

**Colorado Department of Public Health
and Environment**

**Review of Home Health Agencies
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Profile of the Home Health Industry

A home health service provides health care to individuals and families in their place of residence in order to maintain or restore health, or to minimize the effects of disability and illness including terminal illness. Services may include, but are not limited to, the following: skilled nursing care; intravenous or respiratory therapy; physical, occupational and speech therapy; wound treatment; palliative care; and assistance with durable medical equipment where installation, teaching and monitoring occur in the patient's place of residence. The provision of services can vary from intermittent half-hour visits up to continuous care for 24 hours per day, seven days per week.

Although the majority of home health patients are age 65 and older¹, services are provided to a wide variety of recipients. Patients include babies who have life limiting illness or disability that requires a ventilator, artificial feeding tube, or around the clock intravenous infusions to survive. Other home health recipients include growing children with physical and developmental disabilities and adults with chronic diseases such as cerebral palsy or multiple sclerosis, or disabilities such as paralysis and cognitive disorders.

The CDC's National Center for Health Statistics reported that in the year 2000, 75 percent of home health patients received medical or skilled nursing services, 44 percent received personal care services, and 37 percent received therapeutic services. Many patients received a combination of services.² A growing number of patients receive home health services following an acute stay in an ambulatory surgery center, hospital or nursing facility.

A survey conducted by the Kaiser Family Foundation showed that of all U.S. health care expenditures by service in 2004, 2.3 percent was for home health care.³ Colorado was slightly below the national average with 1.7 percent of total health care expenditures distributed to home health care. In comparison, South Dakota had the lowest distribution for home health care at .5 percent, while New Mexico had the highest distribution at 5.3 percent.⁴

The National Association for Home Care reports there are more than 25,000 home health care providers caring for nearly 9 million people living with acute illness, long-term health problems, disabilities or terminal illness. This number represents a phenomenal increase since 1963, when only 1,100 home care providers were in operation.⁵

¹ Home Health Care Patients: Data from the 2000 National Home and Hospice Care Survey, National Center For Health Statistics, March 2004.

² Id.

³ Distribution of Health Care Expenditures by Service by State of Residence, 2004, dated 9/18/2007, on the Internet at: <http://www.statehealthfacts.org/comparemaptable.jsp?ind=592&cat=5>

⁴ Id.

⁵ Home Health Care Industry Focus, Mary Paulsell, Associate Director, University Center for Innovation and Entrepreneurship, Columbia, MO, on the Internet at: http://www.missouribusiness.net/iag/focus_home_health.asp.

The breakdown of Medicaid dollars spent on long term care corroborates the growing trend from institutional to home care. Medicaid spending for long term care services provided in an institutional setting dropped from 90.2 percent in 1987 to 63 percent in 2005, while Medicaid spending for home care services nearly tripled from 10.8 percent in 1987 to 37 percent in 2005.⁶

Currently, annual expenditures for home health care are estimated to be more than \$55 billion and home health services are expected to continue to grow as the result of a shift from inpatient care to less expensive outpatient and home care along with patients' desires to be treated at home.⁷ The growing prevalence of home health care coupled with the vulnerability of the patients needing that care underscore the importance of state regulatory oversight. The only existing oversight of home health agencies in Colorado is by the federal government through the Centers for Medicaid and Medicare Services (CMS).

CMS requires that home health agencies serving Medicaid or Medicare clients be certified and meet certain federal criteria before they are eligible for reimbursement. The applicable federal regulations are, however, quite limited. The definition of a home health agency under the federal program is narrow and does not include providers of in-home infusion, respiratory therapy, personal care or nurse aide services. Moreover, the federal regulations require that certified HHAs need only be inspected every 36 months rather than annual or biennially.⁸

Durable medical equipment suppliers, oxygen suppliers and others get minimal oversight from CMS, but not with regard to the provision of services, teaching and monitoring in patient's homes. Similarly, there is no oversight of home infusion care and services provided to Colorado residents by pharmacies other than the basic requirement that the pharmacy be licensed by the Board of Pharmacy.

The rapid growth and expanding scope of services provided in a individual's place of residence support the proposition that these services be managed through licensure to ensure the safety and welfare of the patients receiving the services.

Status of the Home Health Environment in Colorado

The Colorado Department of Public Health and Environment is the agency charged with performing inspections or surveys of Medicare and Medicaid certified home health entities. In Colorado, the number of certified entities has increased steadily in the past four years (from 129 in FY 03-04 to 140 as of June 2007). Meanwhile, the average number of deficiencies cited by the Department has almost doubled over that same period to more than nine per survey. The following several pages provide some examples of the deficient practices found by the Department.

⁶ Long-Term Care Frequently Asked Questions, by Barbara Coleman for the National Conference of State Legislatures, p.3.

⁷ Id., U.S. Bureau of Labor Statistics, *Career Guide to Industries, 2008-09 Edition*, Health Care, on the Internet at <http://www.bls.gov/ovo/cg/cgs035.htm>.

⁸ 42 U.S.C. 1395i(c)(2)(a) (2007).

- A Colorado Springs agency was cited with failing to treat according to physician orders and failure to communicate with the physician. The agency staff applied a topical ointment that was not ordered by the physician to surgical pin sites on a resident's fractured ankle that caused it to become infected. The infection was not communicated to the physician and by the time the resident returned to the physician, the infection was so severe that the foot and ankle required amputation.
- An Aurora agency was cited with failing to ensure appropriate discharge planning and communication with appropriate persons. A severely depressed bi-polar resident told the agency she was losing everything including her car and home and said she therefore no longer required their services as well. The agency failed to communicate with the physician, social worker, family or adult protective services, leaving the resident alone in her depressed state. The resident was later found dead of an overdose.
- Two separate incidents involved failure to protect patient rights and react appropriately to an allegation of sexual molestation of a bed-bound resident. In the first incident, a Ft. Collins agency hid the allegation from the state health department who was onsite conducting another investigation. Instead of notifying the criminal authorities and suspending the accused immediately, the agency proceeded to inform the accused and place documentation in the clinical record to decrease the resident's credibility. In the second incident, an Aurora agency failed to notify the criminal authorities and failed to suspend the accused or prevent the alleged assailant from caring for other residents who were unable to communicate or protect themselves.
- A Lakewood agency was cited for failure to assess and respond to a quadriplegic resident who had an abnormally low body temperature and was unresponsive. The nurse left the resident without providing intervention or even alerting the physician. Later, after a 911 call, the resident was transported to an emergency room where he was noted to have a body temperature of 90.4 degrees (death can occur at a temperature of 93.2) and an altered mental status. He was subsequently intubated and placed in the intensive care unit.
- A Montrose agency was cited for failure to coordinate care and monitor decubitus ulcers for a resident with profound mental retardation who lived in a group home. The agency's failure resulted in lack of healing for the initial ulcer and the development of eight new ulcers in a three-day period.
- A Lakewood agency was cited with systemically diverting medications (narcotics and others) from its residents and directing nurse aides to provide skilled care. The registered nurse then falsified documents to show that a nurse provided the care provided by the nurse aides.
- An elderly resident being cared for by an Aurora agency was admitted to a hospital in an emaciated and dehydrated state with 19 decubitus ulcers, many of which were foul smelling. Documentation revealed that the resident had no wounds when she

began receiving agency care two months earlier. Although the resident had limited mobility and was totally dependant for all activities of daily living, the agency's registered nurse assigned a CNA to visit for only 1 ½ hours a day. There was no plan regarding how the resident was to be repositioned, fed or kept clean throughout the day. There was also no plan for the CNA to provide or monitor meal or fluid intake. A comparison of medical records showed that the patient had also lost 20 pounds while in the care of the agency.

The Department was unable to cite the agency as it was already under a plan of correction following prior findings of immediate jeopardy. Under CMS rules, deficient practice cannot be re-cited for similar issues that occur during an agency's period of correction.

- An unlicensed personal care provider (PCP) with an Englewood agency arrived at a home to perform services for a patient with multiple sclerosis and other medical conditions. The PCP found the patient slumped over on the toilet and was unable to rouse her. When the PCP called her agency for direction, her manager told her that the patient "slept a lot" in different locations and that she should not disturb her. The PCP spent several hours performing housekeeping chores and departed. When she arrived the next day, she found the patient in the same clothes in the same position as the day before. Upon noticing that the resident's skin now had a bluish tint, she tried to call her manager again. She couldn't reach her manager, so she called 911. The patient was deceased.

The Department is still investigating this incident.

- During a complaint investigation of a Lakewood agency, the Department discovered various medications combined in a single prescription bottle for one resident along with a basket of unused prescription bottles prescribed for other residents. The agency did not have the requisite license and DEA number for handling these medications that were also being redistributed without physician orders. The agency's medical supply room had dressings and other supplies that should be segregated and kept as clean as possible commingled with various items in a haphazard fashion. This agency is no longer Medicaid certified.

Certification and Licensure Distinction

While there is often confusion between licensure and federal certification of eligibility for Medicare/Medicaid reimbursement, licensure provides several consumer safeguards that are not provided through the certification process. In addition, for agencies that operate without federal certification, licensure provides the only safeguards. Standard licensure criteria include:

- A Department determination that the agency is fit to operate the business. This requires a review of the history of the owners and operators of the business,

including whether actions have been taken against them or their licenses previously limited or revoked, as well as their capacity, financial resources, and competence to operate the business.

- Criminal background checks on owner/operators and staff.
- Requirements for administrator qualifications and staff training.
- A Quality Management Program that describes how the agency tracks and responds to issues that arise in patient care.
- A requirement to report occurrences such as death or serious injury, abuse, neglect, misappropriation of patient assets, drug diversion, and failure of medical equipment. These occurrences are investigated by the Department and may result in sanctions, including license revocation.

Although there is limited oversight for federally certified providers, it is not difficult for some providers to escape scrutiny. If too many problems accumulate under one provider number, that agency can easily re-enroll by applying for a new number or by using the inactive account of another provider. The provider agency can then offer healthcare services it may not be qualified to perform and put itself in a position to exploit or abuse vulnerable patients. Moreover, since there is no state license requirement, agencies that are de-certified by CMS for problems such as those listed above are still able to operate by accepting non-Medicare/Medicaid patients.

Licensure would create minimum standards to establish reasonable quality of care and patient safety measures that would apply to all recipients of home health services, not just Medicare and Medicaid beneficiaries. As set forth above, state licensure of home health agencies would also provide oversight of items that the federal certification does not cover. For instance, the only training requirement for personal care providers under current Medicaid regulations is that each provider receive at least 20 hours of training **or** pass a skills validation test.⁹ Many agencies opt for the test rather than the training, yet the regulations contain no standards for either the length or content of the test.

Regulation of Home Health Agencies in Other States

Currently Colorado is one of only five states in the country that does not license home health agencies (HHAs). The other states that do not license HHAs are Alabama, Massachusetts, Ohio, and West Virginia. Although West Virginia does not license HHAs, the state still regulates them to a certain degree. West Virginia requires that any HHA seeking to open or remodel a facility in the state apply for a Certificate of Need¹⁰ so that the state can determine whether such service is warranted. The certificate of need process

⁹ 42 CFR §484.36(e)(2)(2007), 10 CCR 2505-10, §8.489.41 (2007).

¹⁰ Certificate of need (CoN) programs originally developed as part of the federal “Health Planning Resources Development Act” of 1974 and are aimed at restraining health care facility costs by allowing coordinated planning of new services and construction. The CoN process typically requires payment of an application fee in the thousands of dollars and is frequently based upon the size or total cost of the project.

is rigorous and contains standards that the home health agency and its staff are expected to meet if the Certificate of Need is approved.¹¹

Not only do the vast majority of other states license home health agencies, but most states have been doing so for years. Oregon, for example, has required licensing of HHAs since 1977, Kansas and Maine since 1984, and Minnesota and Arkansas since 1987.

In order to give a broad overview of licensing requirements in other states, the statutes, regulations and policies of ten states across the country were examined in depth. A snapshot of each state's licensing criteria is set forth below. All ten share some common features. All require criminal background checks for HHA personnel. All perform on-site surveys for initial and renewal licenses, as well additional surveys deemed necessary for patient safety. The frequency of license renewal inspections varies between states and is based upon the license term. Most require annual on-site inspections. All have some type of injunctive authority to prohibit unlicensed operation of HHAs and most impose criminal penalties for unlicensed operation. All require a patient's bill of rights and most mandate quality improvement programs. Most have minimum criteria for administrator qualifications. Several states also mandate a certain amount of home health aide training in specific areas plus successful completion of a state examination.

Washington:

Washington State has required licenses for home health agencies since July 1, 1990. The enabling statute stresses the need for regulation and reads as follows:

The legislature finds that the availability of home health, hospice, and home care services has improved the quality of life for Washington's citizens. However, the delivery of these services brings risks because the in-home location of services makes their actual delivery virtually invisible. Also, the complexity of products, services, and delivery systems in today's health care delivery system challenges even informed and healthy individuals. The fact that these services are delivered to the state's most vulnerable population, the ill or disabled who are frequently also elderly, adds to these risks.

It is the intent of the legislature to protect the citizens of Washington State by licensing home health, hospice, and home care agencies. This legislation is not intended to unreasonably restrict entry into the in-home service marketplace. Standards established are intended to be the minimum necessary to ensure safe and competent care, and should be demonstrably related to patient safety and welfare.

Licensing is performed under the auspices of the Washington Department of Health. The statutes specify licensing procedures and requirements, survey procedures, civil penalties and other actions regarding the operation of unlicensed agencies.

¹¹ The following states require certificate of need applications for HHAs: AL, AK, AR, GA, HI, KY, ME, MS, MT, NJ, NY, NC, SC, TN, VT, WA (for HHAs providing hospice care), and WV.

All initial licensing surveys are conducted by the state agency.¹² For license renewals, Washington law allows an in-home services agency that is certified by the federal Medicare program or accredited by JCAHO as a home health or hospice agency to be exempt from the state on-site survey if the applicable survey standards of the certification or accreditation program are substantially equivalent to those of the state, the certification or accreditation on-site survey has been conducted during the previous 24 months, and copies of the survey report and other relevant reports are sent to the department. Washington differentiates between the provision of non-medical personal care services and medical services by referring to the first as “home care services” and the later as “home health services.” A license is required for both a home care agency and a home health agency.¹³

The Washington legislature also enacted a broad range of sanctions to be applied to unlicensed HHAs including injunctive action sought by the state attorney general to prevent the advertising, operating, maintaining, managing, or opening of an agency without a license (including fines of up to \$24,000) and the issuance of cease and desist orders.¹⁴ The statute also provides that the operation of an in-home services agency without a license is an unfair or deceptive act in trade or commerce and an unfair method of competition under the state’s consumer protection act.¹⁵ Even licensed agencies are subject to various sanctions as the Department of Health is authorized to assess monetary penalties of a civil nature not to exceed \$1,000 per violation for 25 enumerated violations ranging from failure to comply with state or federal statutory or regulatory standards for HHAs to misleading advertising.¹⁶

Florida:

Florida differentiates between medical home health services and non-medical homemaker services. Any organization that provides only homemaker services is exempt from licensing requirements, but must still register with the Agency for Health Care Administration (AHCA).¹⁷

Florida has extensive rules regarding the personnel requirements for HHAs. For instance, home health aides must successfully complete at least 40 hours of training in specific subject areas or pass a home health aide competency test consisting of two parts - a practical part in which competency is determined through observation of the performance of tasks, and a written question and answer part. In addition to passing the test, an aide must have completed two hours of training on assistance with self-administered medication before being allowed to assist clients with this task.¹⁸ Additional training is required for staff that work with patients with Alzheimer’s disease or other related disorders.

¹² Wash. Rev. Code §70.127.085 (4) (2007), Wash. Admin Code §246-335-050 (2007).

¹³ Wash. Admin Code §246-335-015(19) and (22) (2007).

¹⁴ Wash. Rev. Code §70.127.200 (2007).

¹⁵ Id. at §70.127.216.

¹⁶ Id. at §70.127.170.

¹⁷ Fla. Stat. ch. 400.509(1) (2007).

¹⁸ Fla. Admin. Code §59A-8.0095(d) through (l) (2007).

The Florida statutes establish sanctions based upon various classes of deficiencies. The most serious is a Class 1 deficiency that results in a patient's death, disablement or permanent injury (or imminent risk of same) with a fine of \$5000 for each occurrence and each day that the deficiency exists. The least serious is a Class IV deficiency involving an act, omission or practice related to required reports, forms, or documents which does not negatively affect patients with a fine not to exceed \$200 for each occurrence and each day that the uncorrected or repeated deficiency exists.¹⁹

Florida's statute also provides that failure of the HHA to include its license number in any advertising whether broadcast or written is subject to a fine ranging from \$100 for the first violation to \$500 for each subsequent violation, subject to an injunction proceeding, considered a violation of Florida's Deceptive and Unfair Trade Practices Act, as well as constituting a second degree criminal misdemeanor. If a second violation occurs, the criminal charge rises to a first-degree misdemeanor.²⁰

Oregon:

Oregon issues different licenses and has different requirements for in-home care agencies and home health agencies.²¹ An in-home care agency is defined as providing non-medical, personal care for compensation at an individual's place of residence and does not include a home health agency or portion of an agency providing home health services.²² A home health agency is defined as a public or private entity providing medical or therapeutic services on a visiting basis to an individual for the purpose of maintaining that individual at home.²³ It appears that a home health agency is prohibited from providing personal care services without authorization from the Department of Human Services, Public Health Division.²⁴

Licensure requirements for a home health agency include having policies established by professional personnel associated with the entity, including one or more physicians and one or more registered nurses; physician or nurse practitioner or registered nurse supervision of all agency services; maintenance of clinical, financial and professional records on all patients; and an overall plan and budget.²⁵

The requirements for an in-home care agency license are less rigorous than those for home health agencies. The fees are less and the Department may waive the initial onsite survey and issue a one-time, one-year provisional license upon satisfactory review of an agency's self-assessment form.²⁶

¹⁹ Fla. Stat. ch. 400.84 (2007).

²⁰ Id. at §400.464(4).

²¹ Or. Rev. Stat. §§ 443.005 - 443.095 and 443.305 - 443.350 (2005), Or. Admin. R. §§ 333-027-0000 - 333-027-0170 and 333-536-0000 - 333-536-0100 (2007).

²² Or. Admin. R. §333-536-0005(11) and (12) (2007).

²³ Id. at §333-027-0005(8) and (10).

²⁴ Id. at §§333-027-0040, 333-027-0050.

²⁵ Id. at §333-027-0010.

²⁶ Id. at §333-536-0010.

The only sanctions set forth in the Oregon statutes and regulations (other than the denial, suspension or revocation of a license) are that operation of an unlicensed home health agency is punishable as a Class C misdemeanor.²⁷

Arkansas:

The Arkansas statutes define home health care services as including both skilled medical and non-skilled personal care services.²⁸ The statutes also set forth a number of “exceptions from licensing requirements” that include a durable medical equipment supply company; a pharmacy or wholesale medical supply company that furnishes those services that relate to drugs and supplies to persons in their homes; along with registered nurses, various therapists and social workers when those individuals are providing home health services as a sole practitioner.²⁹ Arkansas also has a statutorily created home health agency advisory council to assist with rulemaking.³⁰ The Arkansas Department of Health conducts an onsite inspection prior to initial licensure and every one, two or three years thereafter depending upon certain criteria including the agency’s deficiency and complaint record.³¹

Minnesota:

In Minnesota, “home care service” includes non-medical and medical services when delivered at home to a person whose illness, disability, or physical condition creates a need for the service.³² A home care provider is defined as an individual, organization, association, corporation, unit of government, or other entity that is regularly engaged in the delivery, directly or by contractual arrangement, of home care services for a fee. At least one home care service must be provided directly, although additional home care services may be provided by contractual arrangement. For purposes of licensure, the term “home care provider” excludes relatives, volunteers, services such as Meals-on-Wheels, and the like.³³

There are five classes of licenses for home care providers in Minnesota.³⁴ A provider must apply for one of the classes of home care license listed in sub-items (1) to (5).

(1) Class A, or professional home care agency license. This allows a provider to provide all home care services in a place of residence, including a residential center, at least one of which is nursing, physical therapy, speech therapy, respiratory therapy, occupational therapy, nutritional services, medical social services, home health aide tasks, or the provision of medical supplies and equipment when accompanied by the provision of a home care service.

²⁷ Wash. Rev. Code §443.991(1) (2005).

²⁸ Ark. Rev. Stat. §20-10-801(5) (2007).

²⁹ Id. at §20-10-802.

³⁰ Id. at §§20-10-804 and 805.

³¹ Ark. Code Reg. Section VIII.

³² Minn. Stat. §144A.43(3) (2007).

³³ Id. at §144A.43(4).

³⁴ Id. at §4668.0012(3).

(2) Class B, or paraprofessional agency license that allows a provider to perform home care aide tasks and home management tasks.

(3) Class C, or individual paraprofessional license that allows a provider to perform home health aide, home care aide, and home management tasks.

(4) Class E, or assisted living programs license that allows a provider to only provide assisted living services to residents of a residential center.

(5) Class F home care provider license. This allows a provider to provide assisted living home care services solely for residents of one or more registered housing with services establishments.

If a provider meets the requirements of more than one license class, the commissioner shall issue to the provider a separate license for each applicable class of home care licensure.³⁵ Staff training requirements vary depending upon the license class.

Maine:

In Maine, licensed home health agencies provide medical or therapeutic services, while unlicensed personal care agencies provide assistance with activities of daily living. A Medicare certified HHA is deemed to meet the state licensure requirements if it meets all federal certification requirements.³⁶ The Department of Health and Human Services surveys HHAs on at least a biennial basis, except that state licensing surveys need not be performed during a year when a Medicare certification survey is performed.³⁷ Surveys shall be done annually under certain conditions. Surveys may be announced or unannounced at the sole discretion of the licensing authority, but all complaint investigations shall be unannounced.³⁸

The only sanction provided for in Maine's statutes (other than denial, revocation or suspension of a license) is that operation of a home health agency without a license is a civil violation and subject to a penalty of \$100 with each day constituting a separate violation.³⁹

Kansas:

In Kansas, home health services include nursing, physical therapy, speech therapy, nutritional or dietetic consulting, occupational therapy, respiratory therapy, home health aid, attendant care services or medical social services.⁴⁰ On-site surveys are conducted within at least 15 months of any prior inspection.⁴¹

³⁵ Id.

³⁶ Code Me. R. §10-119-12 (2007).

³⁷ Id. at §10-119-3.B.7.

³⁸ Id. at §10-119-3.B.3.

³⁹ Me. Rev. Stat. tit. 22, §2150 (2007).

⁴⁰ Kan. Stat. §65-5101(c) (2007).

⁴¹ Id. at §65-5104(b)(2).

The state requires that home health aides successfully complete an approved course of instruction and pass an examination prescribed by the state.⁴² A provider of attendant care services only is exempt from these licensing requirements.

Kansas has a unique statutory provision allowing for reciprocal agreements with other states on its border whereby HHA licenses may be granted without an on-site survey as long as the licensure requirements from the other state are substantially similar to those of Kansas. The applicant requesting reciprocal recognition must submit the prescribed Kansas application form and fee, along with a favorable recommendation from the other state's licensing agency.⁴³

Operators of an unlicensed agency are deemed guilty of a class B misdemeanor and subject to an injunctive action in district court.⁴⁴

New Mexico:

Home health services in New Mexico include both skilled medical and non-medical personal care.⁴⁵ Home health aides must receive classroom and supervised practical training totaling at least 75 hours.⁴⁶ The licensing authority prior to commencement must approve the training curriculum. Similar training requirements are mandated for homemakers and personal care attendants.⁴⁷ Services provided by a homemaker must be supervised by a licensed professional or by an appropriately qualified staff member who has at least one year of direct patient care experience.⁴⁸ New Mexico also has age and health criteria for home health staff requiring that personnel be at least 18 years of age and all personnel be tested for TB.⁴⁹

The New Mexico Department of Health may impose civil monetary penalties for violation of its regulations. The amount of the civil monetary penalty is based upon the total of the following factors: (1) the initial base penalty, (2) a daily penalty which is calculated based on the uncorrected deficiencies that exist for each day following the notice to the facility, and (3) any penalty doubling for repeat deficiencies. Civil monetary penalties shall not exceed a total of five thousand dollars (\$5,000) per day.⁵⁰

Arizona:

A home health agency in Arizona is defined as being primarily engaged in providing skilled nursing services and other therapeutic services, has written policies to govern its services, provides supervision of those services by a physician or RPN, and maintains clinic records on all patients. The agency may also provide related supportive services

⁴² Kan. Admin. Reg. §65-5115 (2007).

⁴³ Id. at §65-5105(f).

⁴⁴ Kan. Stat. §§ 65- 5111, 65-5114 (2007).

⁴⁵ N.M. Admin. Code tit. 7, §28.2.9 (2007).

⁴⁶ Id. at §28.2.30.

⁴⁷ Id. at §28.2.31.

⁴⁸ N.M. Admin. Code tit.7, §28.2.29(F) (2007).

⁴⁹ Id. at §28.2.23.

⁵⁰ Id. at §7.1.8.8(F).

such as meals, housekeeping and transportation.⁵¹ Arizona has a biennial license term. Department of Health and Public Safety waives state inspections for HHAs that are Medicare certified.⁵²

Unlicensed HHAs may be subject to injunctive action and the owner/operator of an unlicensed agency is presumed to be guilty of a class 3 misdemeanor.⁵³ The department may also assess a civil penalty against a person who violates the home health statutes or rules in an amount of not to exceed five hundred dollars for each violation. Each day that a violation occurs constitutes a separate violation.⁵⁴

South Carolina:

Home health services are defined as part-time or intermittent skilled nursing care as ordered by a physician and provided by or under the supervision of a registered nurse and including at least one of the following other services: (1) physical, occupational or speech therapy; (2) medical social services; (3) home health aide services; (4) other therapeutic services; or (5) medical supplies or appliances.⁵⁵

South Carolina has different deficiency classifications depending upon the severity of the violation. The severity of the violation determines the amount of time required to correct the infraction (immediate response is required for the most severe) and the amount of monetary penalty imposed. If a HHA fails to correct a violation within the specified amount of time, each day it is out of compliance constitutes a subsequent violation. Monetary penalties range from zero for the least serious violation to \$5,000 for the most serious.⁵⁶

South Carolina also requires that all staff or volunteers who have contact with patients shall have a health assessment within one year prior to patient contact and a two-step tuberculin skin test within three months prior to patient contact.⁵⁷

Tennessee:

In Tennessee, licensed home health services include both skilled medical and non-medical personal care. Tennessee regulations require that an HHA administrator must either be a physician, registered nurse or trained health service administrator with at least one year of supervisory or administrative experience in home health or a related field.⁵⁸ Home health aides are required to have a minimum of 75 hours of training including 16 hours worth of clinical training prior to or during the first three months of employment.⁵⁹

⁵¹ Ariz. Rev. Stat. §36-151(5) and (6) (2007).

⁵² Id. at §§36-425.01(B), 36-425-01(B).

⁵³ Id. at §§36-430, 36-431.

⁵⁴ Id at §36-431.01

⁵⁵ 61-77 S.C. Code Regs. §101(H) (2007).

⁵⁶ Id. at §302.

⁵⁷ Id. at §1002.

⁵⁸ Tenn. Comp. R. & Reg. 1200-8-8-.01(1) (2007).

⁵⁹ Id. at §1200-8-8-.01(12).

License renewal inspections shall be done within 15 months of any previous inspection.⁶⁰ All health care facilities licensed by the Department of Health Safety and Environmental Protection that have obtained accreditation from a federally recognized accrediting health care organization shall be deemed to meet all applicable licensing requirements. Such facilities will continue to be subject to complaint or safety inspections but may be exempt from standard license renewal inspections as long as the facility remains accredited.⁶¹

Solution

State licensure of home health agencies would create minimum standards to establish reasonable quality of care and patient safety measures that would apply to all recipients of home health services, not just Medicare and Medicaid beneficiaries. Currently, agencies that are de-certified by CMS for problems such as the agency in the example that was not only comingling medications, but also redistributing drugs without physician orders or the requisite DEA license, can continue to operate by accepting private pay or non Medicaid patients. State licensure would remedy that situation by providing oversight for all HHAs, including those that serve the private pay or private insurance market.

State licensure would also provide oversight of all agencies for items that federal certification does not cover. As previously noted, the only training requirement for personal care providers under current Medicaid regulations is that each provider receive at least 20 hours of training **or** pass a skills validation test. Many agencies opt for the test rather than the training, yet the regulations contain no standards for either the length or content of the test. Department surveyors have seen some tests that contain only a few questions focusing on extremely generic policies rather than necessary skills.

State licensure would allow the Department to enact regulations to prevent inadequate or inappropriate care through a Quality Management Program. In addition, licensure would allow the Department to take prompt remedial action in a circumstance such as the elderly patient who was admitted to a hospital in an emaciated and dehydrated state with 19 decubitus ulcers. Currently, because of the lack of licensing authority and the federal regulatory framework, the Department is unable to take any action against an agency. The Department's only options are to refer a case to the appropriate professional licensing board, if one exists, and/or to local law enforcement to consider criminal charges for crimes against persons.

Licensing criteria will close these gaps and and dramatically decrease the likelihood of serious adverse events that result in illness, injury or death.

Conclusion

As the cases and statistics reported herein demonstrate, there is ample evidence to conclude that the public will benefit from state regulation of home health agencies. Forty-five other

⁶⁰ Tenn. Code §68-11-210(a)(1) (2007).

⁶¹ Id. at §68-11-210(b)(5)(A).

states have also reached this conclusion. Federal certification alone has proven insufficient to protect the public welfare and safety of Colorado's vulnerable home health patients. The public can only benefit from legislation authorizing the Department of Public Health and Environment to license home health agencies and there no alternatives other than licensure that would provide sufficient oversight to fully protect Colorado citizens.