TO THE NORTH CAROLINA STATE COORDINATING COUNCIL

**PETITION BY PRUITTHEALTH, INC.
FOR AN ADJUSTED NEED DETERMINATION
TO ADD ONE MEDICARE-CERTIFIED HOME HEALTH AGENCY
IN MECKLENBURG COUNTY, FOR A TOTAL NEED DETERMINATION OF
TWO MEDICARE-CERTIFIED HOME HEALTH AGENCIES
IN MECKLENBURG COUNTY IN THE 2021 SMFP**

July 29, 2020

Email: DHSR.SMFP.Petitions-Comments@dhhs.nc.gov

1. **Name, address, email address and phone number of Petitioner:**

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Founded in 1969 in Toccoa, Georgia, PruittHealth is a family-owned business with a long history of serving North Carolina residents. PruittHealth's operations in North Carolina include eight home health agencies ("HHA"), 18 skilled nursing facilities ("SNF"), including the four North Carolina State Veteran's Homes, five hospice agencies, a continuing care retirement community and a state-wide pharmacy. On any given day, PruittHealth affiliates care for nearly 10,000 North Carolina residents.

PruittHealth provides the full range of long-term care services, including skilled nursing, home health, hospice, assisted living facilities, independent living, pharmacy, nutritional supply and medical supply. PruittHealth promotes a Continuum of Care with the belief that one provider can transition patients across services lines more efficiently and cost-effectively than multiple providers transitioning patients across several service lines. PruittHealth believes that through this model of care, it can provide higher quality care at lower cost to the patient. The PruittHealth model of care is further designed to significantly reduce re-hospitalizations and improve outcomes for all PruittHealth patients.

2. **Statement of the requested adjustment, citing the provision or need determination with the Proposed State Medical Facilities Plan for which the adjustment is proposed.**

At the outset, PruittHealth emphasizes that this Petition is not critiquing the home health need methodology or seeking a statewide change. Rather, PruittHealth is proposing a special need

determination for Mecklenburg County, North Carolina's largest county by population, because the COVID-19 pandemic reinforces the urgent need for a robust home health system to keep people safe and healthy in their homes by utilizing proven methods and resources not currently available in the market and at far less cost than skilled nursing or hospital care. In particular, the pandemic has exposed a vulnerability in the current system as it pertains to the treatment of individuals with and recovering from infectious diseases such as COVID-19. PruittHealth respectfully submits that a need determination for a second HHA should be included in the 2021 SMFP for Mecklenburg County, and that this HHA should have a specific focus on caring for patients with and recovering from infectious diseases. To be clear, PruittHealth is not suggesting that the second HHA serve only infectious disease patients. To ensure long-term financial feasibility, the second HHA should be capable of caring for a wide range of patients.

Because the COVID-19 crisis is unfolding in real-time, no long-term studies or data exist to accurately measure the impacts or effects of this infectious disease pandemic, especially as it relates to home health. However, as a current long-term care and HHA provider, PruittHealth is able to draw from both its own expertise and its real-time experiences treating COVID-19 patients, as well as the experience of its provider network and care partners, to better understand and predict the expected long-term impact of this infectious disease pandemic and others like it, and to better understand the future need in the community. These unique times and circumstances have uncovered both a shortage in the supply of resources, including the inability of some existing Mecklenburg County HHA providers to continue providing therapy and other in-home services to aid this specific and vulnerable population, but also an increased demand in the form of an opportunity to meet a need head-on and to be prepared for future responses under similar circumstances. PruittHealth respectfully submits that waiting for more time to pass so that more data can be accumulated and studied would not be prudent. As illustrated in this Petition, the problem exists now, and waiting would not be in the best interests of the residents of Mecklenburg County.

While COVID-19 affects people of all ages, adults age 65 and over (the Medicare eligible population and the greatest users of Medicare-certified home health) have been hardest hit. This age group accounts for approximately 80% of the COVID-19 deaths in the United States.[1] North Carolina's statistics are similar as DHHS reports that 79% of the COVID-19 deaths in North Carolina have been in the 65 and over age range.[2] In Mecklenburg County specifically, 84% of the deaths due to COVID-19 have been in the 65 and over age group.[3]

Home is the safest setting in which to receive care, regardless of the infectious disease from which the patient suffers. Now more than ever, there is a greater need for home health to care for those suffering from or recovering from COVID-19, and to keep those same people out of the hospital or long term care facilities where they risk infecting others. While the COVID-19 crisis shines a spotlight on the importance and value of home health care, the need for more home health resources in North Carolina's largest county will endure long after a vaccine for

[1] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html. Links to websites and articles in this Petition may be opened by activating the hand or select tool and then CTRL+Click on the link.
[2] https://covid19.ncdhhs.gov/dashboard/cases.
[3] https://covid19.ncdhhs.gov/dashboard/cases.

COVID-19 becomes available and in the face of future infectious disease occurrences. This is a critical public health issue and now is the time for North Carolina to act to protect this older, medically fragile, homebound population.

Chapter 2 of the 2020 SMFP provides:

> People who believe that unique or special attributes of a particular geographic area or institution give rise to resource requirements that differ from those provided by application of the standard planning procedures and policies may submit a written petition requesting an adjustment to the need determinations given in the North Carolina Proposed State Medical Facilities Plan.[4]

PruittHealth respectfully requests that the State Health Coordinating Council ("SHCC") include a need determination in Chapter 12, Table 12D of the 2021 State Medical Facilities Plan ("SMFP") for an additional Medicare-certified home health agency in Mecklenburg County, North Carolina, for a total need determination of **two** Medicare-certified HHAs in Mecklenburg County in the 2021 SMFP. PruittHealth recognizes that the *Proposed 2021 SMFP* contains a recommended need determination for one Medicare-certified HHA in Mecklenburg County. PruittHealth strongly supports this recommended need determination and urges the SHCC to keep the recommended need determination in the 2021 SMFP. However, for the reasons stated in this Petition, PruittHealth respectfully submits that special circumstances exist such that the 2021 SMFP should contain a need determination for *two* Medicare-certified HHAs in Mecklenburg County.

While PruittHealth is not advocating for a need determination for an additional HHA to serve COVID-19 patients exclusively, the second need determination should be for an HHA with a specific focus on serving the needs of infectious disease patients, including but not limited to those patients who have contracted or are recovering from COVID-19. Criteria for such an HHA would include:

- Willingness to accept and treat HHA patients who test positive for infectious disease, including COVID-19: This should be made a condition of the certificate of need ("CON") award for the HHA.

- Full service array for complex patients, including those with infectious diseases: Many patients suffering from infectious diseases like COVID-19 also have multiple comorbidities such as diabetes, congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). The HHA should be able to treat complex patient comorbidities and be able to provide the full range of therapies, including intravenous and infusion therapy, wound care, and other skilled nursing care for high acuity patients.

[4] https://info.ncdhhs.gov/dhsr/ncsmfp/2020/2020smfp.pdf. at p. 9

- Infection protection and prevention: The HHA should have education and training procedures in place to ensure that staff are kept up-to-date with rapidly evolving safety requirements and best practices to prevent the spread of infection. This also includes regular screening and testing of staff as well as the appropriate use of proper personal protective equipment.

- Dedicated Staffing: To minimize the spread of infectious diseases, the HHA should have dedicated nursing and clinical teams in place to treat patients with infectious diseases. Those staff members treating patients testing positive for an infectious disease do not treat other patients so as to prevent the spread of disease.

- Telehealth and remote monitoring: To further reduce the chances of transmission of the disease, the HHA should provide telehealth and remote monitoring options, including regular check-in calls between patients and a nurse to address concerns and to make sure proper clinical pathways are being followed for patients' unique needs.

The current home health methodology in the SMFP allows multiple need determinations in a single county in a given year. In fact, over the last ten years, need determinations for multiple HHAs in a single county have occurred three times, including twice in Mecklenburg County.

TABLE 1
SMFP Need Determinations for Multiple HHAs 2010-2020

County	SMFP	Need Determination
Mecklenburg	2011	2 Medicare-certified HHAs
Mecklenburg	2012	2 Medicare-certified HHAs
Wake	2018	2 Medicare-certified HHAs

Source: 2011, 2012 and 2018 State Medical Facilities Plans

For the reasons stated in this Petition, PruittHealth respectfully submits that the 2021 SMFP warrants a need determination for two Medicare-certified HHA in Mecklenburg County.

3. Reasons for the proposed adjustment, including:

a. Statement of the adverse effects on the population of the affected area that are likely to ensue if the adjustment is not made, and

i. Characteristics of the Growing, Aging Mecklenburg County Population

With a July 2020 estimated population of 1,131,342, Mecklenburg County is North Carolina's largest county by population. The population of Mecklenburg County is projected to be

1,327,648 by 2029[5] and 1,542,808 by 2039.[6] Thus, between 2020 and 2039, the population of Mecklenburg County is expected to increase by 36%.

As Table 12A in the SMFP shows, the age 65 and older population tends to be the greatest users of Medicare-certified home health services in Mecklenburg County. According to CMS, in June 2020, 141,617 Mecklenburg County residents (approximately 13% of the county population) were enrolled in original Medicare, Medicare Advantage and other plans.[7] This number is projected to grow to 212,129 by 2030.[8]

As Tables 2 and 3 below demonstrate, the 65+ population of Mecklenburg County is projected to grow rapidly. According to a 2018 aging profile for each of North Carolina's 100 counties prepared by the Division of Aging and Adult Services of NCDHHS, Mecklenburg County's age 65+ population is projected to increase by 110.3% between 2018 and 2038, and its 85+ population is projected to increase by 177.7% from 2018 to 2038.

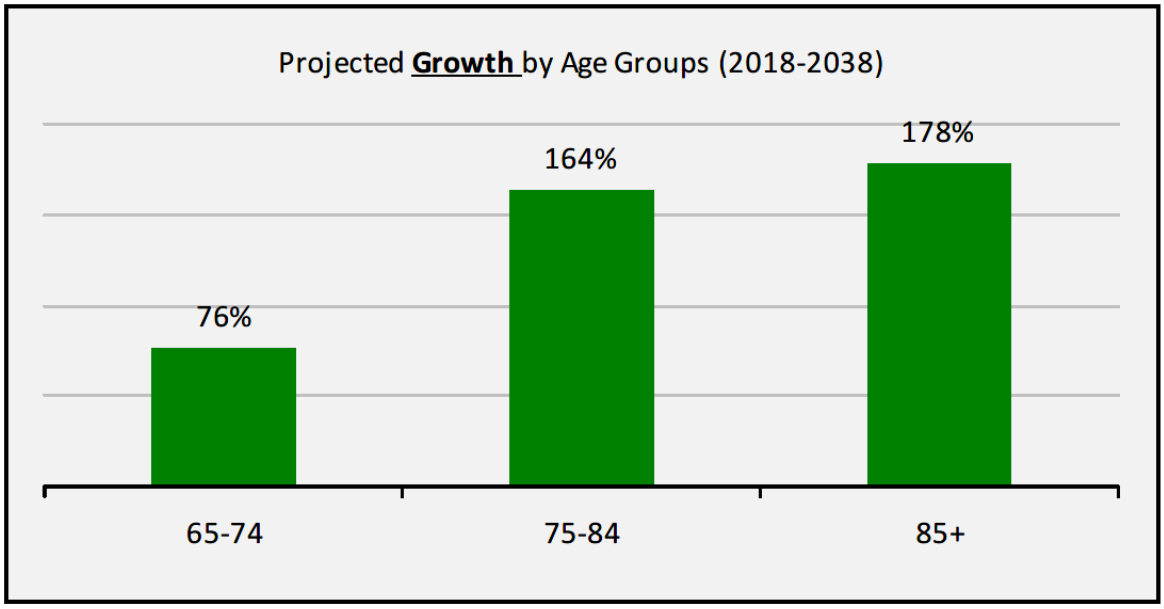
TABLE 2
Mecklenburg County 2018 and 2038 Aging Profile

Ages	2018		2038		% Change (2018-2038)
	#	%	#	%	
Total	1,088,350		1,521,226		39.8%
0-17	259,471	24%	313,859	21%	21.0%
18-44	435,351	40%	563,841	37%	29.5%
45-59	215,243	20%	305,224	20%	41.8%
60+	178,285	16%	338,302	22%	89.8%
65+	122,780	11%	258,239	17%	110.3%
85+	13,109	1%	36,408	2%	177.7%

Source: https://files.nc.gov/ncdhhs/documents/files/NC%20County%20Aging%20Profiles%202018.pdf.

[5] https://files.nc.gov/ncosbm/demog/countytotals_2020_2029.html.
[6] https://files.nc.gov/ncosbm/demog/countytotals_2030_2039.html.
[7] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html.
[8] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html.
[100.0% of 2030 >65 Population + 0.6% of 2030 <65 Population] = [(1.0 x 205,841) + (.006 x 1,142,981) = 212,129], NC Office of State Budget Management, November 15, 2019 County Projections.

TABLE 3
Mecklenburg County 2018-2038 Projected Growth by Age Group



Source: https://files.nc.gov/ncdhhs/documents/files/NC%20County%20Aging%20Profiles%202018.pdf.

According to Chapter 12 of the *Proposed 2021 SMFP*, Home Health Data by County of Patient Origin – 2019 Data, there are 22 Medicare-certified home health agencies serving residents of Mecklenburg County.[9] However, the vast majority (77%) of Mecklenburg County residents receiving Medicare-certified home health services are served by only six agencies. It is PruittHealth's understanding that one of the six, Brookdale Home Health Charlotte, primarily serves patients in Brookdale's continuing care retirement community.[10]

As Table 2 shows, by 2038, approximately 20% of the Mecklenburg County population will be in the 65+ and 85+ age groups and therefore eligible for Medicare-certified home health services. This does not include those in other age groups who may be eligible for Medicare because they are permanently disabled or suffer from end stage renal disease (ESRD).

As shown in Table 4, the top five leading causes of death in Mecklenburg County for those 65 and older are chronic diseases.

[9] https://info.ncdhhs.gov/dhsr/ncsmfp/2020/Ch12_PatientOriginReport_6-25-20-for-posting.pdf. (updated as of 6/12/20).

[10] By comparison, Wake County has a July 2020 estimated population of 1,109,883. https://files.nc.gov/ncosbm/demog/countytotals_2020_2029.html.
Chapter 12 of the *Proposed 2021 SMFP* reports 34 HHAs serving residents of Wake County. https://info.ncdhhs.gov/dhsr/ncsmfp/2020/Ch12_PatientOriginReport_6-25-20-for-posting.pdf. (updated as of 6/12/20).

TABLE 4
Mecklenburg County Causes of Death

Top five leading causes of death, age 65 and over

Rank	Cause	# of deaths	% of total deaths
1	Cancer	924	21
2	Diseases of the heart	892	20
3	Alzheimer's disease	331	7
4	Cerebrovascular disease	297	7
5	Chronic lower respiratory diseases	234	5

Source: https://files.nc.gov/ncdhhs/documents/files/NC%20County%20Aging%20Profiles%202018.pdf.

The SMFP need methodology indicates a need for an additional Medicare-certified home health agency when the projected unmet need in a single county is 325 patients or more. According to Table 12C of the *Proposed 2021 SMFP*, Mecklenburg County's unmet need is -522.48 patients.[11] Mecklenburg County is therefore 62% towards the threshold for triggering a second need determination.

Currently-available SMFP data underestimate the need for Medicare-certified home health in Mecklenburg County. The currently-available data do not and could not consider the impact that the COVID-19 pandemic will have on home health utilization. Since the COVID-19 State of Emergency has only been in existence in North Carolina since March 10, 2020,[12] hard data is not yet available to measure precisely how the pandemic is likely to impact home health utilization in the future. The crisis is unfolding in real time. The absence of multiple years of hard data, however, does not minimize the very real, urgent and readily apparent issues of providing safe, affordable and highly accessible care in Mecklenburg County for the frail elderly population, many of whom suffer from multiple comorbidities and chronic conditions such as diabetes and heart disease. Because of their age and underlying conditions, these individuals are highly susceptible to the virus, have suffered the greatest number of deaths from the virus, and are exactly the patients who should be receiving care at home.

In addition, neighboring Union County is also experiencing significant growth in population. With a July 2020 estimated population of 242,657, Union County's population is projected to increase to 296,479 by July 2029.[13] By July 2039, the population is projected to be 355,872.[14]

[11] https://info.ncdhhs.gov/dhsr/mfp/pdf/2020/ltbh/table12c-5-14-20.pdf.
[12] https://www.ncdhhs.gov/news/press-releases/governor-cooper-declares-state-emergency-respond-coronavirus-covid-19.
[13] https://files.nc.gov/ncosbm/demog/countytotals_2020_2029.html.
[14] https://files.nc.gov/ncosbm/demog/countytotals_2030_2039.html.

Consistent with national trends, the over age 65 population is the greatest beneficiary of home health services in Union County, a fast-growing, suburban community outside of Charlotte.[15] CMS reports that 34,257 Union County residents were enrolled in original Medicare, Medicare Advantage and other health plans as of June 2020 and that number has been steadily increasing.[16] Thus, the Medicare-eligible population will continue to grow with over one-fifth of the Union County population being eligible based on age alone, irrespective of other disabilities or chronic conditions.

According to Table 12A in 2020 SMFP, there are ten Medicare-certified HHAs serving Union County residents, but only two of these agencies are based in Union County.[17] Based on Table 12C in the *Proposed 2021 SMFP*, the unmet need for Medicare-certified HHA services in Union County is 245 patients, just eighty (80) shy of triggering a need determination under the SMFP methodology for HHAs.[18] While these numbers do not trigger a need for a new HHA in Union County, the numbers do not factor in the impact of COVID-19 or its impact on home health care utilization. Given its close proximity to Mecklenburg County, an additional HHA based in Mecklenburg County, particularly one focused on meeting the needs of those battling infectious diseases such as COVID-19, could reasonably be expected to serve the expanding needs of the Union County population as well.[19]

ii. The Need for Increased Access to Home Health in Mecklenburg County Due to COVID-19.

Mecklenburg County has been especially hard hit by COVID-19. Mecklenburg County has had more cases and more deaths due to COVID-19 than any of the other 99 counties in North Carolina. As of July 28, 2020, 19,707 cases have been confirmed in Mecklenburg County and 189 Mecklenburg County residents have died from COVID-19.[20] That is 180 cases for every 10,000 residents.[21] By comparison, Wake County, which has nearly the same size population as Mecklenburg County, has had 10,289 cases and 115 deaths (94 cases for every 10,000 residents).[22] 83% of the deaths due to COVID-19 in Mecklenburg County have been in the 65 and over age group.[23]

[15] *See* 2020 State Medical Facilities Plan, pp. 273-274, Table 12A.
[16] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html.
[17] *See* 2020 SMFP, pages 273-274, Table 12A
[18] *See* Proposed 2021 SMFP, p. 243, Table 12C.
[19] *See* Exhibit H (letter from Union County Nursing Home Administrator Jonathan Thomas).
[20] https://covid19.ncdhhs.gov/dashboard.
[21] https://covid19.ncdhhs.gov/dashboard.
[22] https://covid19.ncdhhs.gov/dashboard.
[23] https://covid19.ncdhhs.gov/dashboard/cases.

(a) The Need and Demand for Alternatives to Congregate Living

The COVID-19 pandemic has created an entirely new population of patients, those who are sicker, with greater comorbidities and long-term effects that we are still learning about each day. The virus is educating providers every day on the needs that can arise during an infectious disease crisis and revealing current shortcomings in health care delivery and support. COVID-19 has also had a profound effect on all aspects of health care delivery, including home health. In fact, the entire dynamic and landscape of healthcare, especially long-term and post-hospitalization care, has changed, likely forever as our country recognizes for the first time in modern history, the ramifications a global pandemic and infectious disease can have on our population, economy and healthcare system. PruittHealth believes a focus on alternative care delivery to address this change and also to meet the needs a new population of patients, those who have or have had COVID-19 or other infectious diseases, is critical in ensuring Mecklenburg County residents have the access they need and deserve to quality, cost-effective, skilled services in the setting in which they feel most comfortable and safe.

While the pandemic has contributed to short-term declines in visits for many HHAs, these declines are easily attributable to a drop in elective procedures (such as hip replacements) at the start of the pandemic that often lead to home health referrals, and patients' concerns about having non-family members enter their homes.[24] However, these COVID-related volume declines are not expected to be a long-term phenomenon. To the contrary, PruittHealth and other industry leaders expect home health to play an increasingly important role in caring for vulnerable populations, especially elderly patients. One major factor driving a projected increase in the demand for home health is the desire to avoid congregate living settings, such as SNFs. *See Letter of Support from Francine Rainer ("Rainer Support Letter"), Chief Clinical Officer of PruittHealth*, Exhibit A. As recently reported by *Home Health Care News*, trends are now expected to include "a revival of SNF-to-home diversion."[25] At the same time, industry leaders expect to see consolidation of HHA services, not only from smaller facilities closing or selling, but also from hospitals dispensing with their in-home health services.[26] Thus, providers with extensive service arrays and solid foundations to continue to provide these services in a safe and effective manner, such as PruittHealth, will be necessary to meet the increased demand for these services. PruittHealth expects to see an increase in demand as we rethink the treatment of infectious diseases in our population.

As a leading provider of SNF services, PruittHealth is certainly not arguing against SNFs or other types of congregate living settings, such as assisted living facilities ("ALF"). For many patients, SNFs and ALFs are appropriate settings that provide safe and effective around-the-clock care. But the inescapable fact is that the pandemic has greatly altered perceptions of congregate living settings. Regardless of when a vaccine becomes available, PruittHealth does

[24] https://thehill.com/blogs/congress-blog/503658-caring-for-american-seniors-at-home-during-crisis-and-beyond.
[25] https://homehealthcarenews.com/2020/06/predicting-covid-19s-long-term-impact-on-the-home-health-care-market/.
[26] https://homehealthcarenews.com/2020/06/predicting-covid-19s-long-term-impact-on-the-home-health-care-market/.

not expect this to be a short-term reaction.[27] In Mecklenburg County, as of July 28, 2020, there are 509 reported cases of COVID-19 in nursing homes and 57 deaths attributable to COVID-19. Another 56 cases and three deaths due to COVID-19 have been reported in residential care facilities in Mecklenburg County as of July 28, 2020.[28] These statistics reflect ongoing outbreaks only.

For a variety of reasons, including concerns about virus exposure, separation from loved ones, costs, or other reasons, PruittHealth anticipates that patients and families will increasingly seek care options that do not involve congregate living. *See Rainer Support Letter*. According to a recent survey reported in *Home Health News*, "over 50% of family members are now more likely to choose in-home care for their loved one than they were prior to the coronavirus. . . ." The report goes on to state:

> In all likelihood, the shift in thinking is not temporary. Within the survey, respondents suggested that their perception of the long-term care options had been changed for good.
>
> 'COVID-19 has changed opinions from this point forward . . . It had such an impact on families that we feel this ripple effect of really wanting to take every precaution, even if a vaccine for COVID-19 does emerge.'

See Long-Term Care Decision-Makers More Likely to Choose Home Care in COVID-19 Aftermath, *Home Health Care News,* June 3, 2020, attached as Exhibit B.

The pandemic is also likely to impact the capacity of congregate living facilities and is, in fact, already doing so. Shared rooms are likely to be less prevalent as facilities work to appropriately and safely care for residents while following current (and evolving) guidelines. SNFs and ALFs may also limit the number of residents they will admit and some may decline to accept COVID-19 positive patients, for fear of causing an outbreak. *Rainer Support Letter*. These are the same types of effects PruittHealth expects to see when dealing with other infectious diseases.

In addition to providing an alternative care option for patients, an HHA with specific expertise in treating patients with infectious diseases will be a valuable partner to SNFs and ALFs that refer patients to HHAs. As one nursing home administrator in Charlotte commented:

> As a skilled nursing provider, my facility is acutely aware of the changing landscape of healthcare and, in particular, COVID-19 and the rapidly increasing prevalence in this market. We have referred many patients to home health agencies in Mecklenburg and surrounding counties since the pandemic begun and can attest

[27] https://homehealthcarenews.com/2020/06/predicting-covid-19s-long-term-impact-on-the-home-health-care-market/.

[28] https://files.nc.gov/covid/documents/dashboard/Weekly-COVID19-Ongoing-Outbreaks.pdf.

> to the fact that some agencies cannot treat these patients due to a lack of resources. Therefore, I have the unique ability to see what options are available on the home health front and what resources limit the care that they can provide.
>
> All of the above leads me to the PruittHealth petition and their desire to add a specialized home health agency. Such an agency focusing in the treatment of those with infectious diseases is greatly needed in this market as COVID-19 cases continue to surge in Mecklenburg County. A new home health agency like this would serve to help mitigate this need and would be able to treat future patients should a pandemic like this one occurs again in the future.

See Letter dated July 21, 2020 from Maher Chaik-Oughli, the Administrator for Wilora Lake Healthcare Center, attached as Exhibit C.

(b) Demand Model of Projected COVID-19 Related Post-Acute Care Patients

The crisis is unfolding in real time, with no end in sight. Currently, no North Carolina agency is tracking the number of recovered, hospitalized COVID-19 patients who are receiving post-acute care from an HHA.

Nevertheless, PruittHealth has developed a model to project demand for Medicare-certified HHA services in light of the pandemic. A recent analysis in *Health Affairs*[29] attempted to estimate the demand for post-acute care following the SARS-CoV pandemic in the early 2000s. The article, attached as Exhibit D, states:

> Given lack of epidemiological data on COVID-19 patients requiring postacute care, we estimated postacute need for COVID-19 by examining SARS-CoV, a viral respiratory infection that had similar rates of severe respiratory complications, albeit a higher case fatality rate. In the SARS-CoV epidemic in the early 2000s, approximately 3 percent of survivors required inpatient rehabilitation (provided by SNFs) and 46 percent of patients required any type of rehabilitative service (such as outpatient programs).

Using this data, PruittHealth utilizes the outpatient rehabilitative rate of 46 percent referenced above to project the need for additional HHA services:

[29] *See* Arora *et al*. How Will We Care for Coronavirus Patients After They Leave The Hospital? By Building Postacute Care Surge Capacity, *Health Affairs* (April 13, 2020).

TABLE 5
Mecklenburg County Estimated COVID-19 Patient Post-Acute Care Need

	Description	Value	Note
A	Reported COVID-19 Patients	17,151	Data for July 21, 2020
B	Hospitalized Patients	858	1 in 20 Hospitalized
C	COVID-19 Deaths	182	Data for July 21, 2020
D	Average Hospitalized COVID-19 Patients	190	For the Previous Week
E	Recovered COVID-19 Patients	**486**	E = B - C - D
F	Recovered COVID-19 Patients Discharged to Home Health	46.0%	Per Health Affairs
G	COVID-19 Home Health Patients	**224**	G = E x F
H	Proposed 2021 SMFP Home Health Patient Deficit	**523.9**	2021 Proposed SMFP, Page 243
I	Revised Home Health Patient Deficit	**747.9**	I = G + H
J	325 Patient Deficit Threshold	**325**	Per Methodology Step 14
K	Revised Home Health Agency Need	**2.3**	K = I / K

Source: A, B, C, D = Mecklenburg County COVID-19 Data for July 19, https://www.mecknc.gov/news/Pages/Mecklenburg-County-COVID-19-Data-for-July-19.aspx.

As shown above, the revised HHA need in Mecklenburg County based on July 21 data, factoring in the impacts of COVID-19, results in a need for 2.3 new HHAs for the 2021 SMFP. As shown previously, the number of COVID-19 cases in Mecklenburg County has risen substantially between July 21 and July 28 (+2,556 cases in 7 days).

(c) PruittHealth's expertise addressing COVID-19 needs

While some long-term care facilities may decline to accept COVID-19 patients, it is also foreseeable that other long-term facilities may convert to COVID-19 only facilities, at least in the short term, so that COVID-19 and non-COVID-19 patients are not located in the same facility.[30] In fact, PruittHealth is already ahead of that curve and has converted its SNF in High Point, PruittHealth – High Point, to a COVID-19 facility, which it will operate as such for the exclusive use of COVID-19 patients for as long as necessary.[31]

PruittHealth has been at the forefront of serving patients, including COVID-19 positive patients, recovering patients and those without the virus, since the beginning of this pandemic. Because of this immersion, PruittHealth has adapted to this "new normal" and developed specific, highly effective clinical protocols that are among the top in the industry in keeping patients and healthcare providers safe while promoting recovery with excellent clinical outcomes. *See Rainer Support Letter*.

[30] *See* L. Dafny and S. Lee, Designating Certain Post-Acute Care Facilities As COVID-19 Skilled Care Centers Can Increase Hospital Capacity And Keep Nursing Home Patients Safer, *Health Affairs Blog,* April 15, 2020, Exhibit E.

[31] https://www.wxii12.com/article/high-point-nursing-home-that-was-converted-to-treat-coronavirus-patients-now-caring-for-three-people-with-covid-19/32588565. PruittHealth-High Point is licensed for 100 SNF beds; its capacity will be reduced to 24 patients as a COVID-19 only facility.

For example, PruittHealth implemented and operates a unique, 24-hour per day, 7 day per week Emergency Operations Center providing care, support and a transparent medium that connects residents to their loved ones.[32] PruittHealth utilizes stringent infection control guidelines in its facilities and home care visits, including the proper use of personal protective equipment to ensure effective infection control and prevention to eliminate the spread of COVID-19 and other illnesses between patients and facilities. PruittHealth has implemented enhanced education and training among staff on these critical protocols as well as enhanced screening and surveillance of staff and patients to ensure the same. PruittHealth has dedicated certain staff (who have volunteered for this role) to treat only those with or recovering from COVID-19 and not patients unaffected by this virus to ensure no cross-contamination among populations. PruittHealth has also implemented the use of telehealth visits where possible and utilizes technology to connect patients and residents with family members through video visits and chats—a measure that has become critical in ensuring the mental and emotional health of all individuals during this time of severe isolation. *See Rainer Support Letter.*

PruittHealth's Rapid Hire program is another innovative initiative that the company has launched in response to the shortage of available nurses as a result of the pandemic. Through Rapid Hire, PruittHealth trains individuals throughout the community to become certified nursing assistants ("CNA"). Program participants are paid as full-time employees during the training and they are guaranteed a CNA position with PruittHealth upon completion of the training.[33]

PruittHealth has also consistently provided its complete array of services to *all* patients amid the pandemic, including the full complement of therapies and in-home treatments. *See Rainer Support Letter.* It is PruittHealth's understanding that this is not true for all HHAs where certain therapy and/or other services are not being provided to COVID-19 patients or any patients. To this point, PruittHealth has learned that there are a number of HHA providers in Mecklenburg County who are unable to provide any care to COVID-19 patients for a number of reasons, including unavailability of staff and/or equipment. This phenomenon serves to reduce the supply of resources at a time when demand for those resources is the greatest.

While the above-referenced responses have been specific to COVID-19, they are demonstrative of PruittHealth's larger ability to meet and address need created by unexpected healthcare circumstances such as infectious disease pandemics. PruittHealth's ability to respond is easily adaptable to any such similar circumstances that may develop in the future.

(d) Need to support hospitals through collaborative approaches

Long before COVID-19, home health care experts advocated that well-designed home health care programs can help reduce average length of stay and avoid hospital stays in certain situations.[34] Collaboration between hospitals and HHAs is increasingly important as hospitals

[32] http://www.pruitthealth.com/emergency-preparedness.
[33] http://www.pruitthealth.com/rapid-hire.
[34] *See* Landers *et al.*, The Future of Home Health Care: A Strategic Framework for Optimizing Value, *Home Health Care Management & Practice* (Oct. 5, 2016) (copy attached as Exhibit F).

face capacity constraints and adjust to changing demands and protocols brought on by COVID-19.

On June 18, 2020, the Advisory Board published an article, 5 Ways Hospitals Can Boost Capacity Through Home Health, (copy attached as Exhibit G), which explores innovative hospital-home health collaborations that are better for patients, reduce cost, and help hospitals manage their capacity. Examples include SNF-at home programs, discharges of lower-acuity patients presenting in the emergency department directly to home through an enhanced home health program, and hospitalization at home programs. The article concludes:

> The successful management of low-acuity acute and post-acute care needs of patients in the home presents a good option for reducing unnecessary hospital days and avoiding risky transitions to facility-based care - and it can be achieved through a coordinated approach between hospitals and their home health partners.

Exhibit G, page 3.

A July 18, 2020 article from the *New York Times*, A COVID-19 Lesson: Some Seriously Ill Patients Can Be Treated At Home (Exhibit I) provides one example of how this works in practice. Northwell Health, a large system in the metropolitan New York area, developed "wraparound" home health services to keep patients out of the hospital or from returning to the hospital post-discharge from COVID-19. The article notes:

> So-called wraparound home care services were created, on the fly, by Northwell Health to deal with the surge in coronavirus cases that New York experienced this spring. Now this model may help relieve health systems in the Sun Belt and other parts of the United States, where rising numbers of cases are putting extraordinary pressure on hospitals, filling intensive care units and sending providers scrambling to hire extra nurses and secure medical supplies.
>
> Northwell doctors are already discussing the program with physicians in Miami, where several hospitals have reached capacity. . . . Now Northwell is expanding the program, in preparation for a potential uptick in cases in New York. 'If there is a resurgence in New York, on a dime we can get this up and running in huge numbers, and other cities can do this, too," Dr. Lister said. 'It's a win for the patient and win for the health system.'

Exhibit I, pages 1-2.

(e) Need to support patients post hospitalization and post discharge from SNFs

Elderly patients hospitalized with COVID-19 are more likely to have underlying conditions such as diabetes and heart disease.[35] When they are discharged from the hospital after receiving treatment for COVID-19, they will still have these underlying conditions plus a range of other health concerns, such as respiratory issues. Especially for elderly seniors who lack a support system, managing a complex set of discharge instructions and myriad medications can be overwhelming. Home health plays a vital role in continuing the healing process and managing the transition from one care setting to another. An April 13, 2020 *Health Affairs* blog post (attached as Exhibit D) observes:

> HHAs will need to ramp up capabilities to provide home-based rehabilitative services for patients recovering from COVID-19. This will require loosening restrictions on HHA eligibility and the developing novel care models that bring into the home a relatively high intensity of services that traditionally can only be provided in inpatient rehabilitation facilities and SNFs. While the new Patient Driven Payment Model reimbursement methodology for SNFs and HHAs that debuted last fall will appropriately shepherd resources to high-need patients recovering from COVID-19, additional reimbursements may be needed to cover the physical, occupational, and respiratory therapy needs of this population. These SNF-level services will need to be provided daily over weeks to months so that COVID-19 patients will be able to recover at home without risking viral transmission to other patients in a postacute care facility.[36]

The same concerns exist for COVID-19 patients who are discharged from hospitals to SNFs and then to home. Their underlying medical conditions will still exist, and their needs may be greater as a result of the damage caused by COVID-19. While much is unknown about the long-term effects of coronavirus, researchers are beginning to see evidence that the impact of the virus is not limited to the lungs; it may also affect other major organs such as the heart, kidneys, pancreas and brain.[37] Thus, PruittHealth anticipates that COVID-19 patients discharged from hospitals or SNFs are likely to be even more medically complex and require a more intense level of home care. *See Rainer Support Letter*.

This means that Mecklenburg County not only needs more home health resources, but also resources that have the expertise to serve this higher acuity population.

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[35] https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm.

[36] *See* Exhibit D.

[37] https://www.nbcsandiego.com/news/local/scientists-uncover-long-term-effects-of-covid-19-virus-attacks-vital-organs/2358577/. *See also* What we know (so far) about the long-term health effects of Covid-19, https://www.advisory.com/daily-briefing/2020/06/02/covid-health-effects.

iii. The Value of Cost-Effective Medicare-Certified Home Health

While patient safety, quality care, access and choice are of paramount concern and serve as core principles for this Petition, the cost savings attributable to home health cannot be discounted.

Medicare-certified home health is a covered service for homebound patients under either Part A or Part B of the Medicare benefit. It consists of part-time, medically necessary, skilled care (nursing, physical therapy, occupational therapy, and speech-language therapy) that is ordered by a physician.[38] Patients receive services such as cardiac and pulmonary care, neurological rehabilitation, intravenous therapy, wound care, pain management, chronic disease care, medication management, and physical therapy.[39] Because of the level of skilled nursing provided, Medicare-certified home health care is distinct from homemaker services, such as shopping, cleaning or laundry or custodial or personal care services such as bathing, toileting, and dressing, when those are the only services needed.[40] Patients needing Medicare-certified home health generally fall into two categories: 1) those who are recovering from a prior hospitalization and recovering from acute injury or illness; and 2) those who need help managing chronic conditions such as diabetes, heart disease, COPD, CHF, and cancer. Infectious disease patients may fall into both categories.

In 2018, there were 11,869 Medicare certified home health agencies throughout the United States. These agencies served 5,125,575 beneficiaries through 7,228,721 episodes of care.[41] The Partnership for Quality Home Health ("PQHH")[42] has observed that Medicare home health beneficiaries tend to be "older, sicker, and poorer than all other beneficiaries."[43] Data collected by Avalere Health[44] shows the following:

[38] https://www.medicare.gov/coverage/home-health-services. Under Section 3708 of the CARES Act, Public Law 116-138, signed into law on March 27, 2020, nurse practitioners, clinical nurse specialists, and physician assistants are now authorized to order Medicare home health, in a manner consistent with state law.
[39] http://pqhh.org/wp-content/uploads/2019/01/What_is_Home_Healthcare_2019.pdf.
[40] https://www.medicare.gov/coverage/home-health-services.
[41] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits.
[42] PQHH was established in 2010 to work in partnership with government officials to ensure access to quality home healthcare services for all Americans. http://pqhh.org/about-us/. PruittHealth is a member of PQHH.
[43] http://pqhh.org/wp-content/uploads/2019/01/PQHH_HHValueKit_2019.pdf, p. 5.
[44] Avalere Health, LLC is a Washington DC based consulting firm. Each year, it prepares a Home Health Chartbook analyzing Medicare data. Table 6 is found on page 12 of the 2019 Chartbook at https://www.ahhqi.org/research/home-health-chartbook. The 2019 Chartbook analyzes 2016 data.

TABLE 6
Avalere Health Medicare Beneficiary Demographics

	All Medicare Home Health Users	All Medicare Beneficiaries
Age 85+	25.6%	11.0%
Live alone	37.8%	29.0%
Have 3 or more chronic conditions	80.5%	58.9%
Have 2 or more ADL limitations*	27.8%	10.4%
Report fair or poor health	46.2%	24.6%
Are in somewhat or much worse health than last year	38.4%	19.4%
Have incomes at or under 200% of the Federal Poverty Level (FPL)**	64.0%	46.8%
Have incomes under 100% of the Federal Poverty Level (FPL)**	27.5%	19.2%

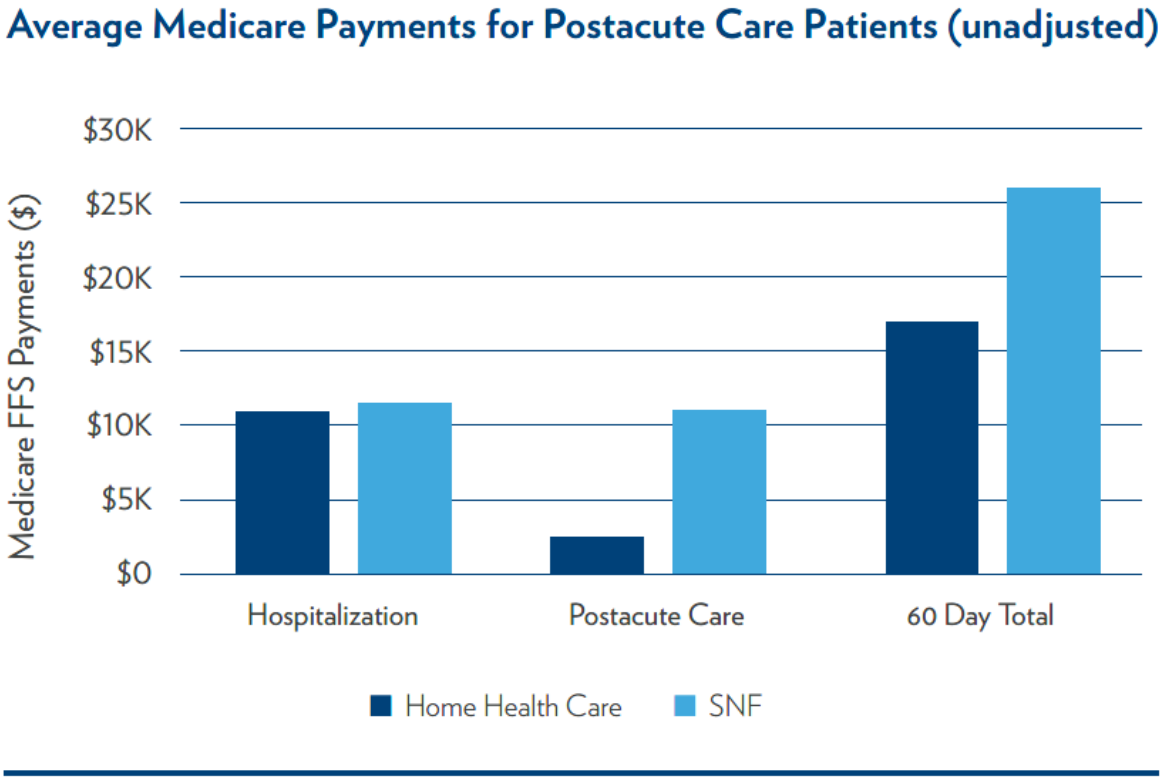
The Alliance for Home Health Quality and Innovation[45] has observed that in North Carolina, Medicare home health users "are typically much sicker than the general Medicare population" with 90.59% suffering from 3 or more chronic conditions.[46]

There can be no doubt that home health services are effective in the delivery of skilled medical care to patients. According to the Centers for Medicare and Medicaid Services, "[h]ome health care is usually less expensive, more convenient, and can be just as effective as care you get in a hospital or skilled nursing facility."[47]

Studies show that compared to skilled nursing care, home health care is drastically less expensive. A 2018 study revealed that post-acute care cost was significantly lower for patients discharged to home health (an average savings of $5,385 per beneficiary) as was the total Medicare payment within the first 60 days following hospital admission, with average savings of $4,514 per beneficiary.

[45] The Alliance is a non-profit organization that pursues a mission of leading and sponsoring research and education on the value home health provides to patients and the entire U.S. health care system. Its members include the Partnership for Quality Home Healthcare. https://www.ahhqi.org/about/history.
[46] https://www.ahhqi.org/images/pdf/states/NC-brief.pdf.
[47] https://www.medicare.gov/Pubs/pdf/10969-Medicare-and-Home-Health-Care.pdf. *See* page 4.

TABLE 7
Medicare Payment Comparison



Source: https://ldi.upenn.edu/brief/patient-outcomes-after-hospital-discharge-home-home-health-care-vs-skilled-nursing-facility.

The cost savings per beneficiary is $5,411 when home health is utilized as the first post-acute care setting after a patient receives a major joint replacement.[48] Major joint replacement readmissions are also lower for HHAs, compared to SNFs.[49]

The value of home health is also evident in other ways. For example, patients in high quality home health and home-based care programs have experienced 26% fewer acute care hospitalizations, 59% fewer hospital bed days, and 19-30% total medical cost savings.[50] The contribution of home health to the overall economy is also significant. According to a 2019 study by Avalere Health, in 2018, the home health industry created more than 66,000 jobs in North Carolina and the annual economic labor impact of the home health payroll in North Carolina was more than $2 billion.[51]

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[48] http://pqhh.org/wp-content/uploads/2019/01/PQHH_HHValueKit_2019.pdf (citing data).

[49] For example, in DRG 469, major joint replacement or reattachment of lower extremity with major complication or comorbidity, the readmission rate in 2018 for HHAs was 8.5% compared to 16.1% for SNFs. In DRG 470, major joint replacement or reattachment of lower extremity without major complication or comorbidity, the readmission rate in 2018 was 4.1% for HHAs compared to 7.6% for SNFs. *See* Avalere Health, Home Health Chartbook 2019, https://www.ahhqi.org/research/home-health-chartbook at pp. 58-59.

[50] http://pqhh.org/wp-content/uploads/2019/01/PQHH_HHValueKit_2019.pdf (citing statistics)

[51] *See* Avalere Health, Home Health Chartbook 2019, available at https://www.ahhqi.org/research/home-health-chartbook at pp. 52-53.

Recognizing the vital role home health plays in keeping vulnerable, homebound people safe and healthy, CMS has demonstrated regulatory flexibility with respect to home health during the COVID-19 pandemic, including use of telehealth, expanding the definition of "homebound," allowing nurse practitioners and physician assistants to order Medicare home health services, and measures to expedite the discharge planning process.[52] While more regulatory relief is needed in both the short and long term, the changes made thus far recognize the importance of home health in the overall delivery system and it is reasonable to expect such additional regulatory relief will be coming in the future.

If this Petition is not approved, residents of Mecklenburg County will be adversely impacted. Mecklenburg County has had more COVID-19 cases and deaths than any other county in North Carolina. Even without factoring in the impact of COVID-19, the population of Mecklenburg County is growing and aging. While everyone hopes that we will not experience another pandemic like COVID-19, the reality is that infectious diseases will always be present, and we must be prepared to address future outbreaks. Expanded home health should be encouraged because it allows people to receive needed care in their homes, reduces cost and also frees up capacity for hospitals.[53]

b. A statement of alternatives to the proposed adjustment that were considered and found not feasible.

PruittHealth considered not filing this Petition and simply leaving the need determination for one Medicare-certified HHA in the 2021 SMFP in Mecklenburg County "as is." After careful review and analysis, PruittHealth respectfully submits that approach is not feasible and that the 2021 SMFP should contain a need for two Medicare-certified HHAs in Mecklenburg County. As demonstrated in this Petition, advanced planning at this critical juncture is necessary so that North Carolina's largest county does not fall behind in having adequate resources in place to address the needs of the aging and sick population with cost effective, safe and quality at-home skilled nursing services. It is imperative that in this "new normal" of global pandemics, our healthcare system makes the necessary adjustments to care delivery now so that we will be prepared and able to work collaboratively across the health care continuum to provide patients with the choice of care that each deserves, regardless of their age, race or financial situation.

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[52] https://www.cms.gov/files/document/covid-home-health-agencies.pdf. (7/9/20) and https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf (6/25/2020). While it is unknown at this time how long the regulatory flexibility will continue, CMS Administrator Seema Verma has indicated that the telehealth waiver may become permanent. https://www.whitehouse.gov/briefings-statements/record-press-call-presidents-action-protect-seniors-diabetes/ (May 26, 2020). Home health providers do not receive direct reimbursement for telehealth, however. https://www.aging.senate.gov/imo/media/doc/SCA_Landers_05_21_20.pdf.

[53] *See* Exhibit H, attached hereto.

4. Evidence that health service development permitted by the proposed adjustment would not result in unnecessary duplication of health resources in the area.

If approved, this Petition will not result in the unnecessary duplication of services. Rather, it will help address a growing need to serve a growing segment of the population, as demonstrated by the data in this Petition.

5. Evidence that the requested adjustment is consistent with the three Basic Principles governing the development of the North Carolina State Medical Facilities Plan: safety and quality, access and value.

The requested adjustment is consistent with the three Basic Principles. This petition is grounded in the belief that patients who have an option to remain in the homes will want to do so. Home health can be provided safely and effectively, and at much lower costs than SNF or hospitalization. Notably, under CMS's new payment model for home health services implemented effective January 1, 2020, known as the Patient Driven Groupings Model ("PDGM"), the volume of therapy visits as a payment level determinant cannot be used as a basis for payment. Episodes of care were also reduced from a 60-day unit to a 30-day unit.[54]

Conclusion

While the COVID-19 crisis shines a spotlight on the importance and value of home health care, the need for more home health resources in North Carolina's largest county will endure long after a vaccine for COVID-19 becomes available. To prepare for future infectious disease outbreaks, it is essential that North Carolina be proactive in addressing future needs of the home health population, most of whom are elderly, suffer from multiple chronic conditions, and have limited resources.

PruittHealth respectfully requests that the SHCC include a need for two Medicare-certified home health agencies in Mecklenburg County in the 2021 SMFP. The second HHA should have a specialized focus on serving patients with infectious diseases. PruittHealth appreciates the SHCC's time and consideration of this Petition.

[54] http://pqhh.org/the-issues/.

EXHIBIT A

PruittHealth
Committed to Caring

July 29, 2020

To the North Carolina State Coordinating Council

Re: ***Petition by PruittHealth, Inc. for an Adjusted Need Determination to Add One Medicare-Certified Home Health Agency in Mecklenburg County in the 2021 SMFP, for a total of two Medicare-Certified Home Health Agencies in Mecklenburg County in the 2021 SMFP***

Dear Members of the State Health Coordinating Council:

I serve as the Chief Clinical Officer for PruittHealth and write to you today in support of PruittHealth, Inc.'s ("PruittHealth") Petition (the "Petition") for an adjusted need determination in the 2021 SMFP for a second Medicare-Certified Home Health Agency ("HHA"). I have served in this position since January 2019; however, I have been a part of the PruittHealth team since 2008. I previously served as Executive Director of Clinical Reimbursement and then as Senior Vice President of Clinical Reimbursement. In my role as Chief Clinical Officer, I am responsible for developing, implementing and ensuring compliance with best practice clinical standards and protocols across the PruittHealth network and its partners. I oversee our clinical staff including staff at our skilled nursing facilities, hospice and assisted living facilities, continuing care retirement community, and our HHAs. I am a graduate of N.C. State University. I began my career as a speech-language pathologist where I enjoyed improving the lives of our most vulnerable citizens. I have recently completed a dual master's program at Georgia State University Robinson School of Business where I earned both an MBA and an MHA. In total, I have spent more than 20 years serving the post-acute care industry.

PruittHealth strongly supports the current need determination for one additional HHA in Mecklenburg County in the 2021 SMFP. However, for the reasons explained in this letter and in our Petition, PruittHealth respectfully requests a need determination for a second HHA in Mecklenburg County in the 2021 SMFP. This HHA should have a particular focus on treating patients with infectious diseases, including but not limited to COVID-19. The COVID-19 pandemic has profoundly changed health care delivery and has emphasized the need for greater access to safe and affordable care provided in the home, where there is less risk of exposure to infectious diseases. The population that uses Medicare-certified home health services the most is the 65 and over population. This population is growing rapidly in Mecklenburg County, and has been especially impacted by the pandemic. Most of these patients are medically complex and suffer from multiple comorbidities, such as diabetes, heart disease, chronic obstructive pulmonary disease (COPD) and asthma. The need this population has for safe and affordable home health

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will endure beyond the immediate crisis, and it is critical that North Carolina's largest county take steps now to prepare for the future and protect this vulnerable population.

Pruitt Health's Home Health Care Experience

PruittHealth has provided expert home health services since 2001. Its mission is unity in care: "Our family, your family, ONE FAMILY." That extended family includes over 170 provider locations throughout North Carolina, South Carolina, Georgia and Florida. PruittHealth has been serving North Carolina communities for over 24 years and currently operates eight (8) Medicare-certified HHAs in this State.

PruittHealth's home health care model utilizes an integrated approach known as PerfectPath, which utilizes best practices treatment protocols for common home health care conditions and challenges. This approach is comprehensive and systematic and relies upon relationships with local healthcare providers to ensure access to services and improve outcomes for its HHA patients. PruittHealth is accredited by The Joint Commission and has implemented its own system-wide quality improvement initiatives, including Strategic Healthcare Programs and proprietary surveys to measure quality outcomes as well as patient and staff satisfaction. PruittHealth regularly tracks performance standards in order to promote transparent accountability with its care teams. It utilizes advanced technology including the Homecare Homebase point-of-care electronic medical system that ensures compliance with all required standards and efficiencies in staffing and telemonitoring to monitor and access patients remotely.

PruittHealth delivers a range of home health services to the vulnerable, and often aging, population, including IV and infusion therapy services (like chemotherapy), chronic disease management services, heart failure, stroke, joint replacement and COPD services, dietary and nutritional services, behavioral and mental health services like memory care, wound care services, palliative care, and specialized therapies, among many, many others.

COVID-19

The impact of COVID-19 has been especially severe in Mecklenburg County, which leads North Carolina in cases and deaths. This is especially true for our most vulnerable populations who are typically receiving home health services, particularly those ages 65 and older and those with multiple comorbidities. This population is often economically underserved as well. From the outset, PruittHealth has made it our priority to address the needs of our patients and to stay on the cutting edge of clinical initiatives intended to ensure positive outcomes and exceed the expectations of the families we serve.

While initially PruittHealth experienced some decreases in the utilization of its home health services due to decreases in hospital procedures that generate post-acute home health visits, such as joint replacement surgeries, and patients' reluctance to seek or continue needed services in some cases (which was common throughout the industry), recent trends have shown that tide has changed. Current trends are now showing an increase in the utilization of home health services, particularly with the age 65 and older population, with that trend expected to continue increasing for the foreseeable future.

At the same time, capacity at other non-hospital-based facilities is decreasing. Skilled nursing facilities have new limitations placed on the ability to serve patients in shared rooms and new isolation procedures and requirements for newly admitted patients who may have had or have COVID-19. These new standards, derived from the Centers for Disease Control ("CDC") guidelines, have led to decreased capacity at these facilities even though certain patients, such as those leaving a hospital, still require skilled nursing or therapeutic care. Those patients will need to seek care elsewhere, such as at home.

Additionally, it has been our experience through talking with patients, their families, and colleagues in the industry, that many individuals are now seeking out home care services more than ever before as a safer alternative to receiving treatment at hospitals or congregate living facilities. While initially some patients were fearful and perhaps even delayed receiving necessary care for fear of getting sick, more recent trends show us that patients and their families now prefer to receive in-home care where feasible, rather than go outside the home or to a congregate living facility for the very same reason—fear of getting sick outside the home.

More importantly, however, these trends and desires of patients are supported by the outcomes that PruittHealth has experienced during this most challenging time. By all measures, patient outcomes have either been maintained or improved during the pandemic, as demonstrated by the fact that PruittHealth facilities most recently earned four or five star CMS Home Health Care Quality ratings. PruittHealth's innovative responses, addressed in greater detail below, are working.

PruittHealth's Response to COVID-19

COVID-19 has dramatically changed the landscape of healthcare and the delivery of services to our most vulnerable populations, likely forever. In response to both our immediate circumstances and to address future infectious disease outbreaks or other health care crises, PruittHealth has established a dedicated Clinical Leadership team to focus on that very issue. This team has made PruittHealth a leader among its peers at caring for patients with infectious diseases, including those who have or are recovering from COVID-19. Among the initiatives we have implemented are:

- Dedicated COVID-19 Treatment Facility: In May 2020, PruittHealth converted its SNF in High Point into a facility exclusively dedicated to serving COVID-19 patients. We are not aware of any other SNF in North Carolina doing this. As such, PruittHealth has developed a particular clinical and administrative expertise in handling these complex and fragile patients and ensuring positive outcomes for them.

- Emergency Operations Center: Our unique Emergency Operations Center serves as PruittHealth's centralized command center connecting patients, providers, families and partners with real-time information and immediate responses. Operating 24 hours per day, 7 days per week, the Emergency Operations Center is staffed by nurses for each type of facility (hospice, HHA, etc.), who have access

to patient records and are there to answer questions, provide guidance and connect families and resources to ensure continuity of patient care. Nursing staff at facilities are focused on additional safety requirements and protocols that did not previously exist and which often keep nursing staff away from the nurses' station where they can answer telephone calls from concerned family members or provider partners. The Emergency Operations Center allows nurses to focus on hands-on patient care and treatment while other dedicated nursing staff work with patients' families and partners to provide critical information, updates and answer questions. The Emergency Operations Center's purpose to keep everyone informed, connected and to ensure that every voice and every concern is heard and addressed in real-time. As of this date, it has served approximately 26,000 calls.

- Full service array for complex patients: PruittHealth treats complex patient comorbidities and is able to provide intravenous and infusion therapy, wound care, and other skilled nursing care for high acuity patients. During this pandemic, PruittHealth has continued, and will continue, to provide its full range of services to patients, including all necessary therapies. This is unlike certain other HHAs who are either unwilling or unable to provide such services for patients.

- Infection protection and prevention: PruittHealth has enhanced its education and training procedures for team members and those it serves to ensure that personnel and partners are kept up-to-date with rapidly evolving safety requirements and best practices to prevent the spread of infection. This also includes regular screening and testing of staff as well as the appropriate use of proper personal protective equipment. PruittHealth is in the process of implementing its own rapid, in-house testing laboratory to meet this continuing need.

- Dedicated Staffing: PruittHealth has dedicated nursing and clinical teams in place to treat patients based on the patient's COVID-19 status. Those staff members treating patients testing positive for COVID-19 do not treat other patients so as to prevent the spread of disease.

- Rapid Hire Program: Launched in response to the shortage of nurses available during the pandemic, PruittHealth designed a system to ensure ample, qualified nursing staff are available at all times and at all facilities so that there are no shortages and that all patient needs are timely met. Through this program, PruittHealth trains individuals to become certified nursing assistants and compensates them as full-time employees through their training. They are guaranteed positions with PruittHealth upon completion of the training program.

- Telehealth: PruittHealth currently provides weekly Caring Calls—telephonic check-in calls between patients and a nurse to address concerns and to make sure proper clinical pathways are being followed for patients' unique needs.

- Communication with Family: PruittHealth works with patients and their families to arrange regular communications using iPads so that loved ones can stay connected during these trying times when in-person visits are not possible. PruittHealth is working towards an on-line signup system for these calls to be implemented in the near future.

These initiatives are among the qualifications that an HHA with a focus on infectious diseases should provide. Because of its experience and commitment to patients during this pandemic and over its more than fifty years in operation, PruittHealth is uniquely poised to address the future long-term healthcare needs of the communities it serves. PruittHealth's proven leadership serves as a foundation and example to providers and it is more than prepared to meet the needs for the home health care patients in the future as those needs evolve and expand.

This is a critical time for our health care system, as all providers grapple with the effects of COVID-19. While much is still unknown, it is clear that greater emphasis needs to be placed on improving access to home health care for our most vulnerable citizens, as care provided in the home is a safe and cost-effective option for many patients. This is true regardless of when a vaccine for COVID-19 becomes widely available. The population of Mecklenburg County is growing and aging, and while we all hope the COVID-19 pandemic ends soon, the challenge of addressing infectious diseases safely and effectively will remain indefinitely. I urge the SHCC to vote in favor of PruittHealth's Petition and include a need determination for two HHAs in Mecklenburg County in the 2021 SMFP. The second HHA should have a particular focus on caring for patients with infectious diseases.

Thank you for your consideration.

Sincerely yours,

Francine Rainer
Chief Clinical Officer
PruittHealth, Inc.

FR/

EXHIBIT B

HOME HEALTH CARE

Long-Term Care Decision-Makers More Likely to Choose Home Care in COVID-19 Aftermath

By **Andrew Donlan** | June 3, 2020

Share

Family health care decision-makers have followed the devastating effects that the COVID-19 virus has had on the long-term care facilities. That experience is now pushing them toward home-based care, new data suggests.

Over 50% of family members are now more likely to choose in-home care for their loved ones than they were prior to the coronavirus, according to a recent survey from health care

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July 23, 2020

MEDICARE

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July 23, 2020

EXHIBIT B

research and consulting firm Transcend Strategy Group.

As part of its survey, Transcend reviewed feedback from about 1,000 respondents, all of whom were family health care decision-makers. Broadly, those decision-makers were more likely to be women between the ages of 40 and 45 years old.

"One of the biggest takeaways ... was that 65% of respondents agreed that COVID-19 had completely changed their perception about the best way to care for aging seniors," Stan Massey, a partner at Transcend Strategy, said Wednesday during a National Association for Home Care & Hospice (NAHC) webinar. "I'll give you a little spoiler alert: That mind-shift has landed squarely in the favor of home-based care providers."

Nearly half of survey participants said they had previously considered placing a loved one in a long-term care facility in the future, but have now taken that option off the table.

Additionally, despite the home-based care arena's own struggles with procuring personal protective equipment (PPE), survey respondents were still overwhelmingly confident that in-home caregivers were following necessary protocols during COVID-19.

HOME HEALTH CARE

Androscoggin CEO Ken Albert: COVID-19 Has Caused a Complete Shift in Our Operational Paradigm

July 22, 2020

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2020 Home Health Care News Outlook Survey and Report

On the heels of the Patient-Driven Groupings Model (PDGM) taking effect, the in-home care market is forging a new path ahead in 2020.

Growing Home Health Admissions and the Bottom Line: A Case Study with Intrepid USA

Within today's regulatory climate and changing payment landscape, home health care agencies are

EXHIBIT B

In all likelihood, the shift in thinking is not temporary. Within the survey, respondents suggested that their perception of the long-term care options had been changed for good.

"COVID-19 has changed opinions from this point forward," Massey said. "It had such an impact on families that we feel this ripple effect of really wanting to take every precaution, even if a vaccine for COVID-19 does emerge."

The concerns are driven, in large part, due to the staggering death toll in facilities across the U.S. Newly released federal statistics show nearly 26,000 people have died from COVID-19 in nursing homes through May.

Family decision-makers' newfound appreciation of home-based care will likely offer future opportunities for providers looking to grow their businesses.

LHC Group Inc. (LHCG) Chief Strategy and Innovation Officer Bruce Greenstein echoed a similar sentiment Tuesday during a presentation at the Jefferies Virtual Healthcare Conference.

"[The coronavirus is going to change] the psyche of the way people are going to view ... long-term care facilities for the rest of our generation," Greenstein said.

Harnessing momentum

tasked with finding new paths toward growth.

EXHIBIT B

In tandem with family members' bullishness on home-based care is their increased interest in the value of telehealth.

Over 60% of individuals who participated in the Transcend survey said they're likely to explore telehealth options in the future.

Telehealth claim lines in the U.S. increased 4,347% between March 2019 and March 2020, according to FAIR Health's Monthly Telehealth Regional Tracker. A claim line is an individual service listed on an insurance claim.

Though the Centers for Medicare & Medicaid Services (CMS) has not yet authorized the ability for home-based care agencies to be reimbursed for telehealth as they would be for in-person visits, restrictions on remote patient monitoring have been eased. The agency has loosened some of the red tape surrounding

EXHIBIT B

virtual care and has encouraged its use during the COVID-19 outbreak.

"When the restrictions started being [removed] off of telehealth, we really thought that it was like letting the genie out of the bottle. And it's only going to improve from here," Massey said.

Even if a provider is unable to bill for telehealth services, having good telehealth practices in place could increase the likelihood of a client initiating care plans with them.

"Even if you're not able to be reimbursed for the delivery of care through telehealth, be thinking holistically about how you deliver adjacent values," Transcend CEO Stephanie Johnston said on the webinar. "There's a lot more openness and flexibility within the regulatory framework now for home health providers to get really creative and innovative."

Companies featured in this article:

Centers for Medicare & Medicaid Services, CMS, NAHC, National Association for Home Care & Hospice, Transcend Strategy Group

Andrew Donlan

Before becoming a reporter for HHCN, Andrew received journalism degrees

EXHIBIT C

Wilora Lake Health Care Center

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July 21, 2020

North Carolina State Health Coordinating Council
NC Division of Health Service Regulation
809 Ruggles Drive
Raleigh, North Carolina 27603

Subject: Addition of a Home Health Agency Specializing in the Treatment of Infectious Diseases to the 2021 State Medical Facilities Plan

Dear Council Members,

My name is Maher Chaik-Oughli and I am the Administrator for Wilora Lake Healthcare Center located in Charlotte, NC. Our skilled nursing facility is located within the heart of the Charlotte metro service area and is very familiar with the needs of this market and how the long-term care industry is evolving. It is with that in mind that I am writing to you to express my support to allow for the addition of a new home health agency that will focus on the treatment of people with infectious diseases, specifically those with COVID-19, to the State Medical Facilities Plan for 2021.

As a skilled nursing provider, my facility is acutely aware of the changing landscape of healthcare and, in particular, COVID-19 and the rapidly increasing prevalence in this market. We have referred many patients to home health agencies in Mecklenburg and surrounding counties since the pandemic begun and can attest to the fact that some agencies cannot treat these patients due to a lack of resources. Therefore, I have the unique ability to see what options are available on the home health front and what resources limit the care that they can provide.

All of the above leads me to the PruittHealth petition and their desire to add a specialized home health agency. Such an agency focusing in the treatment of those with infectious diseases is greatly needed in this market as COVID-19 cases continue to surge in Mecklenburg County. A new home health agency like this would serve to help mitigate this need and would be able to treat future patients should a pandemic like this one occur again in the future.

I appreciate the opportunity to voice my support for PruittHealth's petition and look forward to more resources being dedicated to this and any potential future pandemics.

Thank You,

EXHIBIT C

Maher Chaik-Oughli
Administrator
Wilora Lake Healthcare Center

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EXHIBIT D

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How Will We Care For Coronavirus Patients After They Leave The Hospital? By Building Postacute Care Surge Capacity

Vishal S. Arora, Jonathan E. Fried

APRIL 13, 2020 **DOI:** 10.1377/hblog20200408.641535

The ongoing COVID-19 outbreak in the US has prompted concern that acute care hospitals lack the beds, equipment, and person-power necessary to care for a surge of

EXHIBIT D

patients. While policy makers and health care leaders have rightly focused on prevention and acute treatment, they must also work to ensure that we have the capacity to care for patients who require rehabilitation after they leave the hospital, often referred to as postacute care. Postacute care for COVID-19 survivors will be delivered by two main categories of providers: skilled nursing facilities (SNFs) and home health agencies (HHAs).

We estimate a significant shortage of available postacute care, especially for SNFs. A recent analysis projected that approximately 24 million Americans could require hospitalization and/or intensive care unit-level care over six months due to the pandemic. Given lack of epidemiological data on COVID-19 patients requiring postacute care, we estimated postacute need for COVID-19 by examining SARS-CoV, a viral respiratory infection that had similar rates of severe respiratory complications, albeit a higher case fatality rate. In the SARS-CoV epidemic in the early 2000s, approximately 3 percent of survivors required inpatient rehabilitation (provided by SNFs) and 46 percent of patients required any type of rehabilitative service (such as outpatient programs).

If we assume that survivors of COVID-19–related hospitalization will require rehabilitative services at a similar rate, and that the case fatality rate is 2.6 percent, we would expect that at least 700,000 patients will require inpatient short-stay rehabilitative care and that 10 million more may require other outpatient rehabilitative services. These estimates would change based on identification of cases with effective quarantining, actual case fatality rates, and the possibility of offering more intensive rehabilitative services to patients who are hospitalized.

Nevertheless, our estimate would overwhelm our current capacity of approximately 345,000 available SNF beds and double the current number of annual short-stay residents. This also assumes that all SNFs would accept these patients, regardless of insurance status or geographic constraints, which is unrealistic. In addition to SNFs being overwhelmed, approximately one-third of HHAs have reported that they will not have the staff or stockpile of supplies to care for patients throughout the pandemic.

Therefore policy makers and providers must answer an important question: What is the best way to expand capacity of postacute care during the COVID-19 pandemic? We recommend three strategies that should be employed to prepare our health care system for the upcoming surge in need for postacute care after COVID-19–related hospital discharges: Expand home-based postacute care offerings; train a new workforce to care for patients who are recovering from COVID-19; and designate specialized SNFs or alternative care settings specifically for patients who have suffered from COVID-19.

Expand Home-Based Postacute Care

EXHIBIT D

COVID-19 is especially deadly for chronically ill and elderly nursing home residents. In response to deadly nursing home outbreaks, many SNFs are justifiably limiting admissions. For example, one Veterans' Affairs SNF in Massachusetts (where one of us practices) has begun accepting patients for postacute care only if they have been hospitalized for more than 14 days and have not demonstrated respiratory symptoms suggestive of COVID-19. As a result, there are patients ready for discharge but in need of rehabilitative services that no one is willing to provide at this time. Universal screening of inpatients will improve delays, but millions of recovering patients may still find that no SNF will accept them. While the Centers for Medicare and Medicaid Services has smartly waived the requirement of a three-day inpatient hospital stay to qualify for SNF care reimbursement, fear of nursing home outbreaks will likely dampen the effect of this policy change. A lack of available SNF beds and the imperative to prevent exposing medically frail nursing home residents to COVID-19 necessitate the identification and development of alternative postacute care settings that allow patients to access needed rehabilitative services once they are ready to begin their recovery.

HHAs will need to ramp up capabilities to provide home-based rehabilitative services for patients recovering from COVID-19. This will require loosening restrictions on HHA eligibility and the developing novel care models that bring into the home a relatively high intensity of services that traditionally can only be provided in inpatient rehabilitation facilities and SNFs. While the new Patient Driven Payment Model reimbursement methodology for SNFs and HHAs that debuted last fall will appropriately shepherd resources to high-need patients recovering from COVID-19, additional reimbursements may be needed to cover the physical, occupational, and respiratory therapy needs of this population. These SNF-level services will need to be provided daily over weeks to months so that COVID-19 patients will be able to recover at home without risking viral transmission to other patients in a postacute care facility.

Expand The Workforce For Postacute Care

The postacute care industry is notorious for being staffed by underpaid nurses and aides. Given its relatively low wages and physically intense work, the industry is also marked by significant labor turnover. Payers and policy makers must commit to invest in this workforce if it is to remain viable. They must also realize that the personal protective equipment (PPE) shortage affects postacute care workers as well and commit to distribute PPE equitably across acute and postacute care settings.

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Although current workforce capacity is probably insufficient to meet the demands of patients recovering from COVID-19, rapid workforce development can be achieved by retraining individuals whose jobs will have disappeared or become unstable due to the upcoming economic recession. For example, employees of the travel, hospitality, and other industries that depend on in-person customer service may be well-suited to postacute care work. It is unrealistic to expect HHAs and SNFs to foot the bill for this retraining; dedicated federal funds should be committed to rapidly scale up capacity in the coming months.

Designate Specialized COVID-19 Postacute Care Sites

While home-based care is the preferred method of providing postacute care while maintaining physical distancing, it is not always clinically appropriate. Many patients struggle with unstable housing or live with frail individuals who cannot risk COVID-19 exposure. In circumstances such as these, we need to contain COVID-19 as much as possible to designated health care facilities. Some acute care hospitals in the United States and China have designated themselves as dedicated COVID-19 treatment centers, which enables standardized care and avoids further community transmission to other vulnerable groups.

We must do something similar for postacute care, where certain SNFs in the community should designate themselves as dedicated COVID-19 facilities. As testing expands, patients should also be tested at discharge and be directed to those facilities as well. Recognizing that this could mean dislocation for some patients, other community buildings such as hotels could be repurposed as postacute care sites for COVID-19 patients. Such a re-purposing approach, however, would require extensive flexibility from payers, postacute care providers, and regulators.

Conclusions

Necessity is the mother of invention, and this will apply to the postacute care providers in the COVID-19 pandemic as our country accommodates a surge in coronavirus cases. While a primary focus of policy makers has rightfully been on providing hospital care, there is still more work necessary to help patients actually recover from their illnesses. Implementing these strategies will require billions of dollars from public and payer providers, but it is absolutely necessary to protect our society's most vulnerable patient populations.

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Designating Certain Post-Acute Care Facilities As COVID-19 Skilled Care Centers Can Increase Hospital Capacity And Keep Nursing Home Patients Safer

Leemore Dafny, Steven S. Lee

APRIL 15, 2020 **DOI:** 10.1377/hblog20200414.319963

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In communities nationwide, where the peak need to hospitalize COVID-19 patients has yet to arrive, hospitals are bracing for an influx of patients that exceeds their current capacity to care for them. Some hospitals will need to convert as much capacity as possible into intensive care beds, and to discharge stable patients who still require skilled nursing to facilities willing and able to care for them. In some states hardest hit by the early wave of the virus, governors have mandated that nursing homes accept any patient regardless of COVID-19 status, raising grave and legitimate concerns among current residents.

We recommend designating specific nursing facilities as "COVID-19 Skilled Care Centers." These facilities should prepare for the influx by declining new uninfected patients effective *immediately*, and, if they cannot be well-isolated, transferring uninfected longer-term residents to other facilities.

Academic and industry experts alike have argued for specialized post-acute treatment facilities. Federal authorities have already begun paving the way for such action. On March 13, the Secretary of Health and Human Services, Seema Verma, announced relaxed criteria for Medicare-financed care delivered in nursing homes as well as for the transfer of existing patients. The goal, she stated, is "to allow hospitals to reserve beds for the most severely ill patients by discharging those who are less severely ill to skilled nursing facilities." On April 2, CMS specifically recommended designating separate nursing facilities or units within a facility for COVID-19 treatment, pointing to a Massachusetts plan to dedicate facilities for this purpose. A day later the state halted those plans as dozens of residents slated for transfer tested positive for the virus, underscoring the value of designating facilities well in advance of peak need. A data-driven approach can help local officials to quickly and transparently identify which facilities to designate as COVID-19 Skilled Care Centers.

A Data-Driven Approach To Caring For COVID-19-Positive Patients In Dedicated Skilled Nursing Facilities

We propose each metro area or state gather a limited set of data from every Skilled Nursing Facility (SNF) and construct a simple "COVID-19-Capability Scorecard." The sooner authorities can identify the best candidates for designation as COVID-19 Skilled Care Centers (CSCCs), the fewer current patients that will need to be relocated or risk exposure to COVID-19. We further propose that some combination of the Centers for Medicare and Medicaid Services (CMS) and state/local authorities fully fund the operation of these facilities (i.e. offer complete "pass-through" of costs), and provide funds to hire new staff, even as the facilities empty their beds in anticipation of the surge

projected to arrive. A significant wage increase for staff is likely appropriate under these circumstances and would be a valuable recruiting tool.

Building A COVID-19-Capability Scorecard

Based on information gathered from experts in the field, as well as our independent research on SNFs, we propose the following criteria for scoring and selecting facilities:

1. demonstrated skill and some existing staff trained to care for patients with respiratory distress and other related complications;
2. relatively few long-term residents who might require relocation;
3. significant potential capacity, so care can be provided at scale and isolation of residents without COVID-19 (and who cannot be relocated) is more feasible;
4. high operational readiness; and
5. high-quality management.

Creating a perfect scorecard is infeasible under current circumstances, but a reasonable assessment of capability to serve as a designated CSCC is possible using readily available data.

We have constructed a "COVID-19 Capability Scorecard" for all Medicare- and Medicaid-certified nursing homes located in metropolitan areas that satisfy minimum quality and capacity criteria. We exclude facilities operating as swing-beds for hospitals, containing a retirement community, or having fewer than 50 beds. We also omit any facilities rated a 1 on the 5-star scale for "overall quality" under the SNF Five-Star Quality Rating System, cited in inspection reports for abuse, and/or designated by CMS as having an extended pattern of violations.

The five measures included in our scorecard correspond to the criteria listed above. The measures are: *share in COVID-adjacent DRGs, share short-stay, total beds*, *nursing hours per patient-day,* and *overall quality rating.* ("DRGs" stands for "diagnosis related groups, Medicare's payment categories.) The first two measures, the "*share"* measures, are estimated using Medicare claims data for 2016, and the remaining measures are constructed using current data from Medicare's Nursing Home Compare database.

We define *share in COVID-adjacent DRGs*, our approximation for expertise in handling COVID-19 patients, as the share of each SNF's short-stay Medicare admissions accounted for by patients discharged from the hospital under DRGs that span the most common ICD-10 codes for respiratory illness, coronavirus (non-COVID), and flu viruses, as well as DRGs for all other respiratory and infectious diseases (listed in **exhibit 1**).

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Share short-stay is a proxy for how many patients might need to be relocated; facilities with higher rates of short-stay occupancy can prepare for the influx now by declining new patients, and isolate or relocate longer-stay patients.

Our proxy for operational readiness is *nursing hours per patient-day,* as care for COVID-19 patients is labor-intensive and highly-staffed facilities will require relatively fewer new hires. Last, we use *overall quality rating* as a proxy for managerial skill.

We standardize each measure by metro area, and create a weighted average score by assigning a 25 percent weight to *share short-stay* and evenly allocating the remaining 75 percent across the other four measures. The heavier weight on *share short-stay* reflects the concerns and logistical challenges associated with transferring residents. We use these scorecards to rank facilities within each metro area; facilities missing any data are excluded. (The individual scorecards, including data for excluded facilities where available, are available for download.)

Exhibit 2 presents the mean raw (unstandardized) values for each component included in the scorecard, separately for the 10 largest metro areas. The exhibit lists the number of SNFs satisfying our criteria for scoring, as well as the number of facilities and beds among those ranked in the top-fifth of "COVID-19 Capability." (All SNFs, including those excluded, are weighted by total number of beds in calculating this top-fifth measure.) We also include estimates of COVID-19 cases (total and per capita) in each metro area in the last 30 days, as of April 11. (We construct metro-area case counts using the *New York Times'* county-level database.)

How Might CSCC Designation Alleviate Bed Shortages?

The number of SNFs that should be designated as CSCCs is a decision that will need to be made by local regulatory authorities using the best-available estimates of beds needed. We illustrate how this might work using our scorecards and state-level acute-care bed shortages provided by The University of Washington's Institute for Health Metrics and Evaluation (IHME). In **Exhibit 3**, we list the five states projected by IHME (as of April 10) to face acute-care bed shortages. In four of those states, the projected shortages on the peak shortage date could be (or could have been) addressed by designating half or fewer of the top-fifth COVID-19 Ready SNFs as fully-focused CSCCs. Meeting Connecticut's projected bed shortage would require more than the top fifth of SNFs (if the new CSCCs were the sole source of capacity increases).

Of course, state-level projections can mask important heterogeneity within a state. In addition, projections change frequently and have a wide error band, implying states may

experience bed shortages even if the current average prediction implies otherwise. Hospital-bed shortages are also not the only concern. Arora and Fried recently estimated the number of patients requiring post-acute care "would overwhelm our current capacity" of beds in skilled nursing facilities.

In addition, if enough capacity is made available, nursing home patients who become COVID-positive and cannot be well-isolated in their facilities could be transferred to CSCCs, hopefully reducing spread within high-risk patient populations living in close proximity. Because of the many levels of uncertainty around models predicting the timing and magnitude of peak need, we believe it is judicious for most if not all metro areas to identify and fund potential CSCCs in the very near future.

How Does This Approach Reflect The Current And Future Organization Of Health Care Delivery?

Our emphasis on repurposing facilities where possible reflects strategic concerns about the structure of the health care delivery systems we will have when the pandemic has ebbed. In recent years, inpatient capacity has been removed from our system in part because certain types of care can be provided more cheaply, safely, and conveniently in outpatient or home-based settings. The addition of new, semi-permanent inpatient or residential capacity could lead to over-utilization of care that raises costs.

Moreover, adapting existing facilities to meet changing needs is an important approach to embrace in the uncertain times ahead, which will include other unanticipated challenges. Identifying and creating CSCCs is consistent with basic strategic principles that leading health care organizations are working to put in practice: segmenting patients into groups with similar needs and coordinating with other providers in the delivery system to meet those needs.

Limitations And Conclusions

Although our analysis focuses on nursing homes, we recognize that post-acute settings with existing acute care capabilities such as long-term care hospitals, inpatient rehabilitation facilities, and swing-bed SNFs are likely top candidates for CSCC designations. (We expect much of this capacity is already online or slated to go online for COVID-19 care.) Additionally, while we have produced COVID-19 Capability Scorecards for all CMS-certified nursing homes meeting minimum quality and capacity criteria, we lack data on a number of measures that would ideally be incorporated. For example, local officials can and should consider proximity to current and projected

EXHIBIT E

outbreaks when building their scorecards and designating CSCCs. These officials may also have additional data about the ability of specific facilities to deliver high-quality care, such as whether a certified medical director is on staff or an effective incident command structure is in place.

Finally, while it will also be valuable for authorities to interact directly with facilities to gain a better understanding of their capabilities and constraints, it is important that the scorecard and designation process be as apolitical and transparent as possible. We favor mandated designation over relying on volunteers because mandates can be issued fairly quickly and should mitigate potential gaming or litigation arising from these decisions. CSCC designation will affect the lives of many residents, employees, future patients, and their families. Officials must act quickly and decisively and make clear their decisions are motivated by the public interest.

Authors' Note

Dafny and Lee acknowledge receiving funding from the Agency for Healthcare Research and Quality (Grant No. U19 HS24072). The authors thank David Grabowski, Thomas H. Lee, Jr., Michael McWilliams, Michael Rothman, Michael Wasserman, and Charlene Harrington for helpful comments.

Special Article

The Future of Home Health Care: A Strategic Framework for Optimizing Value

Home Health Care Management & Practice
2016, Vol. 28(4) 262–278

DOI: 10.1177/1084822316666368
hhc.sagepub.com
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Abstract

The Future of Home Health project sought to support transformation of home health and home-based care to meet the needs of patients in the evolving U.S. health care system. Interviews with key thought leaders and stakeholders resulted in key themes about the future of home health care. By synthesizing this qualitative research, a literature review, case studies, and the themes from a 2014 Institute of Medicine and National Research Council workshop on "The Future of Home Health Care," the authors articulate a vision for home-based care and recommend a bold framework for the Medicare-certified home health agency of the future. The authors also identify challenges and recommendations for achievement of this framework.

Keywords

home health, home-based care, hospital at home, hospice, palliative care, technology, workforce, quality

Introduction

America is experiencing a dramatic shift in demographics, and in 2019, people older than 65 years will outnumber those younger than five. As Americans age and live longer, increasing numbers of them will live with multiple chronic conditions, such as diabetes or dementia, and functional impairments, such as difficulty with the basics of life like mobility and managing one's household. One of the greatest health care challenges facing our country is ensuring that older Americans with serious chronic illness and other maladies of aging can remain as independent as possible. Our success with this challenge will help ensure that Americans age with dignity in a manner that meets their expectations, preferences and care needs. The financial health of our federal and state governments also hangs in the balance because of the implications for Medicare and Medicaid costs. Meeting this challenge will require envisioning the potential value of home-based health care, creating a pathway for home-based care to maximize its potential, and integrating it fully into the U.S. health care system.

We propose an initial vision and bold first steps in this article to support the transformation of home health agencies and home-based care and its recognition in the overall health care system. In this article, the terms "home-based care" and "home health care" have distinct meanings. "Home-based care" refers to the spectrum of services provided in the home to support patients, including caregiving and personal care services, skilled services (such as nursing and therapy) provided in the

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home, home-based primary care, hospital-at-home, and even hospice when it is provided at home. "Home health care" in this article refers to Medicare skilled home health care, which is paid for under the Medicare home health benefit and delivered by Medicare-certified home health agencies. Home health care is one type of home-based care.

The article builds upon the themes that arose at an Institute of Medicine (IOM) and National Research Council (NRC) workshop on the "Future of Home Health Care," which was held on September 30 and October 1, 2014.[1] The research and discussion in this article are intended to be a call for action among home health agencies and home-based care providers, policy makers, providers, patients, caregivers, and others interested in the field. The article seeks to clarify and define the spectrum of home-based care, the relevance of this spectrum to overall health care, and the critical roles, characteristics, and capabilities of the home health agency of the future. The article also identifies key needs to address to enable home health agencies to serve patients and the health care system in the future.

Of foremost importance is leadership to build toward a clarified vision for high-value home health care in the U.S. health care system. The authors seek to provide a strategic framework to enable home health care to pursue concrete, meaningful change. The history of home-based care is at least as old as the beginnings of the nursing and medical professions given that health care delivered in the home (in the form of house calls) was the standard of practice, long before the development of hospitals and office-based medical care. The changes that this report seeks to propel are the major next steps in the long history of home-based care.

Background: Factors Driving Change

Demographic impetus and cost. The graying of the U.S. population is a major impetus for change in health care. According to the Medicare Payment Advisory Commission (MedPAC), Medicare enrollment is projected to increase by more than 50% over the next 15 years from 54 million beneficiaries today to more than 80 million in 2030.[2] This reflects an overall aging of the United States population: the Census projects that by 2030, the proportion of U.S. residents older than 65 will have nearly doubled from 2010 (20% vs. 13%).[3] Among the oldest Americans, the Census predicts that the population age 85 and above will double by 2036 and triple by 2049.[2]

Although by some accounts the upcoming Medicare population is healthier than previous generations—life expectancies are longer and smoking rates have declined—baby boomers have higher rates of obesity and diabetes compared with previous generations.[4] According to a 2002 study, 88% of people 65 years or older have at least one chronic condition, with a quarter of these having four or more conditions.[5] The effect of these chronic conditions on spending is massive: Estimates suggest that chronic illness accounts for three quarters of total national health care expenditures.[4] As the number of older beneficiaries with multiple chronic conditions continues to rise, providing care in the most effective and efficient setting will become even more critical.

Health care delivery system reform: The Triple Aim and HHS goals. With demographic trends and spending concerns as a backdrop, the Medicare program began to emphasize achievement of the "Triple Aim" in 2009. A framework initially conceived by the Institute for Healthcare Improvement, but now almost universally accepted in health care policy and delivery, the Triple Aim has focused efforts to innovate in the Medicare program and has propelled considerable change. The Triple Aim declares that to improve the U.S. health care system, it is vital to pursue three goals simultaneously:

1. Improving the patient experience of care (including quality and satisfaction);
2. Improving the health of populations; and
3. Reducing the per capita cost of health care.[6]

The Triple Aim has been used by policy makers and other leaders in health care delivery to focus their goals in reforming the health care delivery system.

Policy movement toward achievement of the Triple Aim can be seen in the many initiatives undertaken by the Center for Medicare and Medicaid Innovation (CMMI), and in the time-specific goals to move Medicare reimbursements from volume to value that the secretary of the U.S. Department of Health and Human Services (HHS) announced in early 2015. HHS's goals are twofold:

1. To tie 30% of traditional (fee-for-service [FFS]) Medicare payments to quality and value through alternative payment models (APMs; including bundled payments or Accountable Care Organizations [ACOs]) by the end of 2016 and 50% by the end of 2018 and
2. To tie 85% of all traditional payments to quality or value by 2016 and 90% by 2018 through programs such as Hospital Value-Based Purchasing Program (HVBP) and Hospital Readmissions Reduction Program (HRRP).[7]

HHS has made strides toward achieving these goals. While quality programs in the Affordable Care Act (ACA) primarily focused on hospitals, recent legislation and regulatory actions have expanded quality and value programs to post–acute care with the skilled nursing facility (SNF) value-based purchasing program and the home health value-based purchasing demonstration. In addition, post–acute care providers are increasingly finding themselves affected "downstream" by programs directed at other entities, such as bundled payments and hospital value-based purchasing. A summary of some of the most recently

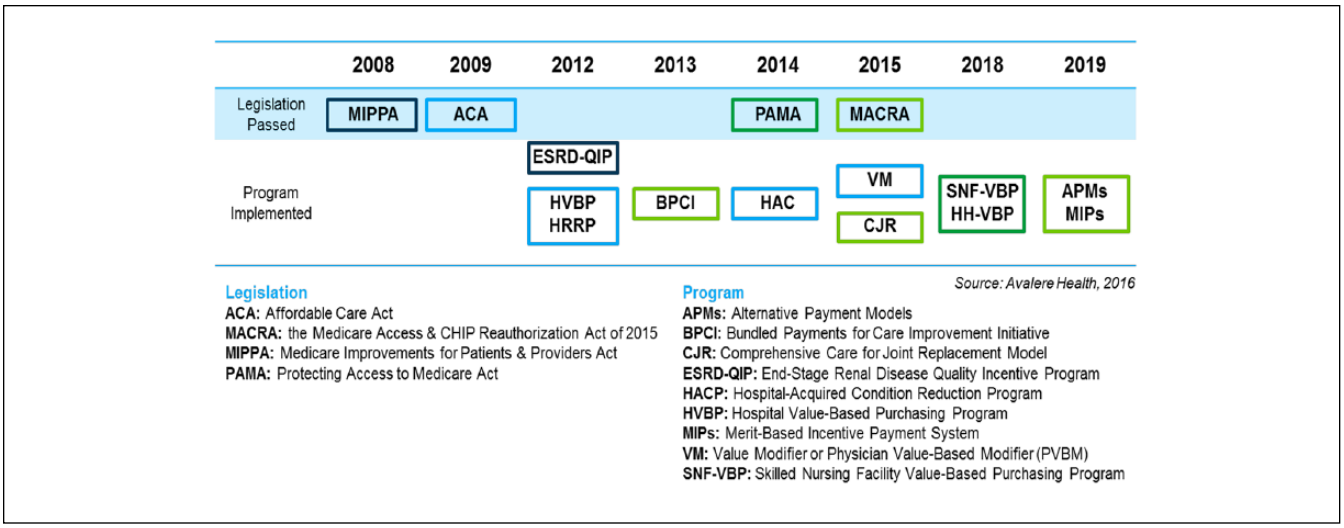

Figure 1. Medicare value-based programs and authorizing legislation.
Source. Avalere Health, 2016.
Note. HHRP=Hospital Readmissions Reduction Program; HH-VBP = Home Health Value Based Purchasing model.

Program	Estimated Impact
Accountable Care Organizations[11]	1. 464 ACOs in 49 states and DC 2. 8.9 million Medicare beneficiaries 3. Generated about $400 million in savings in 2014
Bundled Payments for Care Improvement[12]	I. 1,574 providers participating II. About 14,000 episodes being tested for 48 conditions[a]
Comprehensive Care for Joint Replacement[13]	1. About 800 hospitals in 67 MSAs and 23% of all lower extremity joint replacements 2. $12.3 billion in Medicare spending over five years
Independence at Home Demonstration[14]	3. 17 participating practices 4. $25 million in savings in performance year 1

Figure 2. Medicare alternative payment models impact.
Source. Avalere Health (2016).
Note. ACO = accountable care organization; BPCI = Bundled Payments for Care Improvement Initiative; MSA = Metropolitan Statistical Area.
[a]Avalere Analysis of BPCI participant list.

developed current and future mandated quality and value programs for Medicare providers and the legislation creating them are provided in Figure 1.[8] A description of the estimated impact of these alternative payment models is provided in Figure 2.

There are also more established programs that leverage home-based care. Examples include the Veterans Administration's Home-Based Primary Care program, which administers longitudinal interdisciplinary home-based medical care to veterans in need of skilled services, case management, or activities of daily living (ADLs),[9] and the Program of All-Inclusive Care for the Elderly (PACE), a Medicare and Medicaid program in which PACE organizations contract with providers and specialists to offer nursing home-level medical and supportive services in the community.[10]

Misaligned incentives persist and block progress. Despite these new and existing initiatives, misalignment of incentives remains common in traditional Medicare and in the health care system overall. This misalignment remains a barrier for better care coordination and continues to be a driving force behind initiatives that focus on the Triple Aim and HHS's goals. A further challenge is that the vast majority of the above-mentioned APMs and value-based programs pursued to date are built on FFS architecture. In other words, the APMs pursued tend to use delivery models that are triggered by the delivery of certain services or by a certain episode of care that is paid for under traditional Medicare, with a retroactive opportunity for shared savings or risk against a historical cost target or benchmark; few, if any, APMs are truly pursuing population-based payment. As a result, even within many of these APMs, many of the core issues with traditional Medicare persist, hindering progress toward the Triple Aim.

Consumers driving care. As patients become increasingly engaged with their care and the health care system strives to empower patients in their care, patient preference and satisfaction are increasingly becoming key measures of performance. When asked about their care preferences, older Americans overwhelmingly articulate a desire to age in place and receive care at home rather than in institutional settings. A 2010 AARP (formerly the American Association of Retired Persons) survey found that nearly three quarters of a survey population of those age 45+ strongly agreed with the statement, "what I'd really like to do is stay in my current residence for as long as possible."[15] This is echoed in the last stages of life, where the Dartmouth Atlas researchers found that more than 80% of patients say that they "wish to avoid hospitalization and intensive care during the terminal phase of life."[16]

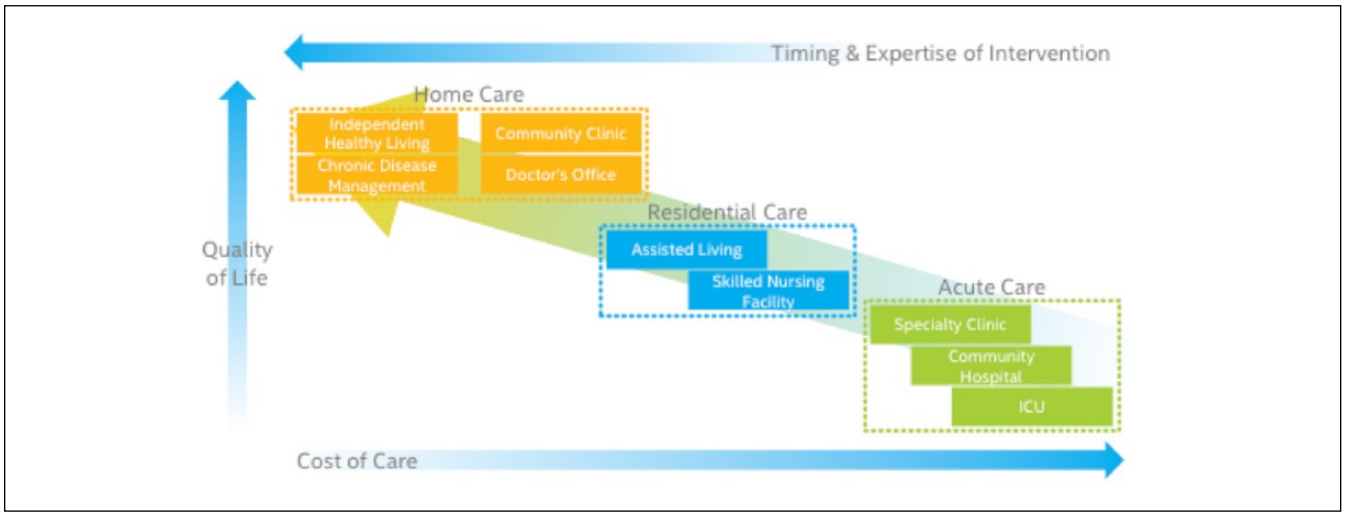

Figure 3. Strategy for innovation.
Source. Eric Dishman, Intel Corporation (presented October 1, 2014, IOM-NRC Workshop on "The Future of Home Health Care").
Note. IOM = Institute of Medicine; NRC = National Research Council; ICU = intensive care unit.

Table 1. Home-Based Care and Medicare Skilled Home Health Care.

Term	Definition
"Medicare skilled home health" care or "home health care"	Services offered by Medicare-certified home health agencies under the Medicare home health benefit.
"Home-based care"	A wide array of different types of care provided in the home by a wide range of parties. The continuum of different types of home-based care delivered in the home varies in terms of different dimensions, including acuity, type of care provided, and degree of physician involvement. Home-based care includes both formal and informal personal care services, Medicare skilled home health, physician house calls, and even "hospital-at-home" services.

Recognizing these preferences and the potential for home-based care to reduce care delivery costs system-wide, policies have begun to prioritize noninstitutional care settings. State Medicaid offices have led this trend toward consumer-based care. In 2013, in the context of Medicaid long-term services and supports, there were more home- and community-based service providers than institutional providers, an 18% increase since 1995.[17] Medicaid expenditures for home- and community-based services have also grown significantly, reflecting the rise in use of home-based services as opposed to institutional care, more than doubling from $25.1 billion in 2002 to $55 billion in 2012.[18]

Shifting to a Community- and Home-Based Model for Health Care

All of these drivers of change point to a shift in the delivery system toward clinically appropriate care in the community, with the home as a central node.[1] As illustrated in Figure 3, technology and policy will need to shift to accommodate these changes and deliver appropriate care to patients.[1]

Consistent with this paradigm shift, payers and providers engaged in APMs are developing a key strategic emphasis on shifting the site of care toward the community and the home.

The spectrum of home-based care. As the health care system shifts toward additional care in the community, the spectrum of available services and supports for home-based care becomes critical. Medicare skilled home health is part of this broad spectrum of home-based care services. In this article, it is important to understand the differences in terms between "home-based care" and "Medicare skilled home health."

As captured in Table 1, "Medicare skilled home health" care or "home health care" refers to services offered by Medicare-certified home health agencies under the Medicare home health benefit. By contrast, "home-based care" refers to a wide array of different types of care provided in the home by a wide range of parties. The continuum of different types of home-based care delivered in the home varies in terms of different dimensions, including acuity, type of care provided, and degree of physician involvement. Home-based care includes both formal and informal personal care services, Medicare skilled home health, physician house calls, and even "hospital-at-home" services.

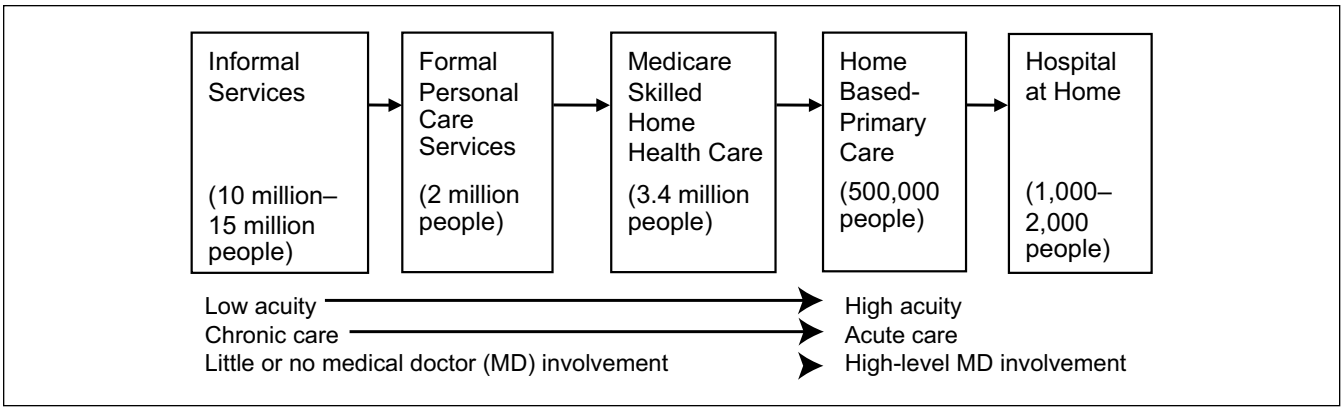

Figure 4. Patients receiving home-based services and supports.
Source. Bruce Leff and Elizabeth Madigan, 2014 (presented September 30, 2014, IOM-NRC Workshop on "The Future of Home Health Care").
Note. IOM = Institute of Medicine; NRC = National Research Council.

As captured in Figure 4, which is drawn from the workshop summary of the IOM-NRC workshop on "The Future of Home Health Care," it is important to note that the vast majority of services provided in the home are provided by family caregivers, sometimes referred to as "informal services."[19] This phrase grossly underestimates the critical role family caregivers play in the care of patients at home. Particularly among patients with multiple limitations on ADLs, caregiving is crucial. Without caregivers in the home, health care at home is simply impossible for those with functional limitations. Upward of 10 to 15 million individuals receive help from family caregivers. AARP estimates that 34.2 million adults have served as caregivers in the last year alone.[18]

According to the Urban Institute's "The Retirement Project," in 2000, approximately 2.2 million individuals received "formal personal care services," defined as personal care services that are paid for by various means; this increased to 2.5 million in 2010 and is projected to increase to 2.9 million in 2020.[19] Some patients may be eligible for Medicaid or other state programs that provide coverage for such services; however, there is considerable variation in such programs and their scope. Some may have private long-term care insurance that enables coverage. Still other patients may have no private or public insurance coverage for formal personal care services and may need to pay out of pocket for such services.

Approximately 3.4 million people receive Medicare skilled home health care, which supports homebound patients by providing coverage for intermittent skilled nursing and therapy services that are provided by Medicare-certified home health agencies subject to a physician's plan of care. In 2014, Medicare spent $17.7 billion on home health care.[20]

Home-based primary care and hospital-at-home are models of care that serve patients with conditions that are more acute or severe are less commonly used. The skill needed to provide the services increases accordingly. Home-based primary care is a model that makes use of home care physicians and nurse practitioners, in connection with an interdisciplinary team of professionals, including skilled home health professionals. The hospital-at-home model serves to supplant hospital admission for certain patients with intensive, hospital-level care in the home. Those receiving this highest acuity level of home-based care have been shown to experience 19% lower costs, higher satisfaction, and equal-to-better care outcomes when compared with similar inpatients.[21]

In addition to these varied services along the spectrum of home-based care, it is also critical to include mention of the role of palliative care and end-of-life care. For patients that have been diagnosed with severe or serious illness, palliative care is often a core element of treatment of the patient in a holistic fashion that emphasizes function.[22] Palliative care may be delivered outside of the Medicare hospice benefit in various settings, including at home by home health agencies, or in facilities including hospitals. For many patients who use palliative care, the Medicare hospice benefit may eventually be used at home or in a facility-based setting as well. Including palliative care and hospice in the spectrum of home-based care services enables a full understanding of how care may be shifted toward the community and the home from birth to death.

Methodology

The Future of Home Health project was a multiphase project initiated by the Alliance for Home Health Quality and Innovation (the "Alliance"). As part of this project, the Alliance sponsored an IOM-NRC workshop on "The Future of Home Health Care" held on September 30 and October 1, 2014. The themes that surfaced during this workshop then became the subject of a literature review and qualitative research to further explore the key considerations for the future of home health care.

The literature review and qualitative research were commissioned by the Alliance. The work was performed by Avalere Health, an independent research firm. As a first step, Avalere Health conducted an extensive literature review of both scholarly and trade publications on the value and role of home health care. Building upon that literature review, Avalere Health conducted unstructured interviews with individuals considered key stakeholders. These key stakeholders were identified by virtue of their leadership in organizations representing patients and caregivers, or their experience as policy makers and payers. The individuals were interviewed regarding priorities to address the needs of these constituents for the future and to understand their perspectives on the role and relevance of home health care.

Specifically, Avalere Health conducted 16 interviews with key stakeholders in health policy and innovative providers throughout the fall of 2015. The key stakeholders in health policy included current and former policy makers from the Centers for Medicare and Medicaid Services (CMS; and the Innovation Center or CMMI), advocates for Medicare beneficiaries, caregivers and disease groups, and payers (large commercial and Medicare Advantage plans). Due to the sensitive nature of their positions and to promote full honesty, Avalere Health promised anonymity to the stakeholders. Appendix C at http://ahhqi.org/images/uploads/APP_C_Interview_Methodology.pdf describes the stakeholders interviewed as well as 12 questions that Avalere Health drew from as the basis for the unstructured interviews.

After completing the interviews with the key stakeholders in health policy, Avalere Health conducted interviews with a diverse array of individuals from provider organizations pursuing new and alternative models of care that leverage home health or home-based care to develop case studies and vignettes that shed light on the framework for the future of home health care. As a general reference, a case study compendium developed by the Visiting Nurse Associations of America (VNAA) was also used to better understand innovations in home health and home-based care. [33]

Institutional Review Board approval was not required for this research activity because it did not meet the regulatory definition of human subjects research. This project involved interviews and information gathering about services and policies, rather than living individuals. All of the people who agreed to be interviewed were volunteers.

Limitations

This article has limitations due to the nature of the qualitative research performed. Individuals were selected for interviews based on the assumption that policy maker, payer, and consumer perspectives would be of highest priority in understanding the future of home health care. This assumption may have skewed the resulting themes by emphasizing government, payer, and consumer priorities for the future.

Results

The unstructured interviews with key stakeholders in health policy yielded a number of key themes involving (1) the future of payment and delivery system reform and (2) the future of home health care. In the context of these interviews, "home health care" was defined as services provided under the Medicare home health benefit by Medicare-certified home health agencies.

The Future of Payment and Delivery Reform

1. Payment and delivery reform is here to stay.

The interviewees emphasized that payment reform will continue in the direction of emphasizing value-based longitudinal payments where an entity—such as a hospital, physician group, or post–acute care provider—is financially responsible for services provided beyond their immediate care setting. There was consensus among interviewees that CMS will meet its goal of 50% of traditional Medicare payments through APMs by 2018. One interviewee stated that "[t]hese models are here to stay."

2. No dominant model is emerging. Continued heterogeneity across markets is expected.

Key thought leaders interviewed were in consensus that no single payment and delivery model is emerging as the dominant model. There was consensus that bundling and ACOs, for example, will have an increasing role over the next 3 to 5 years; however, one model will not dominate across all markets. In general, payment reform will continue in the direction of emphasizing value-based episodic payments where an entity, such as an ACO, is financially responsible for services provided.

3. Greater momentum around bundling and Medicare Advantage than ACOs.

While some strongly supported bundled payment arrangements as a model for future payment and delivery reform, others noted that bundling currently represents a relatively small fraction of Medicare expenditures, which will likely remain the case for the next 3 to 5 years. For example, the Comprehensive Care for Joint Replacement (CJR) model is an expansive use of bundling for Medicare relative to the Bundled Payments for Care Improvement Initiative (BPCI), but CJR accounts for a small proportion of payments. The movement toward bundled payments suggests that CMS will be growing the base of a small percentage of payments. The interviewees also noted that continued growth of Medicare Advantage plans is expected, potentially with increased provider (i.e., hospital)-owned plans.

4. Locus of control (physician vs. hospital) unclear.

Key thought leaders varied in their perspectives about whether the locus of control for payment and delivery will lie with hospitals or physicians. Several key thought leaders noted that markets will likely be a hybrid of control, in which hospitals will predominate in most locations because they have more resources and market power, but other markets will have multispecialty physician practices that are sophisticated enough to succeed. For example, the CMMI was very intentional when giving hospitals control of the CJR bundles, but it is foreseeable that different entities would be in control in other clinical episodes or models.

Other key thought leaders stated that absent policy support to buttress physician practice capacity to be the convener of ACOs, hospitals will likely retain and grow control. One interviewee noted that early evidence indicates that physician-led services may lead to better outcomes, but there is not sufficient evidence to have clarity on this issue. Several interviewees also acknowledged that as hospitals increasingly acquire physician practices, the distinction may be moot.

5. Payment and delivery will continue to rely on FFS systems with retrospective reconciliation. No large-scale movement toward prospective, capitated models for bundling and ACOs.

Currently, almost all of the APMs involve continued FFS payment with a retrospective reconciliation. While capitation and prospective payment offers more opportunity to experiment with services covered and service delivery, key thought leaders agreed that the original Medicare payment system will not move to prospective payment system in the near future. Ultimately, the system is moving toward capitated payment, but the time frame to get there is unclear. It will be important to continue watching CMS to see how quickly the system evolves. Within 3 to 5 years, the Medicare system will still largely emphasize a retrospective shared savings model.

6. Flexibility greater with shared risk but limitations on innovation persist within existing FFS structure.

When providers are operating in an at-risk environment (with both upside and downside risk) and bear the consequences, then policy makers (e.g., Congress and CMS) may be more amenable to expanding or altering the home health benefit.

For example, CMS has offered waivers of certain home health benefit requirements for providers participating in APMs where they take on downside risk. CMS is willing to provide additional flexibility, including toward the home health benefit, where providers take on risk. However, providers are currently bound by the existing home health FFS payment structure, limiting potential innovation.

The Future of Home Health Care

7. Home health "big winner" in payment and delivery reforms.

All key thought leaders interviewed stated that home health stands to be a "big winner" with a substantial increase in utilization as a result of payment and delivery reforms. Payment reforms create incentives for upstream referral partners to utilize home health more substantially because it is a lower cost setting of post–acute care. In addition, patients prefer to receive care at home. The economic trend more generally is toward personalized, on-demand, direct-to-consumer services; the health care industry will similarly see shifts in consumer demand for how people consume health services.

The timing of the shift toward home health is a big question, as it is currently unclear when more services will be covered in the home. However, ultimately, the system is moving toward a broader use of home health.

8. Lack of consensus around modifying the home health benefit.

Stakeholders and key thought leaders were not in consensus about whether to revise the Medicare home health benefit, and if so, how to redefine the benefit. A majority of interviewees thought that the Medicare home health benefit needed to be more flexible, to be provided based on patients' care need, and more integrated with a patient's care, that is, more integrated with the primary care physician.

Several noted that it was not politically viable to expand the Medicare home health benefit to cover more services, and others went further to suggest it was unnecessary to alter the eligibility for services covered by the benefit because payments are increasingly going to shift to bundling, ACOs, and Medicare Advantage, where entities taking on risk will have more flexibility to define home health care coverage.

Some suggested removing the homebound requirement and instead focusing on whether beneficiaries have a certain number of ADL limitations or chronic conditions. One key thought leader noted the Medicare benefit should be more "nimble," rather than being defined by a 60-day episode.

A variety of stakeholders discussed the need for home health care that is more responsive to patients' needs and preferences, particularly as it relates to significant unmet need for long-term care. Some acknowledged that Medicare does not provide a long-term care benefit. Others asserted that the Medicare benefit must evolve to respond to the needs of the Medicare population, which increasingly live for a

period of time with a variety of ADL limitations and chronic conditions.

9. No single model identified for managing patients

Key thought leaders did not identify a single emerging model for managing post–acute care patients, high-risk patients, or patients with chronic conditions and long-term care needs. Some noted that there is not enough evidence in post–acute care around exactly what clinical care pathways are most effective. There is not one single post–acute care model, and it will be impossible to establish a single post–acute care model for Medicare patients because their needs and socioeconomic status are so varied.

ACO providers and hospitals in bundled payments will increasingly give attention to evidence regarding efficient, high-quality care for determining clinical care pathways and post-acute care (PAC) utilization. ACOs are concerned about the lack of evidence-based protocols for different patient populations. Managed care plans generally report having a more firm understanding of post–acute care, which they manage through selective contracting and prior authorization. However, one health plan representative stated that they are struggling to address their home health network because the industry is so fragmented.

Within Medicare FFS spending, post–acute care spending has the most variation; within post–acute care spending, home health has the most variation. Therefore, providers under pressure to manage bundles are probably going to be taking a close look at their home health utilization and network.

Several noted that the definition of rehabilitation and criteria for when rehabilitation is appropriate should be reconsidered. For example, people may need assistance with ADL limitations to avoid falls. Rehabilitation to improve mobility or speech may prevent loss of function.

10. Needs of community-referred beneficiaries less well understood.

Interviewees agreed that the composition and care needs of community-referred beneficiaries receiving home health under Medicare Part B are less clear.

Stakeholders varied on how they characterized the community-referred beneficiaries. Some noted that the increased number of episodes covered by Part B is indicative of the problem that the United States does not have long-term care coverage, and in this instance, the benefit may be acting as a long-term care benefit.

Stakeholders representing patients and caregivers emphasized that eligible patients sometimes have trouble accessing the benefit for the duration of the time that they would benefit from home health episodes. For example, physicians may be resistant to recertifying home health episodes for patients who do not have any post–acute care needs. Other practitioners may not recognize the eligibility of and benefit to certain patient populations, such as people with dementia. Several noted that the Part B population is where there is opportunity for innovation.

11. Home health agencies must adapt to the changes to Medicare payment and delivery.

Agencies will need to develop the capabilities to contract with Medicare Advantage plans and providers that are taking on financial risk. Some interviewees noted that agencies tend to focus on maximizing volume under the current episodic-payment FFS payment system, but that paradigm will quickly fade. Agencies will need to be able to articulate the value they bring to upstream referral partners, which requires being able to report on quality metrics, being able to regularly communicate with a nurse liaison, and having disease management programs.

Some interviewees suggested that the industry might undergo a period of significant consolidation. Payers and providers taking on risk will start to more carefully vet and manage their post–acute care network, including their home health agency partners. Agencies that cannot cover a large market for around-the-clock care may be excluded. The industry is currently very fragmented with many operators that may be unsuited to meeting referral partner and payer needs for a home health partner that can manage care across an episode and potentially over a large geographic area. In addition, referral partners and payers may be looking for agencies that can support patients with higher acuity postdischarge to prevent readmissions.

Linking payments to value and putting upstream referral partners (e.g., hospitals) at risk will contribute to reigning in potential fraud and abuse in home health because payers and providers will not refer patients to agencies providing unnecessary care.

12. Caregiver burden is a crisis necessitating a long-term care solution.

The growth in unmet home care needs, particularly for long-term care, is resulting in an increasing burden on family caregivers. Stakeholders indicated that caregivers are expected to provide medical services in the home with minimal training or advance notice. Many stakeholders noted that Medicare does not cover long-term care and Medicare coverage of home health care services should be expanded to include unskilled services and other long-term care services. However, some acknowledged that original Medicare program is a medical benefit and should not be expanded to provide a long-term care benefit.

Discussion

Based on the information gained in the interviews, the IOM-NRC workshop, the literature review, and case studies, we

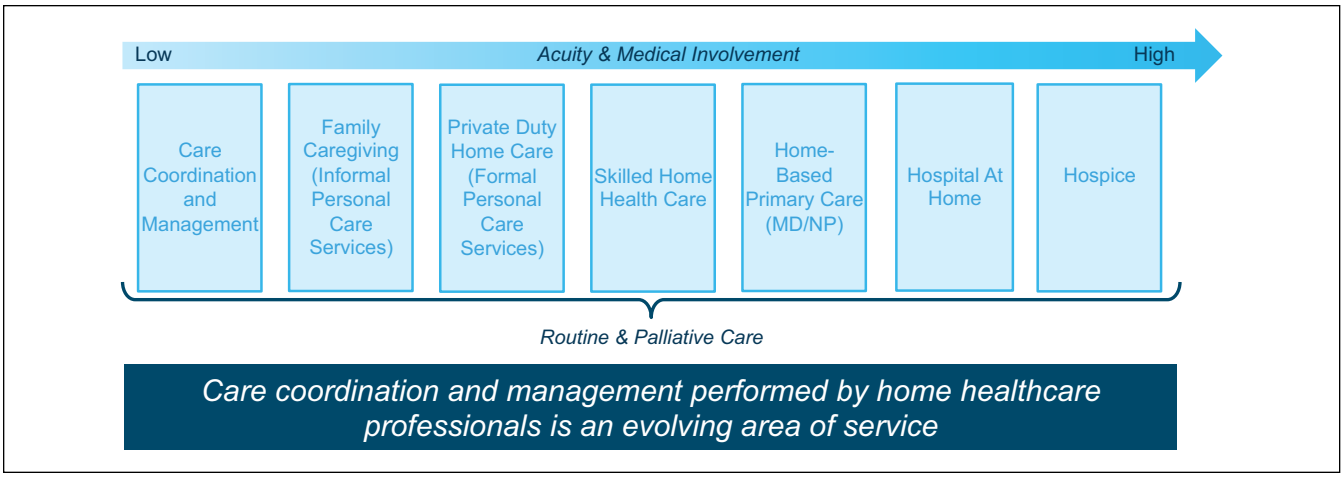

Figure 5. Spectrum of home-based services and supports.
Source. Avalere Health, 2016.
Note. MD = Physicians; NP = Nurse Practitioners.

have identified key issues and themes for future focus and synthesis. The framework and recommendations presented in the "Discussion" section of this article represent synthesis drawn from these various primary and secondary research approaches to understanding the future of home health care.

Vision and Framework for the Future of Home-Based Care

Home-based care is well positioned to drive progress toward key U.S. health care system–wide goals. As discussed, many patients prefer to receive care in the home, so the use of high-quality home-based care could support the goal of patient-centered care. Home health care is also a relatively low-cost setting of care. As the health care system grapples with high costs and expenditures, home health's efficiency could support the goal of high-quality, low-cost care.

Despite its alignment with key goals, the home health industry must evolve to capture the opportunities stemming from changes in the health care system. Specifically, the home health industry must develop the capabilities necessary to treat higher acuity patients with broader care needs in the home and community. The spectrum of home-based care services described in Figure 5 could serve as an array of offerings that are flexibly and seamlessly leveraged depending on patient need and preference. To achieve this vision, home health agencies also need to develop new capabilities to coordinate and collaborate with other care providers, ensuring that the patient receives appropriate, high-quality care regardless of the setting or location.

To allow home health agencies to fulfill this mandate to provide high-quality, efficient care as part of ongoing reforms, the regulatory environment needs to shift to allow greater flexibility for care in the home when appropriate. A variety of new and alternative health care delivery models are creating incentives for increased use of home health and home-based care, but additional flexibility would allow home-based care to be deployed in innovative ways based on patient's needs and preferences. The following vision for the future outlines the characteristics and capabilities that would be needed to support broader use of home health, as well as some of the barriers that may inhibit the broader use of appropriate home-based care.

Although the vision for home-based care is broader than the Medicare context, it is important to understand the specific role and relevance of Medicare-certified home health agencies in achieving this goal of providing high-quality, efficient care to more beneficiaries in the community and the home. Medicare home health agencies are by no means the only stakeholder that will be key to achieving this broad vision, but this article seeks to focus on the key characteristics and roles of Medicare home health agencies as a first evolutionary step.

Today's Home Health Agency and the Medicare Benefit

Today, Medicare-certified home health agencies are specialists in providing in-home skilled nursing and therapy services to homebound patients who (1) have had a prior hospitalization and are recovering from acute illnesses or conditions and/or (2) need community-based care management to address their chronic conditions. Home health agencies are unique as the only Medicare providers that are specifically certified to provide skilled care to beneficiaries at home for acute, chronic, or rehabilitative conditions. Home health agencies use interdisciplinary clinical teams of health professionals, including nurses, physical therapists, occupational therapists, speech-language pathologists, medical social workers, and home health aides.

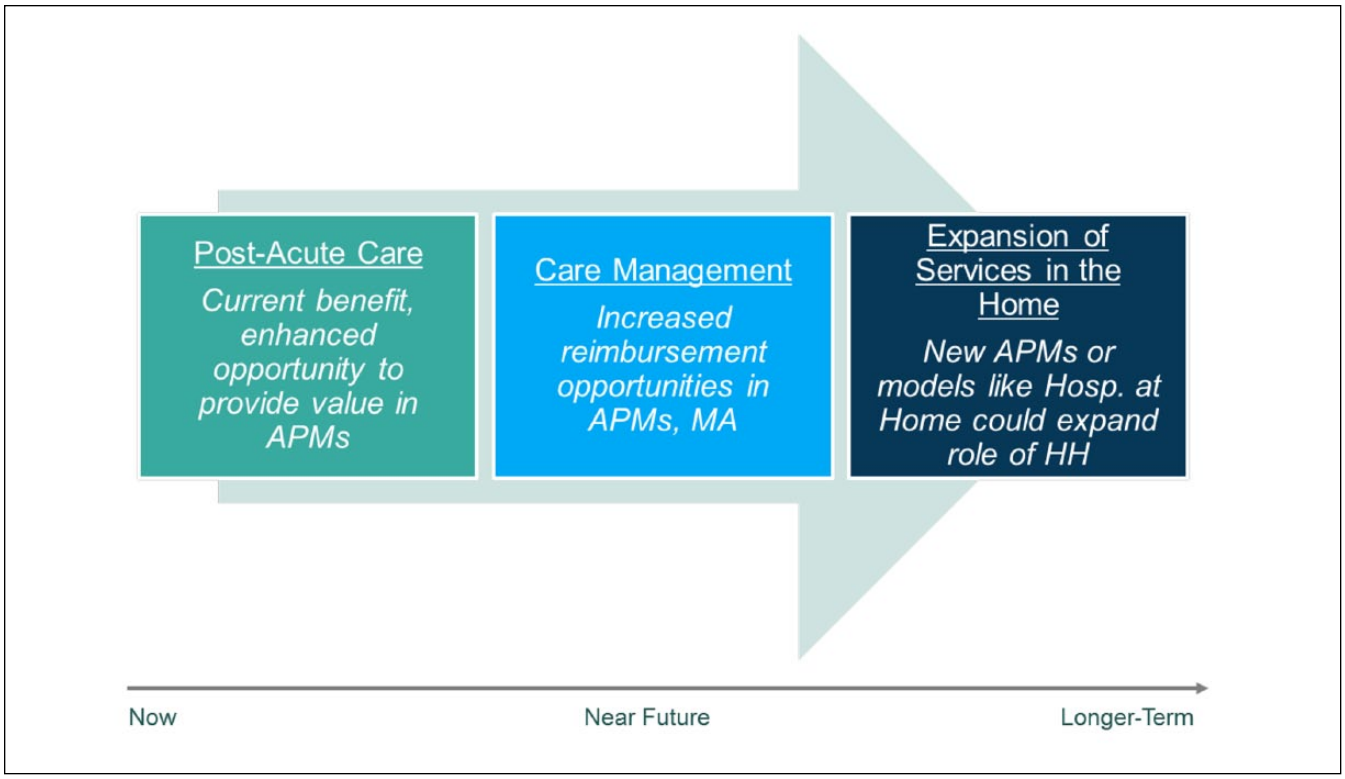

Figure 6. The evolving role of Medicare home health.
Source. Avalere Health, 2016.
Note. APMs = alternative payment models; MA = Medicare Advantage; HH = Home Health Care.

The traditional Medicare program pays in separate payment systems for different health care provider and professional services. Thus, Medicare pays short-term acute care hospitals under the hospital inpatient prospective payment system, Medicare pays physicians under the physician fee schedule, and Medicare pays home health agencies under the home health prospective payment system. Each payment system is separate and unrelated to the other payment systems.

Under the home health prospective payment system, Medicare beneficiaries are eligible to receive home health care services delivered by a certified home health agency if the beneficiary is homebound, needs intermittent skilled nursing and/or therapy services, and is under the care of a physician and needs reasonable and necessary home health services that have been certified by a physician and established in a 60-day plan of care. Medicare pays for home health care services with both Medicare Parts A and B funds in 60-day episodes of care, and pays agencies by home health resource groups (HHRGs) that are based on clinical and functional status (drawn from the Outcome and Assessment Information Set [OASIS] instrument), and service use. In general, Medicare pays with Part A funds if the home health care services follow discharge from an acute care hospital, or Medicare pays with Part B funds if a physician refers the beneficiary for home health care services as part of community-based care.

Given that traditional Medicare is largely FFS (and fee for episode in Medicare home health care), it is not surprising that the federal government is now emphasizing value over volume, and coordination over fragmentation. Each provider is paid only for delivering their own services, not for delivering quality care as defined by key measures. Providers and professionals historically have not been paid to coordinate care across the continuum. Home health agencies are no exception. Notwithstanding, it is clear that the health care system is evolving toward a value-based system and that home health agencies will need to change in the future to support achievement of the Triple Aim.

As the health system evolves, home health agencies increasingly will need to partner with entities formally accepting risk and even accept risk on their own. The evolving role of Medicare home health agencies is captured in Figure 6. This will be a gradual process as more agencies develop the capabilities to fully manage care and handle risk. As a first step, home health agencies must provide value to their partners (often other providers or payers) that are accepting risk in value-based arrangements. Going forward, home health agencies must partner with risk-bearing entities and actively manage patient care across settings, going beyond their current role. Finally, longer term, home health agencies can expand their role to formally accept risk under new payment models, sharing in potential savings and losses with their care partners.

The Medicare benefit's emphasis on skilled nursing and therapy could allow home health agencies to play a pivotal and unique role supporting patients, caregivers, and other health care providers and professionals in pursuit of the Triple Aim. Nurses and therapists could help teach patients and caregivers self-management skills, and the home health interdisciplinary team could serve as critical boots on the ground, acting as an extension of primary care practices to manage patient care in the home and community.

Home Health Care and Recent Changes in the Health Care Delivery Environment

As stated above, the interviews with key policy and health care stakeholders confirmed their unanimous belief that these payment and delivery reforms are "here to stay" and already have broad reach in the health care system. They believed that there will continue to be variation across markets as to whether Medicare Advantage, bundled payments, ACOs, or some combination emerges as the dominant risk-based model, either nationally or regionally.

As a result of the ongoing payment and delivery reforms, all key thought leaders stated that home health had the potential to be a "big winner" with substantial increases in patient volume because of its relatively low cost compared with institutional setting.

As reflected in the evaluation of the CMS BPCI, risk-bearing providers are increasingly utilizing home health care as they look to reduce total cost throughout episodes or enrollment periods. In BPCI SNF initiated episodes, overall unadjusted average Medicare payments were lower compared with comparison groups ($11,311 vs. $16,896), but "[a]verage Part A payments for home health agency services increased significantly relative to comparison group patients during the 90-day post-discharge period."[23] If such patterns continue under the CJR demonstration, increased utilization of home health could lead to significant savings under an episode of care. An Avalere analysis of 2012 to 2013 Medicare claims data indicates that about 31% of joint replacement episodes are discharged directly to home health, compared with nearly 40% discharged to an SNF. However, when comparing the total average episode spending, Medicare spends nearly twice as much ($27,990 on average) for episodes where the beneficiary is discharged to SNF compared with those discharged to home health ($16,755; Avalere analysis of 2012 and 2013 Standard Analytic Files [SAF]; episodes initiated between January 1, 2012, and September 30, 2013; excludes Part B physician spending). We note, however, that this analysis did not control for differences in patients who receive care in nursing facilities versus home health care; the determination of whether a patient receives SNF-based or home health care after a joint replacement requires assessment of clinical appropriateness and the needs of the patient, in addition to considerations related to cost-effectiveness.

The Medicare Home Health Agency of the Future

To fulfill critical roles in the health care system, Medicare home health agencies of the future would need to have newly strengthened capabilities and characteristics. Home health agencies would need to possess key characteristics (articulated in "four pillars") to meet "three critical roles" that the home health agency will play in the health care system.

Four pillars: Key characteristics of the home health agency of the future. Home health agencies must develop the capabilities and workforce to achieve the following key characteristics that are organized into four pillars. Home health agencies of the future must provide care that is:

1. Patient and person centered: The IOM defines patient-centered care as "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions," and includes it as one of the key components of high-quality health care.[24] Because home health is, by definition, provided in a patient's home, it offers an optimal opportunity to identify and respond to the needs of individual beneficiaries and families. A participant in the IOM workshop on home health described this more intimate relationship as one "around the kitchen table," where health care decisions are truly made and managed.[1] As the home health industry begins to care for patients more broadly, the industry needs to identify what constitutes person-centered home health care and how it is defined and measured.
2. Seamlessly connected and coordinated: The home health agency of the future must be part of a seamless, connected and coordinated home-based care continuum, as well as being connected with primary care, and facility-based care. Many of the stakeholders interviewed highlighted the potential role that home health could play in coordinating care for beneficiaries. As health care moves toward paying for value, not volume, home health agencies must coordinate patient care and ensure successful transitions from institutional care to the home. During this transition, beneficiaries interact with a wide range of health care providers, professionals, services, supports, and suppliers, so home health agencies must have the tools to manage care across these disparate entities and coordinate care and services in the transition home. In the future, all home health agencies should have these capabilities; however, the home health agency's care coordination activities could expand beyond coordinating care after an acute event. Home health is well positioned to manage medical care with nonmedical supports, including

family and other social supports (e.g., food assistance, transportation, etc.) and provide other services such as nurse visits. As more services are provided in the home, home health agencies are a natural partner for risk-sharing entities under APMs but would need to build additional capabilities that allow them to manage care not only after an acute event but also across the care continuum.

3. High quality: Home health agencies must ensure that they can consistently deliver the highest quality care for their patients. Medicare home health providers already serve a vulnerable population. Users of Medicare home health services are more likely to be older than 85, live alone, have multiple chronic conditions and ADL limitations, and generally have lower incomes than beneficiaries who do not use home health.[25] Home health is and will continue to be a critical tool in ensuring that these beneficiaries received skilled nursing and therapy services, thereby supporting the patient's goal of remaining safely at home and out of more expensive institutional settings. While home health agencies must be able to reliably care for a wide range of patients, in the current environment, some interviews with innovative home health agencies suggested the increasing need to provide specialized care for clinical conditions, such as heart failure or major joint replacement (as required by the CJR model), particularly under condition-specific bundled payment arrangements. In other cases, gerontological expertise or palliative care may be critical competencies. With the transition to value-based care, the home health industry must be flexible and responsive to changes in patient population and consistently provide reliable, high-quality care that allows patients to get and remain at home as safely and quickly as possible.
4. Technology enabled: Finally, technology is changing how health care is performed in this country. It allows patients to more easily connect with health care professionals and receive more intensive services in new settings. While this can improve access to care for many patients, it will also change the way care is delivered and chronic conditions are treated. Many of the innovative organizations Avalere Health interviewed as part of this study reported using technology, such as remote monitoring, to improve patient care, but they also noted that Medicare generally does not reimburse for this technology. Health information technology also promises to enable improved care coordination, quality, and efficiency, but home health agencies were not eligible for meaningful use incentive payments to implement electronic health records. Thus, going forward, home health agencies may face a "catch-22," as they are expected to implement new technology without any associated reimbursement.

Three critical roles for the home health agency of the future. With these "four pillars" of characteristics in mind, and within the emerging value-based payment world, the home health agency of the future should serve three critical roles:

1. Post–acute care and acute care support: Home health agencies should serve as key partners that support patients' transition home and facilitate high-quality care in the community. When deemed clinically appropriate for the patient, home health agencies could serve as posthospital and postemergency department resources for intense episodes of skilled nursing, care coordination, therapy, and related services.
2. Primary care partners: Home health agencies should be partners with longitudinal, outpatient primary care medical homes and home-based primary care, with responsive skilled nursing, care coordination, therapy, and related services during time-limited episodes where care recipients need an escalation in home-based care to avoid hospitalization or other undesired outcomes. Home health agencies should also provide limited ongoing skilled nursing services to enable ongoing primary care in the community (e.g., providing catheter care, ostomy care, and so forth, to support primary care efforts to enable patients to stay healthy at home).
3. Home-based long-term care partners: Home health agencies should be partners in home-based long-term care and social support models (i.e., formal and informal personal care providers) with responsive skilled nursing, therapy, and related services during episodes where care recipients need a brief escalation of home-based care to avoid hospitalization or institutionalization. Occasionally, home health agencies should provide limited ongoing skilled nursing services to that enable ongoing long-term care in the community (e.g., catheter care, ostomy care, etc.).

The home health agency of the future increasingly has new payment incentives and shared savings contracts for performing these roles capably and efficiently. In many instances, the home health agency of the future is structurally and formally more connected (as the owners, partners, or subsidiaries) of entities that integrate a range of home-based services beyond home health agency care.

Capabilities

In the context of the above-mentioned four pillars and three critical roles, home health agencies must develop new capabilities and business models to maximize their potential as a high-quality provider within the financial constraints that are inherent in most Medicare APMs. Figure 7 captures the overall framework for the future of home health care, which hinges

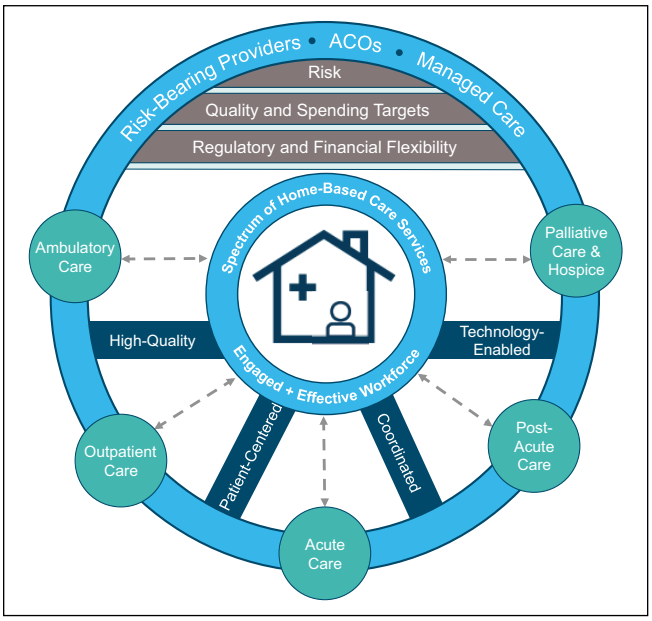

Figure 7. Framework for home health of the future.
Source. Avalere Health, 2016.
Note. ACO = accountable care organization.

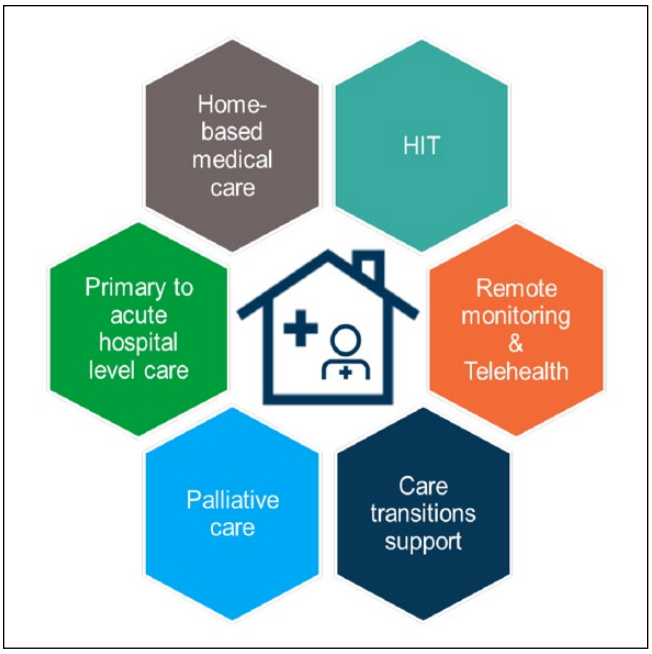

Figure 8. Capabilities of home health agencies for the future.
Source. Avalere Health, 2016.
Note. HIT = Health Information Technology.

on the home health providers' ability to provide broader services allowing them to keep high-risk beneficiaries safely in the home for as long as possible. In addition to the proven expertise of providing skilled care in the home, agencies may be responsible for offering services to high-risk beneficiaries that substitute for institutional care, prevent unnecessary acute care utilization, improve patient experience and adhere to patient preference for care in the home, and maintain function and clinical condition for as long as possible.

A subset of home health providers are already developing these capabilities and can be seen as harbingers of the future for how home health providers may ultimately progress and experience risk-based payments. Case studies highlighting innovative agencies can be found in Appendix A at http://ahhqi.org/images/uploads/APP_A_Case_Studies.pdf. In the future, these types of agencies and activities should become the norm, rather than the exception. Vignettes that illustrate the key roles, characteristics, and capabilities of the home health agency of the future can be found in Appendix B at http://ahhqi.org/images/uploads/APP_B_Vignettes.pdf.

Interviews with providers suggest that some home health agencies are finding solutions and promoting value-based care by leveraging existing capabilities and partnering to improve patient experience and outcomes. These new capabilities were relatively constant across innovative providers suggesting areas for additional investment.

The majority of these interventions, summarized in Figure 8, particularly physician house calls, telehealth, remote monitoring, and care transitions support, are intended to prevent high-cost events, including emergency department visits and hospital readmissions. Many of the providers described focus on specific clinical conditions, most often chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and diabetes. Notably, most of the interviewees said that they were not currently reimbursed separately for providing these services. One organization said that they fund these programs as part of their mission statement. Another noted that within their health system, the cost avoidance for the system as a whole through the care coordination program far outweighed any direct costs of running the care coordination program. However, this stakeholder noted that freestanding home health agencies likely face significantly greater reimbursement concerns if costs incurred and avoided are seen only within siloes. Interviewees indicate that innovative home health agencies were able to increase their value significantly in population health management initiatives primarily because of their connections to or integration within (and support from) a larger health system or network. This trade-off represents a fundamental challenge with the current home health reimbursement system: Home health agencies incur higher costs for care coordination and other services that prevent future health care system spending, but stand-alone providers often are not recognized for driving the decreased spending for the health care system.

Challenges to Address in the Current Environment

There is abundant literature describing the challenges that home health providers face to provide the type and quality of care that beneficiaries, and the health care system as a whole,

will demand in the future. These challenges can be loosely categorized into eight groups:

1. Financing mechanisms

The standard 60-day episode payment under the home health prospective payment system (PPS) includes payment for all services and supplies, including various skilled nursing services, therapy, and medical supplies (with the exception of durable medical equipment).[26] However, in interviews with stakeholders, multiple people noted that the FFS payment system does not reimburse for services that are essential for integrating patient care, including health information technology (HIT) capabilities, telehealth, and staffing for care coordination and care transition support. Numerous home health providers also brought up the need for better communication and coordination across the spectrum, including referring hospitals, physicians, and other medical and nonmedical providers. These providers often created mechanisms to improve this communication but did so without additional Medicare reimbursement. CMS acknowledged in recent rulemaking that "effective adoption and use of health information exchange and health IT tools will be essential . . . [to] improve quality and lower costs," yet home health agencies, like all post–acute care providers, were ineligible for Medicare EHR (Electronic Health Records) Incentive Programs to offset the significant costs of acquiring these capabilities.[27] Recently, CMS announced that home health agencies may be among the parties who can be eligible for Medicaid meaningful use incentive payments, but it is unclear as yet whether such incentives alone will be able to support investments in HIT for the future.

2. Regulatory constraints

Stakeholder interviews also highlighted several regulatory barriers within the structure of the home health benefit that preclude effective care coordination, provisions that prevent the necessary level of integration and coordination with other providers. Other stakeholders highlighted the Medicare requirement that the beneficiary be homebound, which does not include all beneficiaries who truly have limited capabilities to seek services outside the home. When discussing the homebound requirement, some interviewees recommended determining eligibility based on whether the beneficiary had a certain number of ADLs or chronic conditions, as well as using Hierarchical Condition Categories (HCC) scores, similar to Medicare Advantage, but there was no consensus among interviewees on the best method to establish eligibility. In the context of APMs, where there is accountability for overarching costs in a bundled payment or shared savings construct, selective waiver of the homebound requirement was often mentioned as a means to increase access to home health services for those who need it.[28]

3. Addressing program integrity and fraud and abuse

As with any service in which demand rises significantly in a short period of time, instances of fraud and abuse have occurred in the home health space. These issues must be addressed while also allowing patients access to needed services. CMS lists on its web site a range of actions the agency is taking and has taken to support fraud and abuse detection. To prevent fraud, these include efforts around timely licensure and accreditation, transparency, and auditing. These efforts are critical to eliminating bad actors and ensuring that patients maintain access to high-quality home health services. Notwithstanding, it is imperative that such measures do not hinder patient access to quality care, and place undue burden on agencies.

4. Measuring performance: Quality and patient experience

To improve quality of care and address variation across home health agencies, CMS and others have pursued value-based purchasing, quality ratings, and other forms of reporting.[1] In the context of the health care system's shift toward value, these initiatives to link payment to performance and to provide public reporting have been important changes. Over time, it will be critical to identify a parsimonious measure set that enables home health agencies to focus on core measures that matter most for performance improvement. Today, a parsimonious measure set has not yet been identified; CMS's home health value-based purchasing model demonstration project began on January 1, 2016, with 24 different performance measures that will be used to determine whether agencies in the selected states will receive positive or negative payment updates that will begin in 2018. The IOM recently called attention to the risks inherent in using too many measures in its report on *Vital Signs: Core Metrics for Health and Health Care Progress*.[29] A key consideration for the future will be to identify the core measures that home health agencies should focus on as it aligns with the rest of the health care system to achieve the Triple Aim.

5. Workforce limitations

Studies have raised a number of concerns related to the home health workforce, particularly for registered nurses (RNs), including turnover and clinical training in skilled areas of care.[30] One study identified nursing residency programs as an opportunity to gain skills and reduce turnover, but found that the prevalence of these programs in home health and hospice providers was relatively low (only 2.2% vs. 42.9% for hospitals).[30] The IOM workshop on the future of home health raised additional concerns about the home health workforce, including availability of family caregivers, changing demographics of care workers and patients, the

need to improve geriatrics training among the home health workforce, the need to address low wages and benefits, and the overall health of the U.S. economy.[1] The workshop describes the Department of Veterans Affairs' (VA) home-based primary care as a comprehensive model, one in which care is provided by an interdisciplinary team of nurses, physicians, social workers, rehabilitation therapists, dieticians, pharmacists, and psychologists. This model is effective, but potentially expensive, and therefore the VA targets high-cost veterans for the intervention. In scaling such a program to the general Medicare population, the skills and workforce to staff such a comprehensive, interdisciplinary team would be critical. CMS's Independence at Home demonstration is based on home-based primary care and may be one model that could be expanded more broadly to support the use of interdisciplinary teams.

6. Clinical capabilities related to diseases focused on by APMs

While some APMs require a focus on population health (e.g., ACOs), others would require home health agencies to develop increased clinical capabilities to address specific conditions. For example, the CJR model discussed above requires an increased focus on caring for joint replacement patients, whereas the HRRP currently focuses on heart failure, acute myocardial infarction, pneumonia, COPD, and total hip/knee replacements.[31] Home health agencies would need to develop key capabilities to not only better manage patient care across a population of patients but also handle patients with specific needs or conditions.

7. Operational capabilities

As discussed previously, home health agencies would need to develop new capabilities in a changing health care environment. Many of these capabilities require home health agencies to provide new services or interact with a broader range of providers. However, beyond these capabilities focused on care delivery, home health agencies would need to make operational changes to align their systems with the current environment. For example, home health agencies may need to hire or otherwise develop relationships with new staff, such as medical directors to link home health services with those offered by other providers or emergency medical technicians to provide rapid responses in the case of acute events.[1] Current staff may need to be trained to handle new responsibilities and functions, such as using information technology and developing and following patient centered-care plans.[1] Similarly, as home health providers become greater care partners and accept risk under APMs, they may need to change their financial or accounting practices to be able to accept risk-based payments and ensure accurate revenue recognition and reserves to handle bonus payments or potential losses.

8. Long-term care

All told, the discussion about patients' preferences and the appropriateness of care speaks more broadly to the clinical imperative of addressing each patient's full range of needs, which may go beyond Medicare home health benefits. These long-term care needs, which include functional capacity, care transitions, care coordination, and support for caregivers, are not strictly medical.[1] However, they have been shown to have meaningful impacts on patients' ability to maintain their health and remain in the community. Stakeholders, including MedPAC, have expressed concern that the increase in community-referred (or "Part B") home health episodes may be indicative of Medicare home health being used as long-term care.[32] The United States faces an unmet long-term care need due to a relatively weak and fragmented benefit system. Some home health agencies have separate lines of business that currently provide long-term care services through Medicaid and private duty and so are important to the broader long-term care discussion.

Recommendations and Conclusions

The demographic imperative of the quickly aging population, the shift from siloed to coordinated, value-based care, and the need to meet consumer preferences demand that home health agencies provide care consistent with the four pillars of characteristics and three roles laid out in this article's framework for the future. The future of health care delivery hinges on the ability of payers and providers to leverage the spectrum of home-based care, with Medicare skilled home health as a formidable linchpin in that spectrum.

Medicare officials have already signaled their willingness to enable some flexibility in new payment models when providers have a financial stake in their performance against quality and cost targets; however, current challenges and structures do not allow home health care to be used optimally. We offer the following recommendations to enable the future of home health care:

- To develop the capabilities needed to fully integrate and coordinate with high-quality, population-driven health systems, home health care needs to be empowered as a full partner that both shares in risk and has freedom to deploy the best care to the patient populations who can undoubtedly benefit. Policy makers should consider opportunities to reduce regulatory barriers to risk sharing, creating the incentive to provide seamless, coordinated care.
- CMS should address financing and regulatory challenges in the context of APMs as means of enabling appropriate use of Medicare home health care in these contexts. Testing waiver of regulatory limits such as the homebound requirement in select cases may lead

the way toward using clinically appropriate and cost-effective care. Further reforms that enable greater flexibility in the delivery of home health care in APMs should also be considered.

- Program integrity and fraud should be addressed in a targeted fashion, directed toward fraud "hot spot" areas that are identified for further investigation through aberrant claim patterns. Removing the albatross of fraud in home health care will enable greater confidence in using Medicare home health by multiple stakeholders in the future.

Consistent with this report, the home health industry must commit to pursuing a process to transform home health and home-based care to benefit patients and the U.S. health care system. Through collaboration with multiple stakeholders, including patients, caregivers, policy makers, payers, and providers and professionals across the spectrum of care, pursuit of this transformation process has the potential to improve the way health care is delivered in America.

Acknowledgments

The authors acknowledge Jennifer Schiller for assisting in preparation of this manuscript.

Authors' Note

A version of this article was presented at the National Leadership Forum on "The Future of Home-Based Care" on June 21, 2016, in Cincinnati, Ohio, and at a briefing sponsored by the Alliance for Home Health Quality and Innovation on June 30, 2016, in Washington, D.C.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The authors gratefully acknowledge the support of the following organizations that provided funding for the Future of Home Health project: Axxess, CHAP (Community Health Accreditation Partner), UnityPoint at Home, Corridor, and Simione Healthcare Consultants.

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EXHIBIT G

5 ways hospitals can boost capacity through home health

June 18, 2020

By Aliki Karnavas, Analyst, and Monica Westhead, Practice Manager

Post-acute providers play a critical role in relieving pressure on hospital beds—now more so than ever, given that hospitals need to ensure bed availability amid any surge of Covid-19 patients. However, post-acute care organizations—such as SNFs, which are limiting admissions to avoid outbreaks—face challenges of their own accepting discharged patients from hospitals. One way to solve both challenges is to **bypass facility-based care altogether when possible in favor of sending select patients directly home with home health.**

The missing piece of your Covid-19 capacity strategy: Post-acute care

Not only do home health agencies have the capacity to take on these volumes[1], research has also shown that home health outperforms other post-acute care sites on key metrics such as readmissions and overall care costs[2]. Additionally, within the context of Covid-19, the home setting offers lower risk of infection spread than facility-based settings, due to a lack of direct exposure to other patients.

However, the range and scope of services delivered via home health have long been limited by regulatory and financial barriers. With CMS' recent expansion of the homebound definition and lifting of restrictions on telehealth use in home health, hospitals now have additional incentives to explore non-traditional home health benefits. **Our research has identified two roles home health can play in increasing hospital capacity: getting patients out of hospital beds faster and keeping patients from being admitted to the hospital in the first place**. Below are five ways —categorized within those two roles—that progressive hospitals are expanding care in the home:

Role 1: Get patients out of hospital beds faster

1. *Discharge patients early when possible*

   Reducing length of stay by discharging patients early and providing follow-up care at home can create capacity while diminishing the risk of Covid-19 exposure. However, hospitals recognize—and must account for—the potential lack of adequate support and follow-up care among early discharges, which could lead to adverse outcomes, such as readmissions.

   Michigan Medicine has adopted this approach, while prioritizing patient safety, by **discharging certain types of patients early to home health**. To ensure patient safety, multi-disciplinary teams determine and prioritize patients who meet clinical criteria for early discharge. For example, postpartum mothers and their newborns are being discharged from the hospital earlier than is typically routine. Before discharge, parents are assigned to home health providers to conduct all the necessary postpartum care either in-person or virtually.

2. *Increase the intensity of care delivered in the hospital to enable safe transitions to home*

   To further propel safe transitions from hospital to home, hospitals can increase the levels of therapy delivered in the hospital, thereby reducing the intensity of care needed when patients are discharged to home health.

EXHIBIT G

For instance, Michigan Medicine is also **increasing the levels of therapy delivered in the hospital for patients who would ordinarily need SNF-level care.** Patients eligible for this additional therapy include those with neuropathies, or myopathies, and those who struggle to carry out activities of daily living. Ambulatory rehab staff are deployed to supplement the care delivered by inpatient rehab staff. The additional therapy is delivered while they are recuperating or coming off of oxygen in the hospital.

3. *Leverage caregiver capacity to deliver SNF-level care in the home*

Patients who are medically stable but need 24-hour skilled nursing and personal care are often referred to SNFs, because home health agencies typically provide intermittent care. But because SNFs are limiting admissions, hospitals can leverage caregiver capacity to deliver the needed 24-hour support.

UnityPoint's SNF-at-home model combines support from the home health provider and the patient's caregiver to provide 24-hour care to patients needing SNF-level care post-hospitalization. To ensure caregivers can safely assist patients with activities of daily living, they receive adequate training from home health clinicians and therapists, which can happen via telehealth.

Role 2: Reduce unnecessary hospitalizations using home-based services

4. *Discharge low-acuity patients from the ED directly to home*

Not all patients seen in the ED necessarily require admission, even those who need observation or the initiation of therapy. Instead, these patients can receive those services in the home setting with home health.

For example, Starwell Health Care (a pseudonym) **is discharging low-acuity patients presenting in the ED directly to home through its Enhanced Home Health program**. After ED stabilization, the patient is discharged, and the home health nurse can initiate therapy on the same day or within 24 hours under physician oversight. Starwell conducted a training to ensure home health nurses were well versed with IV initiation procedures in patient homes. A liaison—typically an RN or LPN, with care management experience—coordinates all the necessary care and orders any DME needed directly to the ED so patients can go home fully equipped.

5. *Deliver hospital-level care in the home*

One bold, though resource intensive, model for reducing reliance on acute-care beds is delivering acute-level care at home through hospital-at-home models. A number of hospitals in the United States already have these programs in place, and research has shown that they are safe and effective alternatives to hospital admissions. Amid the epidemic, hospitals can expand these programs to include more patients who present in the ED or those admitted to the hospital.

For instance, **Mount Sinai, Contessa Health, and the Visiting Nurse Service of New York are expanding their hospitalization-at-home program to increase the number of patients they can take care of.** In addition to those presenting in the ED for acute care, patients eligible for the program now include those who are stable and nearing the end of their hospital stay but still need acute-level services like intravenous antibiotics, as well as Covid-19 patients stable enough to remain at home.

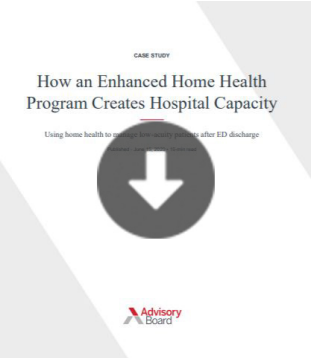
The successful management of low-acuity acute and post-acute care needs of patients in the home presents a good option for reducing unnecessary hospital days and avoiding risky transitions to facility-based care—and it can be achieved through a coordinated approach between hospitals and their home health partners.

1. Post-Acute Care Collaborative, Advisory Board analysis projects 10% declines in home health volumes due to elective procedure cancellations. Actual declines could be greater as hospitals have also decreased the volume of non-elective procedures^

EXHIBIT G

2. Post-Acute Care Collaborative, Advisory Board analysis of outcomes across the same DRG groups for patients referred to home health vs. SNF, IRF, and LTACH.^

How an enhanced home health program creates hospital capacity



Amid the Covid-19 pandemic, health systems need to create capacity to prepare for the surge in demand for acute care. While most systems are adopting a home first approach for discharge, doing so without the proper structure and support for patients could lead to poor health outcomes such as increased lengths of stay and hospital readmissions.

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Advisory Board

EXHIBIT H

PruittHealth
Union Pointe
A Skilled Nursing and Rehabilitation Center

July 20, 2020

North Carolina State Health Coordinating Council
NC Division of Health Service Regulation
809 Ruggles Drive
Raleigh, North Carolina 27603

Council Members,

I serve as administrator for PruittHealth – Union Pointe, a 90-bed skilled nursing facility located in Monroe, NC. I am writing you today to express my support of the PruittHealth petition for the addition of a home health agency specializing in the treatment of infectious diseases which will soon be submitted to your office.

Our skilled nursing facility provides an abundance of referrals to home health agencies on an annual basis. Since this pandemic began, we have learned that some of the home health agencies in this market have been unable to provide care for COVID positive patients due to a lack of resources, either in the form of staffing, PPE, or other factors. Further, skilled nursing facilities like ours need assurance that strict guidance on needed protocols and standards are enacted and followed by any home health agency treating people with infectious diseases before referring our patients to them for extended care. It is with that in mind that the idea of a home health agency specializing in the treatment of infectious diseases seems like a great proposal and one that would be of great value to the residents in this market.

I would like to stress that our facility is not advocating for the approval of any one agency and, instead, the ability for all home health providers to meet this need through the CON process in 2021. And even though this particular COVID-19 pandemic may be resolved by that time, such an agency will inevitably be needed again in the future.

Thank you for your time in reading this letter and I hope you approve the PruittHealth petition.

With regards,

Jonathan Thomas
Administrator

3510 US 74, MONROE, NC 28110
Phone: 704-291-8500 • Fax: 704-291-8501
PruittHealth.com

The New York Times | https://nyti.ms/3elk9VH

EXHIBIT I

A Covid-19 Lesson: Some Seriously Ill Patients Can Be Treated at Home

To ease pressure on hospitals, Northwell Health brought medical workers, oxygen tanks and intravenous equipment into patients' homes. Now Florida is taking cues.

By Roni Caryn Rabin

Published July 18, 2020 Updated July 22, 2020

Joan Murray had been home with Covid-19 for about a week when she ran into trouble. She had a fever of 103 degrees and chills that sent shivers up and down her spine. Her oxygen levels were dropping, and the tightness in her chest felt "as if somebody had bound up my lungs with string."

But the 77-year-old, a retired registered nurse who lives alone in Westbury, N.Y., was adamant that she wanted to fight the illness at home. "As a nurse, maybe I knew too much," she said. "The last place I wanted to be was the hospital."

So the hospital came to her.

Northwell Health, which has cared for thousands of coronavirus patients in its network of facilities in New York State, sent a nurse manager to Ms. Murray's home in May. Covered head to toe in protective gear — gown, gloves, mask, shield and disposable bootees — she spent nearly eight hours doing an assessment.

Ms. Murray was dehydrated and in need of supplemental oxygen. Within hours, she was hooked up to an intravenous line, set up in her bedroom to replenish her fluids. A phlebotomist in an N95 mask came to draw blood, an oxygen machine was delivered to her home, and Ms. Murray was prescribed a powerful blood thinner to prevent clots.

Over the course of the next week, nurses dropped by every day, and a Northwell critical care physician and lung specialist, Dr. Gita Lisker, called daily to talk with Ms. Murray.

"I was always waiting for her call — I would tell her all my troubles, and she would reassure me," Ms. Murray said. "I was like a child at that point, and she was my security blanket."

So-called wraparound home care services were created, on the fly, by Northwell Health to deal with the surge in coronavirus cases that New York experienced this spring. Now this model may help relieve health systems in the Sun Belt and other parts of the United States, where rising numbers of cases are putting extraordinary pressure on hospitals, filling intensive care units and sending providers scrambling to hire extra nurses and secure medical supplies.

Northwell doctors are already discussing the program with physicians in Miami, where several hospitals have reached capacity. Florida has more than 300,000 Covid-19 cases, and more than 10,000 new cases were identified on Thursday.

The concept of hospital-at-home programs is not new, but they had been used primarily to treat patients with flare-ups of chronic conditions like heart failure.

In response to the coronavirus epidemic, Medicare relaxed the requirements for such care. Now patients are considered homebound if a medical practitioner advises them not to leave the home because of a diagnosis of confirmed or suspected Covid-19 or a condition that makes them more susceptible to contracting the virus.

In those situations, if a doctor says skilled services are needed, a home health agency can provide them under the Medicare Home Health benefit, officials said.

Since the start of the pandemic, some hospitals have switched to at-home services to open up hospital beds for Covid-19 patients or to provide follow-up care after Covid-19 patients are discharged from the hospital.

Northwell's outreach is different because it focuses on acutely ill Covid-19 patients in the community. A team of Northwell specialists uses telehealth to advise doctors and patients in the community with mild or moderate illness.

When necessary, a comprehensive health service sends nurses and equipment into the homes of patients with severe symptoms or underlying medical conditions who might need hospitalization without such close monitoring. Pulmonologists use telemedicine to follow these patients.

During New York's crisis, "80 to 90 percent of the patients who had the virus never went to the hospital," said Dr. Thomas McGinn, Northwell's senior vice president and deputy physician-in-chief, who helped create the program.

Many Covid-19 patients did not need to be hospitalized, while others — including some who would have been admitted — simply refused to go, he said: "Hospitals were becoming this place that scared everybody."

With a shortage of diagnostic tests, many sick patients were afraid that if they didn't already have the virus, they'd catch it at the hospital. And they were put off by the knowledge that they'd be cut off from friends and family, because visitors had been barred from health facilities to prevent further spreading of the virus.

At first, physicians were nervous about managing patients at home, Dr. McGinn and Dr. Lisker said. Since then, experts have learned a lot and have developed evidence-based protocols that rely on educating patients on how to monitor their temperature fluctuations, track their blood oxygen levels using pulse oximeters and report changes to their health care providers.

Pulmonologists, experienced in caring for very sick patients with lung disease, consulted with patients over the phone, Dr. Lisker said.

"I can have a phone conversation with a patient, and after the first two sentences, I can tell if they're going to have respiratory problems," she said. "We're trained to listen."

Any patient in respiratory distress would be hospitalized, she added. But most patients were able to ride out their illnesses at home.

Between April 27 and June 1, Northwell enrolled 182 patients in its home care program. They ranged in age from 24 to 100, and many had underlying chronic conditions like diabetes or obesity, which have been linked to worse outcomes in Covid-19 cases.

Several, like Ms. Murray, were older and lived alone. But they had been carefully screened by their regular doctors; only two eventually needed hospitalization, Dr. Lisker said.

The program also provides care for Covid-19 patients who have been discharged from the hospital but have lingering symptoms that require care. Other hospital systems, like Mount Sinai Health System in New York, have also created post-discharge programs that provide care across several specialties to Covid-19 patients and evaluate the long-term effects of the disease.

Ms. Murray, who has recovered from her illness, said that it was "fortuitous" that the hospital team had intervened when it did, because her condition was deteriorating. "I don't know what I would have done otherwise," she said.

Now Northwell is expanding the program, in preparation for potential uptick in cases in New York. "If there is resurgence in New York, on a dime we can get this up and running in huge numbers, and other cities can do this, too," Dr. Lisker said. "It's a win for the patient and a win for the health system."

A version of this article appears in print on July 26, 2020, Section A, Page 9 of the New York edition with the headline: Some Seriously Ill Patients Can Be Treated at Home