED, AND PATIENT POINT OF ORIGIN

Indigent Care – Report as indigent any unpaid charges for services to patients whose family income is less than or equal to 125% of the Federal Poverty Guidelines. Indigent Care patients should be patients who were income-tested and found to be at or below 125% FPG, without eligibility or coverage by an insurance plan, and having received home health care services for which the agency expects to receive compensation. Do not include unpaid charges for patients who were eligible for Medicare, Medicaid, a Third-Party carrier, or patients who were provided free care (care for which the agency did not expect compensation). Patients who are eligible under Medicare, Medicaid, or a Third-Party plan can be considered Charity Care under the guidelines defined below, but should never be treated as Indigent Care. The unpaid charges for patients who would qualify as Indigent due to income, but who are eligible for Medicare, Medicaid, or a Third-Party carrier can be accounted for as

Contractual Adjustments as defined below.

Charity Care – Report as charity care any unpaid charges for services to patients whose family income is greater than 125% of the Federal Poverty Guidelines, and which were provided in accordance with the agency's formal written charity care policy, and which were written off to a formal charity account in the agency's accounting records. Charity care represents that portion of billable health care services that an agency provided where payment is not expected because the patient qualified under the agency's charity care policy. Charity care is provided to a patient with demonstrated inability to pay for some or all of the billable service. Only the portion of a patient's account that meets the organization's charity care criteria is recognized as charity.

***Indigent and Charity Care Write-Offs:* Unpaid charges for indigent and charity care cases should be related only to the provision of licensed home health services as defined above for a home health visit. Unpaid charges from other lines of business such as assessments, pharmacy services, or medical equipment should not be included.**

Gross Patient Revenue – Gross patient review includes charges generated by all patients at full-established rates before provisions for contractual and other adjustments are applied. Please include any revenue forgone for provision of care for indigent/charity patients at full-established rates. Gross Patient Revenue must balance throughout the survey.

Contractual Adjustments – Contractual adjustments represent any charges that go unpaid by Medicare, Medicaid, Peachcare for Kids™, or Third-Party payers and cannot be billed to the patient pursuant to contractual agreements. Contractual adjustments for Medicare, Medicaid and other payers are reported separately in the Annual Home Health Survey.

> ***Net Medicare Revenue vs. Gross Medicare Revenue:* When Medicare reimbursement exceeds the agency's gross charge the difference should be reported as patient revenue and not as a contractual adjustment.**

Bad Debt – Bad Debt is an amount that a party has an obligation to pay but that is considered uncollectible. Bad debt represent the portion of a patient's account not expected to be collected from the patient or other responsible party (the patient's portion). The patient's portion of a bill should not be categorized as a bad debt for patients whose income is less than or equal to 125% of the federal poverty guidelines. Bad debt must be differentiated from charity services. Patient charges otherwise eligible for classification as charity care should only be treated as bad debt if all conditions of your agency's charity care definition are not met.

Gross Indigent and Charity Care Patient Charges – Gross indigent and charity charges are the total uncompensated charges for patients who qualify as indigent or charity under the definitions above.

Total Indigent and Charity Compensation – Funds provided by all public and private sources that are earmarked as compensation to offset uncompensated charges from indigent or charity care cases.

Other Free Care – Other uncompensated care provided as a result of employee discounts, administrative adjustments, courtesy discounts, small bill write-offs, or other similar write-offs not based on a patient's inability to pay. Should not include amounts properly classified as "contractual adjustments" as defined above.

Other Revenue -- Other revenues or gains are derived from services other than providing services to patients. This may include revenues shared with the agency from another organizational entity (hospital, long term care facility, etc.)

Total Expenses -- The sum of resources consumed in fulfillment of an agency's ongoing major or central operations. Expenses may result from current expenditures, incurring obligations to make future expenditures, or consuming resources obtained from previous expenditures. Expenses associated with non-home health agency services should be excluded from the Survey. Expenses related to activities shared with entities other than the agency (such as a hospital) should be allocated between the entities. The expense component not allocated to the agency should be eliminated from the Survey. Appropriate matching of the revenues and expenses excluded from the Survey should be made. Do not include bad debt as a total expense, but as a

deduction from revenue. Total expenses must be greater than zero.

Adjusted Gross Revenue -- Adjusted Gross Revenue (AGR) is calculated by subtracting Medicaid (including any Peachcare for Kids) and Medicare contractual adjustments *only* and bad debt from the agency's total gross revenues. AGR is used as the basis for determining an agency's level of uncompensated indigent and charity care services. Generally, these figures are presented as a percentage of the facility's AGR.

Adjusted Gross Patient Revenue – Adjusted Gross Patient Revenue (AGPR) is AGR minus Other Revenue.

Calculated Financial Totals – The following financial items will be automatically calculated from the financial information provided on the survey webform.

Total Contractual Adjustments
Uncompensated (Net) Indigent Care Total
Uncompensated (Net) Charity Care Total
Total Uncompensated Indigent and Charity Care
Total Net Patient Revenue
Total Net Revenue
Adjusted Gross Revenue (as defined by DCH)
Percentage of AGR that is Uncompensated I/C Charges

Indigent and Charity Care Commitments – Some home health agencies have commitments to provide a specified level of indigent and charity care as part of their Certificate of Need authorization. For those agencies that have a CON commitment to provide indigent and charity care, the commitment (expressed as a percentage) is multiplied by the agency's AGR to calculate the amount of uncompensated indigent and charity care provided.

Indigent and Charity Care Patients – Report the number of home health care patients who were classified as indigent or charity care cases consistent with the definition provided above. Report only indigent and charity care patients who received home health care services and who had charges included in the indigent or charity care reported in Part E, Question 4.

Healthcare Point of Origin – Report the number of patients referred from each of the categories listed as applicable. The point of origin should represent the setting from which the referred patient was referred home. For example, if a patient is referred for home health care by a hospital discharge planner or another individual working under the auspices of the hospital then the point of origin should be hospital. If a patient is referred for home care directly from a physician or physician's office visit then the point of origin is physician. The point of origin should represent the healthcare setting in which the patient was treated last before home.

Referring Hospitals – Please list the name of hospitals from which patients were referred to your agency during the report period and provide the number of patients from each hospital that were referred during the report period.

PART F: AGENCY WORKFORCE INFORMATION:

The Office of Health Planning collects workforce information to support the State's workforce planning activities. The Office is currently focusing on planning efforts for Registered Nurses, Licensed Practical Nurses, Nurse Aides/Assistants, and other direct care staff. Please report the budgeted number of full-time staff (FTE) and the number of vacancies as of **December 31, 2022**.

Also, please report the average time your facility has spent during the past six months filling vacant positions. Use one of the four time periods provided for each professional category.

PART G: MONTHLY ADMISSIONS AND READMISSIONS AND UTILIZATION BY PATIENT COUNTY

Monthly Number of New Admissions -- Provide the number of new admissions for each of the twelve (12) months of the report year. A new admission is a patient admitted for the first time during this report year and who was not captured in the caseload total reported for January 1, 2022. A person should be counted as a new admission only once during the report year.

Monthly Number of Re-Admissions – Provide the number of readmissions for each of the twelve (12) months of the report year. A readmission is a patient who was admitted previously during the 2022 report year.

Patients and Visits by Patient County of Residence and Age -- Please report the number of patients served and number of visits made by the patient's resident county for your agency during the report period. The caseload as of January 1, 2022 should represent the total number of patients your agency served on that day. Please be aware that patient and visit totals must balance throughout the survey. Note that the Total Patients column will be calculated by the survey form from the patients provided in each age group. However, the Ages 60 to 79 column is not included in the calculation of total patients. We are seeking patients ages 60 to 79 for informational purposes only and this category stands alone.

Patient Charges by Patient County of Residence – Report total patient charges, adjusted gross patient revenue and net uncompensated charges by patient county for your agency during the report period. Totals for each charge category should balance to totals reported elsewhere in the HHSS. Adjusted Gross Patient Revenue is patient charges minus Medicare, Medicaid, and Peachcare for Kids™ contractual adjustments and Bad Debt. Note that this total will not balance to Adjusted Gross Revenue for agencies reporting Other Revenue or Gains because Other Revenue cannot be broken down by patient county.

SIGNATURE PAGE

The Signature Page is where the agency's chief executive or administrator electronically authorizes the survey for release to the Department of Community Health. The agency's chief executive officer or administrator must sign to certify that the responses are complete and accurate for the report period specified. An electronic manually entered version of the signature is being accepted as an original signature pursuant to the Georgia Electronic Records and Signature Act.

The Signature Page also will identify any out of balance edit checks and any validation rule criteria that are not correct. All edit and balance requirements and all required fields must be completed before the survey can be submitted.