Home Health Overview

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Home Health & Hospice Regulations

- Home Health and Hospice agencies are highly regulated and must meet both federal certification requirements known as the Conditions of Participation as well as NC Licensure requirements.
- The certification requirements are very extensive and dictate patient acceptance requirements, patient rights, patient assessment content and time frames, qualifications of management and staff, clinical record requirements, physician orders, supervision requirements, quality and data requirements, infection control, emergency preparedness, coordination of care, when discharge is allowed, etc.
- Both HH and Hospice services are available 24/7 via an on call system

North Carolina

- Per the SMFP 2017- 209 certified Home Health Agencies listed on the DHSR site – covering all NC counties
- Nearly 98% are accredited either by JCAHO, Accreditation Commission for Health Care or CHAP.
- Per the SMFP 2017 - 238 total hospices are listed – total inpatient beds are 449 and total residential beds are 159 – about 90% of providers are accredited
- Per DHSR there are 32 dually certified HH and Hospice agencies
- Both Home Health and Hospice are on the CMS Compare Web sites that rate agencies based on CMS measures – both HH and hospice have mandated Quality Reporting Programs

North Carolina

- Altogether, there are over 1,600 licensed home care, home health, hospice, nursing pool licenses – that also includes DME companies licensed for home care, Infusion therapy companies, licensed only home care aide agencies (both private pay and Medicaid) and private duty companies (such as companies that provide services for ventilator dependent patients) and companion sitter agencies
- While historically most referrals for services came from hospitals, we see that shifting with referrals from community settings surpassing hospital referrals.

HH Eligibility

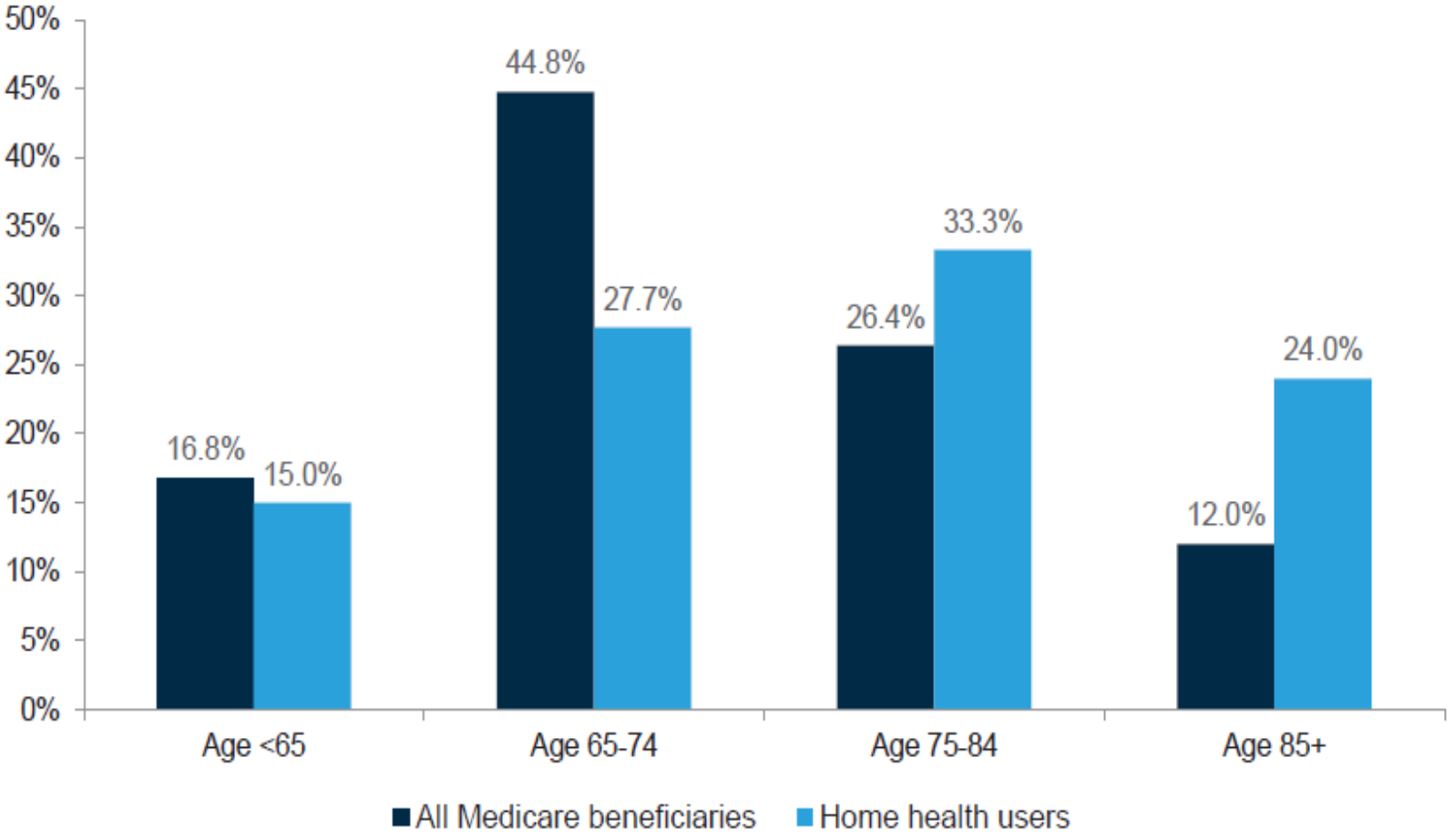
- All services must be ordered by a physician (at this time Medicare does not allow NPs or PAs to certify services**)**
- Both Medicare and Medicaid Home Health require a physician Face to Face as part of the certification of services - challenging
- Under traditional Medicare, patients must meet Medicare's **strict** definition of home bound and services be provided in the patient's place of residence.
- Medicaid does not require the patient be homebound but currently does require services be delivered in the residence and has very strict visit limits on both nursing and therapy services provided at home (For example a patient with a wound vac can only have 75 visits a year despite general best practices indicating 3 visits a week are needed).

HH Services

- Traditional Home Health Services are Nursing, PT, OT, ST, MSW and aide services and they are provided on a per visit basis
- Home Health services are both acute (such as IVs, post-surgical services, therapy, etc) or chronic disease services (for diabetes, wounds, cardiac issues, strokes, etc.).
- Home health agencies also provide palliative care and telehealth services although there is not separate payment for those services under traditional Medicare.

Demographics of Home Health Users

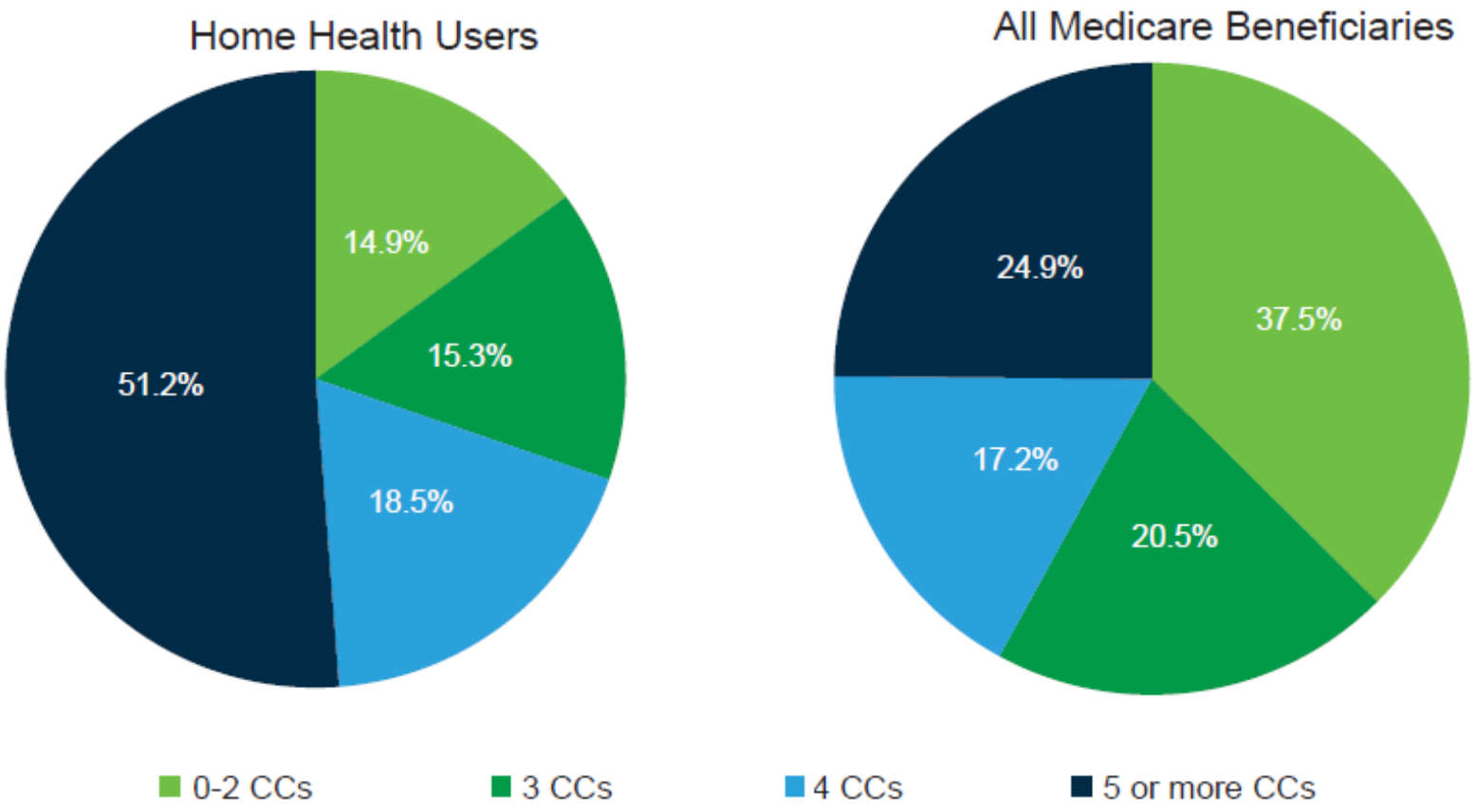
Chart 1.1: Age Distribution of Home Health Users and All Medicare Beneficiaries, 2013



Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file, 2013.

Demographics of Home Health Users

Chart 1.7: Percentage of All Medicare Beneficiaries and Home Health Users by Number of Chronic Conditions (CCs), 2013



Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file, 2013.
Totals may not sum to 100 percent due to rounding.

Demographics of Home Health Users

Table 1.8: Selected Characteristics of Medicare Home Health Users and All Medicare Beneficiaries, 2013

	All Medicare Home Health Users	All Medicare Beneficiaries
Age 85+	24.0%	12.0%
Live alone	36.7%	28.8%
Have 3 or more chronic conditions	85.1%	62.5%
Have 2 or more ADL limitations*	31.9%	12.0%
Report fair or poor health	48.7%	27.2%
Are in somewhat or much worse health than last year	41.9%	22.2%
Have incomes at or under 200% of the Federal Poverty Level (FPL)**	67.2%	52.1%
Have incomes under 100% of the Federal Poverty Level (FPL)**	31.2%	21.3%

Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file, 2013.
*ADL = Activities of daily living, such as eating, dressing, and bathing. Limitations with at least 2 ADLs is considered a measure of moderate to severe disability and is often the eligibility threshold for a nursing home level of care.
**In 2013, 100 percent of FPL for a household of 1 was $11,490, a household of 2 was $15,510, a household of 3 was $19,530, and household of 4 was $23,550. 200 percent of FPL was double each amount.

Clinical Profile of Home Health Users

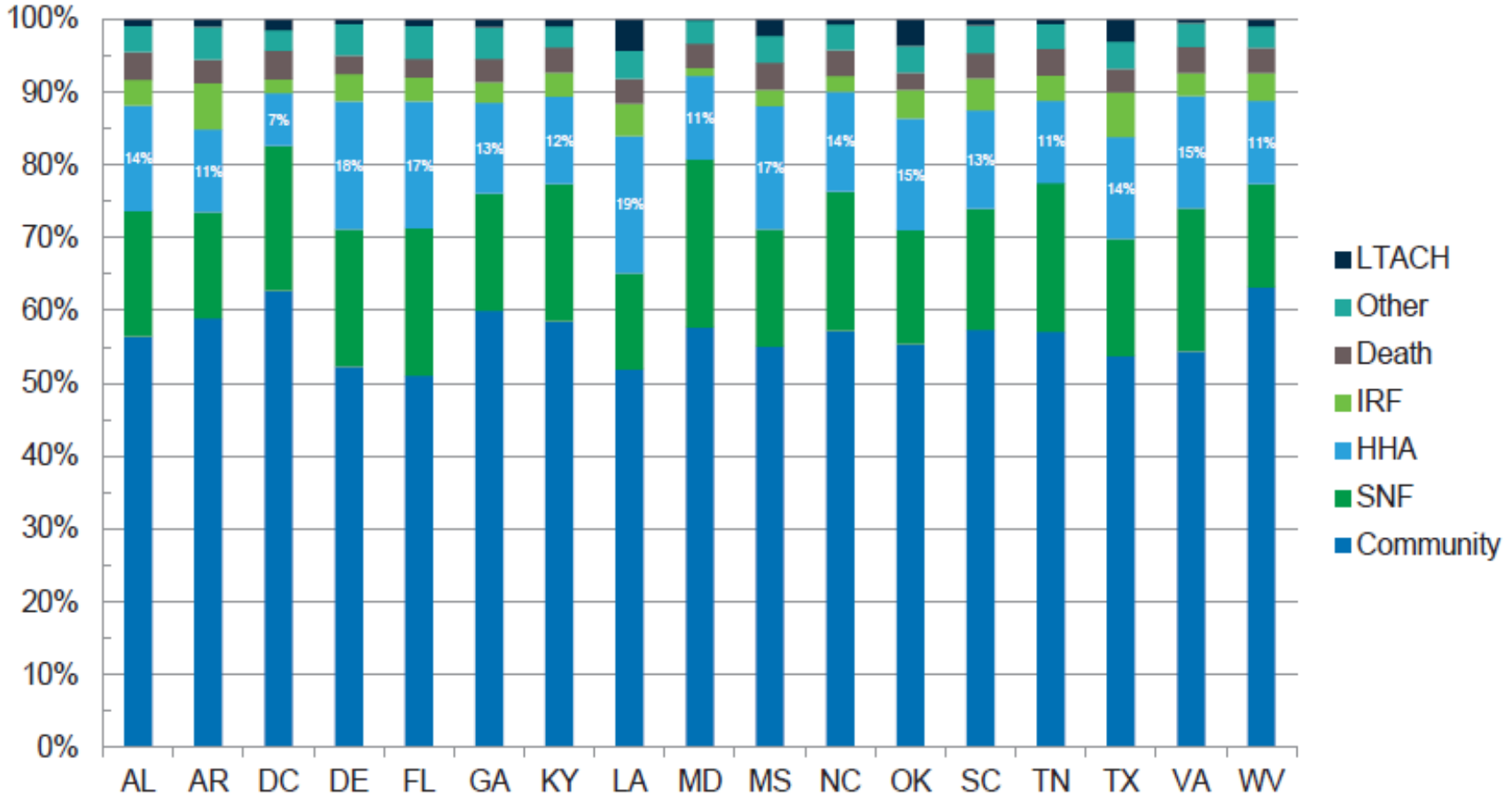
Table 2.2: Top 20 Primary International Classification of Diseases, Version 9 (ICD-9) Diagnoses for All Home Health Claims, 2015*

ICD-9 Diagnosis	Number of Medicare Home Health Claims, 2015	Percent of Total Medicare Home Health Claims, 2015
Care involving use of rehabilitation procedures	443,817	8.75%
Diabetes mellitus	392,670	7.74%
Other orthopedic aftercare	368,932	7.27%
Other and unspecified aftercare	303,801	5.99%
Heart failure	299,652	5.91%
Essential hypertension	210,534	4.15%
Chronic ulcer of skin	210,070	4.14%
Chronic bronchitis	160,903	3.17%
Osteoarthrosis and allied disorders	146,489	2.89%
Late effects of cerebrovascular disease	143,638	2.83%
Disorders of muscle, ligament, and fascia	122,711	2.42%
Cardiac dysrhythmias	103,731	2.04%
Hypertensive heart disease	73,838	1.46%
Symptoms involving nervous and musculoskeletal systems	72,676	1.43%
Other disorders of urethra and urinary tract	71,046	1.40%
Other complications of procedures, not elsewhere classified	65,310	1.29%
Other cellulitis and abscess	60,905	1.20%
Pneumonia, organism unspecified	60,449	1.19%
Hypertensive renal disease	58,829	1.16%
Other disorders of circulatory system	57,969	1.14%
Total for Top 20 Primary ICD-9 Diagnoses	3,427,970*	67.57%

Source: Avalere analysis of Medicare Standard Analytic Files, 2015.
*On October 1, 2015 the conversion from the 9th version of the International Classification of Diseases (ICD-9-CM) to version 10 (ICD-10-CM) occurred. Regardless of when a claim was submitted for payment, services that occurred prior to October 1, 2015, use ICD-9 codes. This analysis is limited to the first three quarters of 2015 (January-September) and includes the total volume for those three quarters only and identifies chronic conditions based on ICD-9 codes.

Post-Acute Care Market Overview

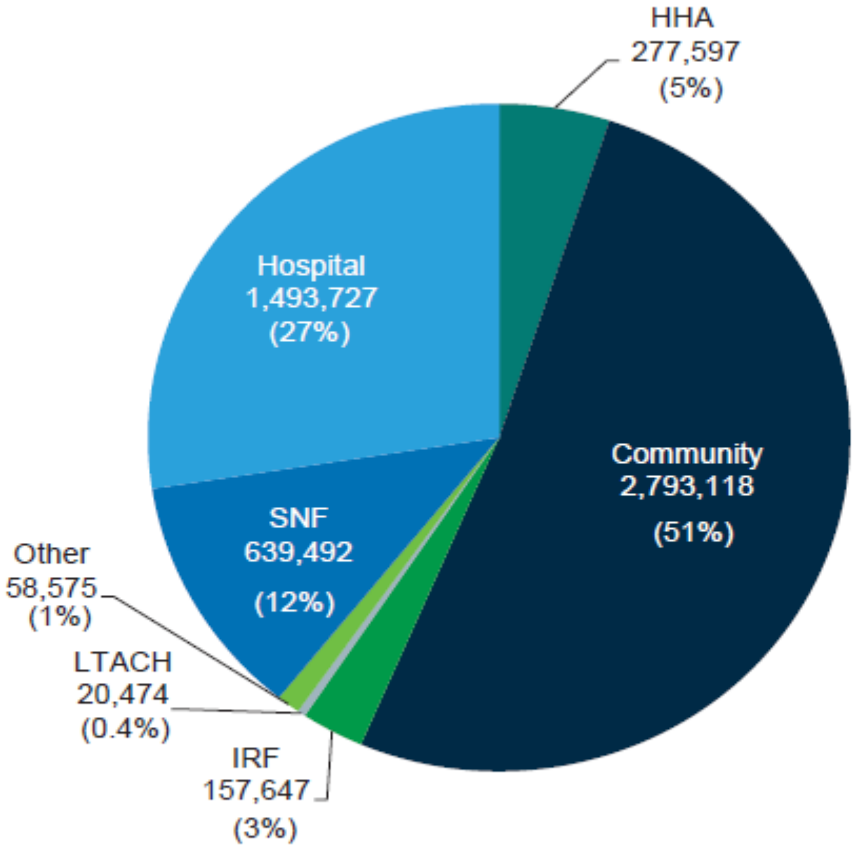
Chart 3.6: Initial Patient Destinations Following an Inpatient Hospital Stay for Medicare Beneficiaries in 2015, for States in Southern Region



Source: Avalere analysis of Medicare Standard Analytic Files, 2015.
Note: U.S. Census Bureau defines which states are in the Southern Region; includes AL, AR, DC, DE, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV.
Community: Discharges to the community without skilled home health care; includes individuals living at home, assisted living facilities, and retirement communities.
Formal Post-Acute Care Settings: Settings designated as post-acute care by Medicare. Includes skilled nursing facilities (SNF), home health agencies (HHA), inpatient rehabilitation facilities (IRF), and long-term acute care hospitals (LTACH).
Other: Hospice, another inpatient hospital, or other inpatient hospitals such as inpatient psychiatric facilities.

Post-Acute Care Market Overview

Chart 3.8: Distribution of Care Settings Prior to Home Health Episodes, 2015



Source: Avalere analysis of Medicare Standard Analytic Files, 2015.
Note: Analysis includes care setting in three days prior to home health episode.
SNF: Skilled nursing facility, HHA: Home health agency, IRF: Inpatient rehabilitation facility, LTACH: Long-term acute care hospital, Hospital: Short-term acute care hospital (STACH), Other: Hospice, another inpatient hospital, or other inpatient hospitals such as inpatient psychiatric facilities.
Community: Discharges to the community without skilled home health care; includes individuals living at home, assisted living facilities, and retirement communities.

Payment

- Home Health services are provided and paid for in 60 day episodes of care under traditional Medicare. Home health is also paid for via Medicare Managed Care, private insurance, VA, Medicaid and private pay – either per visit or episodic
- For 2018 the national, standardized 60-day episode payment for agencies that submit quality data to CMS is $3,039. In NC the episodic payments range between $2,219 to $2,683 per 60 day episode.

Hospice

- In order to be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and certified as being terminally ill by the hospice MD and the patient's attending physician (if they have one) and having a prognosis of 6 months or less if the disease runs its normal course.
- The patient must sign a statement choosing hospice care instead of other Medicare-covered treatments for the terminal illness and related conditions
- Hospice care is usually given in the home, but it also may be covered in a hospice inpatient facility. Depending on the terminal illness and related conditions, the plan of care can include any or all of these services:
- Doctor services
- Nursing care
- Medical equipment (like wheelchairs or walkers)

Hospice Services continued

- Medical supplies (like bandages and catheters)
- Prescription drugs for symptom control or pain relief (related to the terminal illness
- Hospice aide and homemaker services
- Physical and occupational therapy
- Speech-language pathology services
- Social work services
- Dietary counseling
- Grief and loss counseling for the patient and family
- Short-term inpatient care (for pain and symptom management)
- Short term respite care
- Any other Medicare-covered services needed to manage pain and other symptoms related to the terminal illness and related conditions, as recommended by the hospice team
- Hospices are also leaders in providing palliative care

Hospice Services

- Patients can get hospice care for two 90-day benefit periods, followed by an unlimited number of 60-day benefit periods.
- At the start of the first 90-day benefit period, the hospice doctor and the patient's regular doctor (if the patient has one) must certify that the patient is terminally ill (with a life expectancy of 6 months or less).
- At the start of each benefit period after the first 90-day period, the hospice medical director or other hospice doctor must recertify that the patient is terminally ill
- A hospice physician or hospice NP must have a face-to-face encounter with a hospice patient prior to, but not more than 30 days prior to the third benefit period recertification and each recertification thereafter to determine continued eligibility for the hospice benefit

- Hospice care costs are covered by Medicare (through the Medicare Hospice Benefit), Medicaid (in most states), and The Veteran's Health Administration and many insurances
- Medicare pays hospices a daily rate for each day a patient is enrolled in the hospice benefit. The payments are intended to cover the costs patient's incur in furnishing services identified in the patient's Plan of Care. Payments are made based on the level of care required to meet the patient's and family's needs. The levels of care are:

- Routine home care (RHC) – Effective January 1, 2016, RHC payments are made at: A higher payment rate for the first 60 days of hospice care
- A reduced payment rate for hospice care for 61 days and over
- Continuous home care
- Inpatient respite care
- General inpatient care
- Effective January 1, 2016, a service intensity add-on (SIA) payment, which is in addition to the per diem RHC rate (requires extensive supporting documentation)

Demographics & Data

AGE AT ADMISSION

THIS SECTION REFLECTS NEW ADMISSIONS IN 2015 BY AGE GROUP AT ADMISSION WITH A YEAR OVER YEAR COMPARISON.

AGE GROUP	PATIENT COUNT NC 2015	PATIENT % NC 2015	PATIENT COUNT NC 2014	PATIENT % NC 2014	*NHPCO PATIENT % 2014	PATIENT COUNT NC 2013	PATIENT % NC 2013
0-24	146↑	0.3%	121	0.3%	0.5%	121	0.3%
25-34	147↑	0.3%↓	145↑	0.4%↑	0.3%	141	0.3%
35-64	7,068↑	15.8%↓	6,748↓	16.5%↑	15.3%	7,028	16.4%
65-74	8,673↑	19.3%	7,898↓	19.3%↑	16.8%	8,132	19.0%
75-84	12,634↑	28.2%↓	11,352↓	27.8%↓	26.0%	12,035	28.1%
85+	16,171↑	36.1%↑	14,592↓	35.7%↓	41.1%	15,310	35.8%
TOTALS:	44,839↑	-	40,856↓	-	-	42,767	-

Source: National Data from NHPCO Facts & Figures Published in 2015

AVERAGE AND MEDIAN LENGTH OF STAY

THIS SECTION REFLECTS THE AVERAGE LENGTH OF STAY AND MEDIAN LENGTH OF STAY DATA OF REPORTED HOSPICE AGENCIES.

LENGTH OF STAY	AVERAGE	MEDIAN
Less than 7 days	3%	9%
7 to 30 days	9%	59%
31 to 60 days	19%	26%
61 to 90 days	38%	5%
91 to 180 days	26%	1%
Over 180 days	4%	0%

PAYOR SOURCE ANALYSIS (DESCENDING BY DAYS OF CARE)

THIS SECTION REFLECTS PAYOR SOURCE ANALYSIS BY DAYS OF CARE.

PAYOR SOURCE	DAYS OF CARE 2015		DAYS OF CARE 2014		*NHPCO 2014	DAYS OF CARE 2013	
Medicare	3,005,495↑	92.4%	2,783,975↑	92%	90.3%	2,745,913	92%
Medicaid	107,650↑	3.3%	104,693↑	3%	4.3%	95,440	3%
Private Insurance	101,468↓	3.1%	103,697↑	3%	4.0%	95,316	3%
Self-Pay	25,728↓	0.8%	27,356↑	1%	0.4%	26,808	1%
Other	12,131↑	0.4%	11,371↓	<1%	1.0%	15,604	1%

Source: National Data from NHPCO Facts & Figures Published in 2015

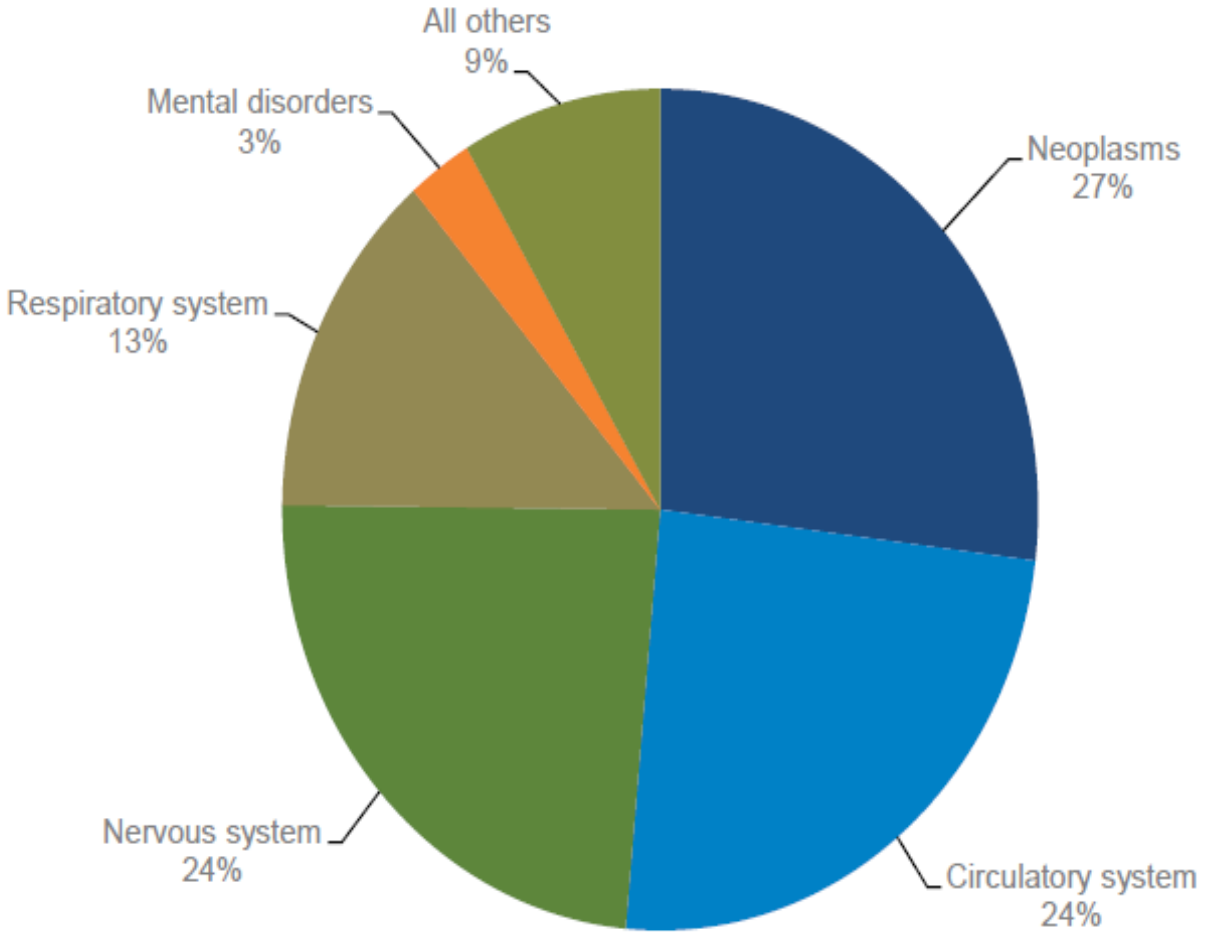
BY LOCATION OF CARE (WITH YEAR OVER YEAR COMPARISON)

THIS SECTION REFLECTS THE PERCENTAGE OF UNDUPLICATED ADMISSIONS AND DEATHS, BY LOCATION, INCLUDING A YEAR OVER YEAR COMPARISON.

LOCATION OF CARE	HOME	NURSING FACILITY	HOSPICE UNIT	HOSPITAL	HOSPICE INPATIENT FACILITY	RESIDENTIAL CARE SETTING
2015 % of Admissions	**50.4%↓**	**13.2%↑**	**1.6%↑**	**5.4%↓**	**20.1%↑**	**9.2%↑**
NC 2015 % of Deaths	**38.6%↓**	**13.9%↓**	**2.1%↑**	**5.5%↓**	**32.1%↑**	**7.8%↑**
2014 % of Admissions	52%↑	13%↓	1%↑	7%↑	19%↓	8%↓
NC 2014 % of Deaths	39%↑	14%	1%↓	7%↑	32%↓	7%↑
*NHPCO 2014 % of Deaths	35.7%	14.5%	-	9.3%	31.8%	8.7%
2013 % of Admissions	51.9%	13.1%	0.7%	6.0%	20.2%	8.1%
NC 2013 % of Deaths	38.8%	14.0%	2.4%	5.8%	33.3%	5.8%

Source: National Data from NHPCO Facts & Figures Published in 2015

PATIENT DAYS BY LARGEST CONTRIBUTING DISEASE CATEGORIES - 2015



Source: Percentage of Patient Days by Most Common Disease Categories – NC 2015

PERCENTAGE OF DEATHS SERVED BY HOSPICE (BY YEAR)

THIS SECTION REFLECTS THE OVERALL PERCENTAGE OF TOTAL DEATHS SERVED BY HOSPICE BY YEAR.

NORTH CAROLINA STATE TOTALS	TOTAL POPULATION	TOTAL DEATHS	HOSPICE PATIENT DEATHS	% OF DEATHS SERVED
2015 NC State Totals	**10,042,802↑**	**89,130↑**	**39,454↑**	**39.0%↓**
2014 NC State Totals	9,953,687↑	85,212↑	36,071↑	42.3%↓
2013 NC State Totals	9,860,149↑	83,317↑	35,357↑	42.4%↑
2010 NC State Totals	9,535,691	78,604	30,075	38.3%

Home Care

- Several non medical providers in NC have developed programs to assist with patient transitions from hospital to home. These services may include errands, companion/sitter services, transportation, home management, meal preparation, etc.
- Other providers such as Wake Forest Baptist Health Care at Home, is a new partnership that focuses on providing a more complete program of post-hospital solutions for older adults throughout the Triad, but also adult patients of all ages with complex health problems who need help adjusting to living at home after they are discharged from the hospital into the community.
- Novant's Hospital to Home program offers transitional services through 13 partner hospital and organizations. These transitional care programs work. A study by Novant Health's Post Acute Services completed in June 2012 showed that a transitional program for at-risk seniors decreased readmissions by **61%**.