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

May 15, 2020

MEMORANDUM

TO: All Interested/Affected Parties

FROM: Emily T. Marsal
Executive Director

RE: Emergency CON Application
AL2020-027-E
Alabama Home Health, LLC

An emergency Certificate of Need application was filed May 14, 2020, on behalf of the referenced provider.

ALA. ADMIN. CODE r 410-1-10-.01(1)(c) provides that within fifteen (15) days [June 2] of publication [May 15], any affected person may file with the agency comments regarding the application, regardless of whether it has been approved by the Chairman and Vice-Chairman.

All comments must be filed in accordance with Ala. Admin. Code r 410-1-3-.09, Electronic Filing.

ETM/kwm

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

RECEIVED
May 14 2020
STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

Emergency CON Application

For

One Home Health Provider

In

Montgomery County, Alabama

Submitted by:

Alabama Home Health, LLC

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- Exhibit 1: Map of Montgomery County, Alabama
- Exhibit 2: Expert Report on the Current and Projected Need for Additional Home Health Operators in Montgomery County, Alabama.
- Exhibit 3: CMS Report on Coverage and Payment Related to COVID-19 Medicare.
- Exhibit 4: CMS Report, *FAQs on Essential Health Benefit Coverage and the Coronavirus (COVID-19)*
- Exhibit 5: Letters of Support
    - Montgomery City Councilmember Clay McInnis, District 7.

Rev. 6-16

ALABAMA
CERTIFICATE OF NEED APPLICATION

For Staff Use Only

Filing Fee Remitted: $ 3,500

Project # _____
Date Rec. _____

INSTRUCTIONS: Please submit an electronic pdf copy of this completed form and the appropriate attachments to the State of Alabama, State Health Planning and Development Agency, in accordance with ALA. ADMIN. CODE r. 410-1-7-.06 (Filing of a Certificate of Need Application) and 410-1-3-.09 (Electronic Filing). Electronic filings meeting the requirements of the aforementioned rules shall be considered provisionally received pending receipt of the required filing fee and shall be considered void should the proper filing fee not be received by the end of the next business day. Refer to ALA. ADMIN. CODE r. 410-1-7-.06 to determine the required filing fee.

Filing fees should be remitted to: State Health Planning and Development Agency
100 North Union Street, Suite 870
Montgomery, Alabama 36104

Or the fee may be submitted electronically via the payment portal available through the State Agency's website at www.shpda.alabama.gov.

PART ONE: APPLICANT IDENTIFICATION AND PROJECT DESCRIPTION

I. APPLICANT IDENTIFICATION (Check One) HOSPITAL (____) NURSING HOME (____) OTHER (X) (Specify) Home Health

A. Alabama Home Health, LLC
Name of Applicant (in whose name the CON will be issued if approved)

184 Commerce Street,	Montgomery,	Montgomery
Address	City	County
Alabama,	36104,	(334) 206-3130
State	Zip Code	Phone Number

B. _____
Name of Facility/Organization (if different from A)

Address	City	County
State	Zip Code	Phone Number

C. Patrick T. Mitchell
Name of Legal Owner (if different from A or B)

10615 Jefferson Highway	Baton Rouge,	East Baton Rouge
Address	City	Parish
Louisiana	70809	(225) 368-3175
State	Zip Code	Phone Number

D. G. Dennis Nabors, Attorney, Rushton, Stakely, Johnston & Garrett, P.A.
Name and Title of Person Representing Proposal and with whom SHPDA should communicate

184 Commerce Street, Montgomery, Montgomery
Address City County

Alabama, 36104, (334) 206-3130
State Zip Code Phone Number

Wm. Wilson Blount, Attorney, Wilson Blount Attorney at Law, LLC.
Name and Title of Person Representing Proposal and with whom SHPDA should communicate

5529 Ash Grove Circle, Montgomery, Montgomery
Address City County

Alabama, 36116, (334) 303-0799
State Zip Code Phone Number

I. APPLICANT IDENTIFICATION (continued)

E. Type Ownership and Governing Body

1. Individual (____)
2. Partnership (____)
3. Corporate (for profit) (X) Limited Liability Company
Name of Parent Corporation
4. Corporate (non-profit)(____) _____
Name of Parent Corporation
5. Public (____)
6. Other (specify) (____)
_____

F. Names and Titles of Governing Body Members and Owners of This Facility

OWNERS	GOVERNING BOARD MEMBERS
Patrick T. Mitchell, CEO	Carla Bonvillian, RN
	Trudy Martin
	Carmel Drago

II. PROJECT DESCRIPTION

Project/Application Type (check all that apply)

X New Facility
Type: Home Health

_____ Major Medical Equipment
Type_____

X New Service
Type: Home Health

_____ Termination of Service or Facility

_____ Construction/Expansion/Renovation

_____ Other Capital Expenditure
Type_____

_____ Change in Service

III. EXECUTIVE SUMMARY OF THE PROJECT

Novel coronavirus (**COVID-19**) is a new virus strain spreading from person-to-person throughout the world, including the United States and Alabama. Health experts are concerned about this new virus and its potential to cause severe illness and pneumonia. On March 11, 2020, the World Health Organization (**WHO**) announced this virus had reached pandemic levels, and on March 13, 2020, the President of the United States declared a National Emergency.[1]

This emergency declaration called for health care providers on the entire continuum of care to assess their preparedness and processes to face the strain on our health care system.[2] It also enacted additional measures to both contain and prevent the spread of the virus. These include waiving certain requirements of Medicare and Medicaid, as well as other measures to allow and promote flexibility in handling this crisis.[3]

Following suit, on March 13, 2020, Alabama Governor Kay Ivey declared a state of emergency under the Alabama Emergency Management Act of 1955.[4] The declaration allows healthcare providers to use alternative standards of care when treating patients due

[1] https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/
[2] *Id*.
[3] *Id*.
[4] Ala. Code §§ 31-9-8.

to the unprecedented nature of this crisis.[5] The aim is to promote flexibility in regards to regulations that may impede the state and health care provider's ability to adequately address the situation.

Further, on April 2, 2020, Governor Ivey supplemented her state of emergency declaration due to the increasing number of COVID-19 patients.[6] The proclamation called for "cutting the red tape for health care providers" by allowing out of state and professionals and those with expired licenses to operate in Alabama.[7] Similarly, the declaration called for "expanding capacity of health care facilities."[8] Specifically, it called for the following:

> The State Health Planning and Development Agency and, as appropriate, the Statewide Health Coordinating Council and the Certificate of Need Review Board, is hereby authorized and directed to promulgate emergency rules to provide for temporary waivers to the Certificate of Need process to permit new services, facilities, and other resources needed for the treatment of patients affected by the appearance of COVID-19, or to free up bed and treatment space at existing health care facilities to permit such needed treatment.[9]

In light of this crisis, Alabama Home Health, LLC (**AHH**) is seeking an Emergency Certificate of Need (**CON**) in order to provide additional home health services in Montgomery County, Alabama.[10] AHH is prepared to provide COVID-19 tests to any home health patients showing symptoms. This novel approach to dealing with this pandemic will serve several purposes. First, it will provide better access to testing by giving the test to the patient in the home. Second, it will help contain the virus, as the test is administered in the patient's home as opposed to a clinic or hospital. Third, it will reduce hospital beds by identifying the most at risk patients before they require costly inpatient care.[11] This novel approach for addressing the crisis has been successfully implemented by AHH's parent company, the Carpenter Health Network (**CHN**), in several states such as

[5] *https://governor.alabama.gov/newsroom/2020/03/state-of-emergency-coronavirus-covid-19/*
[6] https://governor.alabama.gov/assets/2020/04/2020-04-02-Fifth-Supplemental-SOE_COVID-19.pdf
[7] *Id*.
[8] *Id*.
[9] *Id*.
[10] Ala. Code §§ 410-1-10-.01
[11] https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications/older-adults.html

Arkansas, Louisiana, and Texas. Furthermore, it is reimbursable under Medicare and Medicaid, and the copay is waived for private insurers such as Blue Cross Blue Shield.

According to the Center for Disease Control (**CDC**), 80% of the deaths associated with COVID-19 have been from Americans 65 and older.[12] For a better perspective on COVID-19's effects on seniors, see the following:
Among adults with confirmed COVID-19 reported in the U.S.[13]:

- Estimated percent **requiring hospitalization**
  - 31-70% of adults 85 years old and older
  - 31-59% of adults 65-84 years old
- Estimated percent requiring **admission to intensive care unit**
  - 6-29% of adults 85 years old and older
  - 11-31% of adults 65-84 years old
- Estimated percent **who died**
  - 10-27% of adults 85 years old and older
  - 4-11% of adults 65-84 years old

For perspective, 13.8% of Alabama residents are over the age of 65.[14] Moreover, Montgomery and its contiguous counties have a higher number of seniors than the State average. (See Tables 1 and 2 below).

In light of the declarations calling for flexibility, containment and prevention of the spread of COVID-19 from both the President and the Governor, an Emergency CON review is warranted. If there was ever a time for additional health care services, it would be during the current uncertain times. Due to its population demographics, Montgomery County is particularly susceptible to COVID-19. In fact, on May 7th, the White House listed the

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

Montgomery Metro area as one of the top 10 at risk for COVID-19.[15] At the end of April, the Montgomery area had nearly 300 confirmed COVID-19 cases.[16] In just the first week of May alone, Montgomery added 235 additional cases. Considering AHH's original and cost effective approach to the crisis, they should be awarded a CON as a home healthcare provider (**HHCP**) in Montgomery County, Alabama.

IV. COST

A. Construction (Includes modernization, expansion)	
1. Predevelopment	N/A
2. Site Acquisition	N/A
3. Site Development	N/A
4. New construction	N/A
5. Professional Fees	N/A
6. Renovation	N/A
7. Interest during time of construction	N/A
8. Attorney and Consulting Fees	N/A
9. Bond Issue Costs	N/A
10. Contingency	N/A
11. Other	N/A
12. Other	N/A
TOTAL COST OF CONSTRUCTION	
B. Purchase	
1. Facility	N/A
2. Major Medical Equipment	N/A
3. Other Equipment	N/A
4. Interest during time of construction	N/A
5. Debt Issuance Costs	N/A
TOTAL COST OF PURCHASE	**$ -**
C. Lease (Capitalized per GAAP)	
1. Facility Cost Per Lease Period ($1,800/mo x 3 Years)	**$ 64,000.00**
2. Equipment Cost Per Lease Period ($4,000 x 2 Months)	**$ 8,000.00**

[15] https://www.al.com/news/2020/05/montgomery-county-emerging-as-alabamas-latest-coronavirus-hotspot.html

[16] *Id*.

3. Land-only Lease Cost Per Lease Period	**$ -**
TOTAL COST OF LEASE(S)	**$ 64,000.00**
(compute according to general accepted accounting principles)	
Cost if Purchased	N/A
D. Services	
1. (X) New Service	
2. (___) Expansion Existing Services	
3. (___) Reduction or Termination	
4. (___) Other:	
FIRST YEAR ANNUAL OPERATING COSTS	**$ 240,833.00**
E. Total Cost of this Project	**$ 312,833.00**
(total A. through D. should equal V.C. on page 10)	

IV. COST (continued)

F. Proposed Finance Charges		
1. Total Amount To Be Financed (Gross Loan)- Facility	N/A	
2. Anticipated Interest Rate- Facility	N/A	
3. Term of Loan in ears- Facility	N/A	
4. Total Amount To Be Financed (Gross Loan)- Equipment	N/A	
5. Anticipated Interest Rate- Equipment	N/A	
6. Term of Loan in Yeas- Equipment	N/A	
7. Method of Calculating Interest on Principal Payments	N/A	
V. ANTICIPATED SOURCE OF FUNDING		
	Amount	**Source**
A. Federal		
1. Grants	N/A	
2. Loans	N/A	
B. Non-Federal		
1. Commercial Loan (or equivalent if not bonds)	$ -	
2. Tax-exempt Revenue Bonds (or equivalent)	$ -	
3. General Obligation Bonds	$ -	
4. New Earnings and Revenues (First Year)	$ -	
5. Charitable Fundraising	$ -	
6. Cash on Hand	**$312,833.00**	
7. Other	$ -	

C. TOTAL	**$312,833.00**	
(Should Equal IV. E. on previous page)		
VI. TIMETABLE		
A. Projected Start Date:	**Upon CON Approval**	
B. Projected Completion Date:	**Within 30 Days of receipt of CON**	

PART TWO: PROJECT NARRATIVE

Note: In this part, please submit the information as an attachment. This will enhance the continuity of reading the application.

The applicant should address the items that are applicable to the project.

I. MEDICAL SERVICE AREA

A. *Identify the geographic (medical service) area by county (ies) or city, if appropriate, for the facility or project. Include an 8 ½ x 11" map indicating the service area and the location of the facility.*

The State Health Plan (**SHP**) defines the service area for a Home Health Provider (**HHCP**) as the county level. As a result, a map of Montgomery County is presented below and at "Exhibit 1."

B. *What population group(s) will be served by the proposed project? Define age groups, location and characteristics of the population to be served.*

Traditionally home healthcare serves Alabama's 65 years and above population. The demographics and population projections of Montgomery and its surrounding counties is provided below at Tables 1 and 2.

Table 1: Montgomery and Surrounding Counties' Demographics[17]

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

Table 2: Percentage of the Population Projected to be 65+[18]

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

C. *If medical service area is not specifically defined in the State Health Plan, explain statistical methodologies or market share studies based upon accepted demographic or statistical data available with assumptions clearly detailed. If Patient Origin Study data is used, explain whether institution or county based, etc.*

The SHP defines the service area for a HHCP as the county level. Under the contiguous county rule, a HP can operate in a contiguous county after a year of operation. Ala. Admin. Code § 4-10-2-4-.07(1)(d); Section 22-21-265, Code of Ala. 1975. This CON application covers Montgomery County, but the surrounding county data was also included for clarity.

[17] Data taken from the Center for Business and Economic Research ("CBER") at the University of Alabama, County "Population Estimates by Race/Age/Sex, 2016," *available at* https://cber.cba.ua.edu/edata/est_prj/AL%20County%20population%20by%20RaceAgeSex2016.xls.

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

D. *Are there any other factors affecting access to the project?*

(__) Geographic (X) Economic (X) Emergency (X) Medically Underserved

Please explain.

Economic:

On one end of this continuum of care you have acute hospital care. This provides serves inpatient from doctors, nurses and other hospital staff. Consequently, it is the most expensive stage in the US healthcare system. On the far end of this continuum of care is Home Healthcare followed by Hospice services. These are the least expensive because, with some exceptions, they are outpatient services provided in the patient's home. Hospice care includes services for patients and families experience during the final stages of illness and death.[19] Home Healthcare provides the patient with care in the home, as opposed to another inpatient or outpatient facility.[20] This allows patients to be comfortable, providing better outcomes and sometimes ending or postponing the need for hospitalization.[21]

The reduction in healthcare costs by utilizing HHCPs can be seen in a variety of ways. For instance someone recovering from surgery with home healthcare for a month will receive a bill around $1,200 but someone who recovers in a facility (such as a nursing home) would be billed around $12,000.[22] From a bird's eye perspective, the Medicare Payment Advisory Commission (**MedPAC**) reports that 3.4 million, or 17 percent, of traditional fee-for-service Medicare beneficiaries used home health in 2016.[23] Center for Disease Control (CDC) data shows that approximately 81.9 percent of home health users are age 65 or older, 55.1 percent are 75 or older, and nearly 25.2 percent are 85 or older.[24]

In summary, research and historic utilization patterns demonstrate that access to home health care provide, not only a cost savings to the payor, but also improved health outcomes for the recipient. As a result, they should be expanded as part of a more cost effective and efficient health care delivery system.

Medically Underserved:

Montgomery and its contiguous counties have two major demographic trends that demonstrate they require more HHCP than the average county in Alabama. One, the area shows a disproportionally high number of African-American residents. According to the latest census update, just over 26% of

[19] Alabama Department of Public Health; Rules, Chapters 420-5-17-.01 (1) Definitions (h) "Hospice Care Program".
[20] http://www.alabamapublichealth.gov/homehealth/
[21] *Id.*
[22] https://www.usnews.com/news/articles/2014/09/30/is-home-health-a-solution-to-rising-health-costs
[23] http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch9_sec.pdf?sfvrsn=0 at 251.
[24] https://www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf at 20. Figure 20.

Alabama residents are African-American.[25] Montgomery County's African-American population is 58.1%, over double the State average. The adjoining counties of Bullock, Lowndes and Macon have African-American populations almost three times the State average. Two, 13.8% of Alabama residents are over the age of 65.[26] Moreover, Montgomery and its contiguous counties have a higher number of seniors than the State average. Groups that are particularly at risk for COVID-19.

Emergency:

As discussed above, COVID-19 is a pandemic and initiated emergency declarations at the federal and state level. Due to its population demographics, Montgomery County is particularly susceptible to COVID-19.

II. HEALTH CARE REQUIREMENTS OF THE MEDICAL SERVICE AREA

A. *What are the factors (inadequacies) in the existing health care delivery system which necessitate this project?*

First, no other Home Health provider in Montgomery County is offering in home COVID-19 tests.

Second, as shown above, Alabama, like the rest of the nation, is getting older. The landscape and scope of home healthcare services are being propelled by those population trends. For instance, 65% of those enrolled in Medicare have three or more chronic conditions. In addition, half of this number live below the poverty line.[27] It is estimated that by 2040, 80 million Americans will be 65 and older. Moreover, the number of Americans 85 and older will be about 14.1 million. As individuals age, not only does their health tend to decline, but their healthcare costs increase.[28] As stated above, in 2011, 83.2 percent of HHCP patients have three or more chronic conditions requiring a higher level of care.[29]

As America's population ages, we are starting to see more people over the age of 65 than at any time in our nation's history. As a result, home healthcare will become crucial in serving that population effectively. Nowhere is this more true than in Alabama, in which roughly 16% of residents are over the age of 65.[30] As seen above, Montgomery and its surrounding counties are disproportionately older than the State's average.

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

[26] *Id*. at Table 1.

[27] Kaiser Family Foundation. Medicare at a glance. 2014. [December 31, 2014]. http://kff.org/medicare/fact-sheet/medicare-at-a-glance-fact-sheet. [Reference list]

[28] https://www.usnews.com/news/articles/2014/09/30/is-home-health-a-solution-to-rising-health-costs

[29] https://members.elevatinghome.org/files/Education-Quality/VNAA%20CSfinal.pdf via CMS.

[30] https://www.census.gov/library/visualizations/interactive/population-65-years.html

B. *How will the project correct the inadequacies?*

First, AHH is prepared to provide COVID-19 tests to any home health patients showing symptoms.

Second, due to its growth as a cost effective alternative, and its propensity to reduce readmission rates, home health care is a facet of the industry that is becoming a more critical part of the American healthcare system. As the numbers decline in the hospital readmissions costs go down due to shorter stays. HHCPs provide an excellent way to facilitate this shift. It achieves the same readmission rates as hospitals. Moreover, it provides critical procedures like depression treatment, fall risk and instructions to families.

INSERT MINORITY OUTREACH

C. *Why is your facility/organization the appropriate facility to provide the proposed project?*

AAH has a plan and process in place to provide for in home testing for COVID-19. In fact, it been successfully implemented by AHH's parent company, CHN, in Arkansas, Louisiana, and Texas. Furthermore, it is reimbursable under Medicare and Medicaid, and the copay is waived for private insurers such as Blue Cross Blue Shield.

In addition to its novel approach to COVID-19 testing. AHH and have through CHN has implemented the AIM program that provides in-home palliative care for patients facing life-limiting illnesses in Louisiana and Texas. It specifically targets those who wish to continue actively fighting an illness, even during late phases that require symptom control and interventional pain management. This program gives the following patients time and information in regards to treatment and healthcare options:

- Dialysis patients who plan to continue dialysis treatments
- Cancer patients who plan to continue radiation treatments
- Cancer patients who plan to continue chemotherapy treatments
- Advanced heart disease patients who want to explore options
- Advanced COPD patients who want to explore options

The AIM program provides these options by using experts specifically trained in understanding the challenges and needs of those facing life-limiting illness. This team includes Hospice certified physicians, licensed nurses, certified nurse assistants, medical social workers and chaplains. They offer the patients expert care in the symptoms associated with their illness, treatment strategy and guidance,

social services, emotional and spiritual support, as well as support for the family. With this focus, palliative care can improve the quality of care and reduce the costs associated with more expensive medical services.[31] By offering this unique service, the AIM program gives those with life-limiting illnesses the option, guidance, education about the services available to them.

D. *Describe the need for the population served or to be served for the proposed project and address the appropriate sections of the State Health Plan and the Rules and Regulations under 410-1-6-.07. Provide information about the results of any local studies which reflect a need for the proposed project.*

The text below is a summary of a report examining this issue prepared by George S. Ford, PhD., and R. Alan Seals, PhD., of Applied Economic Studies. A more in depth report is filed as "Exhibit 2."

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

As the method requires, we use data from years 2016-2018 to estimate "need" for years 2019-2021. Population forecasts are obtained from the SHPDA website and population for years 2016-2018 are obtained from the Census Bureau's Factfinder.[32] We provided a mathematical summary of the calculations in our initial filing, so we do not repeat it here.[33] SHPDA states that additional home health providers are needed when the "New persons required to be served in a county" exceeds 100. Implementing the SHPDA method indicates that the "new persons required to be served" in Montgomery County is 204 persons.[34] Thus, the threshold for "need" in the county is satisfied.

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

[31] Temel JS, Greer JA, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *NEJM*. 2010;363:733–42. 734.

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

[33] See Exhibit 2; Section III.

[34] Calculations are conducted using Stata 16.

conclude that a reasonable forecast of future home health patients must account for both the growth in population and growth in utilization.

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

Whether using our forecast of need or SHPDA's method[35], we conclude that a Certificate of Need is justified for Montgomery County, Alabama."

E. *If the application is for a specialized or limited-purpose facility or service, show the incidence of the particular health problem.*

While this Emergency CON Application is for a HHCP, AHH would be the only provider offering in home COVID-19 tests to those patients who showed symptoms. Moreover, AHH would be the only HHCP providing "home vent." This is crisis is particular in nature and granting this CON would help alleviate the strain on Montgomery County's existing health care infrastructure.

F. *Describe the relationship of this project to your long-range development plans, if you have such plans.*

St. Joseph's Hospice of South Alabama (**STJ**), another part of the CHN, has sought to expand its services to Montgomery County. In addition to home healthcare, they ultimately seek to meet the need for routine and inpatient hospice in Montgomery County. CHN is committed to making a significant investment for a full-range of palliative care in Montgomery County if the CON is granted.

III. RELATIONSHIP TO EXISTING OR APPROVED SERVICES AND FACILITIES

A. *Identify by name and location the existing or approved facilities or services in the medical service area similar to those proposed in this project.*

Name of Facility	County	Number of Visits	Number of Patients Served
Kindred at Home	Montgomery (Prattville)	16,155	539

[35] See Exhibit 2; Section III.

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

B. *How will the proposed project affect existing or approved services and facilities in the medical service area?*

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

a) **The aging population.** As shown above, Montgomery County is above the State average in citizens over 65 years of age. As the county and the country ages, and people live longer, HHCPs will be critical providing quality healthcare. Due to this increase, it is not expected to have an effect on existing providers. If a CON were granted, the majority of patients at any new facility would be new patients.

b) **The County's demographics show an underserved population**. Montgomery County has a higher than average African American population that continues to grow and age. This demographic is already underserved in the area and the demand will only increase.

C. *Will there be a detrimental effect on existing providers of the service? Discuss methodologies and assumptions.*

As discussed in Section B. above, due to Montgomery Counties demographics, including its underserved and aging population, AHH does not expect a detrimental effect on HHCPs.

However, no other HHCP in Montgomery County is screening for COVID-19 in their patients. As result, there is no other provider of this service in the area.

For an expert report on the methodologies, please refer to "Exhibit 2"

It is also of note that of the 14 HPs listed in Section A. above, only 5 of them have CONs in Montgomery County. The rest operate through the contiguous county rule.

D. *Describe any coordination agreements or contractual arrangements for shared services that are pertinent to the proposed project.*

AHH will use laboratory testing for COVID-19 tests. CHN currently has a relationship with a company to provide the service. The name is redacted for proprietary reasons.

Further information on COVID-19 testing and its billing implications can be found on the guidelines released by the Center for Medicare and Medicaid Services (**CMS**) provided as "Exhibit 3" and "Exhibit 4"

E. *List the new or existing ancillary and/or supporting services required for this project and briefly describe their relationship to the project.*

Not applicable.

IV. POTENTIAL LESS COSTLY OR MORE EFFECTIVE ALTERNATIVES

A. What alternatives to the proposed project exist? Why was this proposal chosen?

There is no alternative to this proposed project, except to not to offer in home COVID-19 test to patient's utilizing home healthcare.

B. How will this project foster cost containment?

The reduction in healthcare costs by utilizing HHCPs can be seen in a variety of ways. For instance someone recovering from surgery with home healthcare for a month will receive a bill around $1,200 but someone who recovers in a facility (such as a nursing home) would be billed around $12,000.[36] From a bird's eye perspective, the Medicare Payment Advisory Commission (**MedPAC**) reports that 3.4 million, or 17 percent, of traditional fee-for-service Medicare beneficiaries used home health in 2016.[37] Center for Disease Control (CDC) data shows that approximately 81.9 percent of home health users are age 65 or older, 55.1 percent are 75 or older, and nearly 25.2 percent are 85 or older.[38]

C. How does the proposal affect the quality of care and continuity of care for the patients involved?

AHH believes that the quality of care for HHCP patients will increase because they will be able to tested in their homes if they show symptoms of COVID-19. Furthermore, it would increase the quality of care for all of Alabama in that a potential COVID-19 carriers would not be forced to seek tests from hospitals, clinics or drive throughs. As a result, this would reduce the risk of exposure to the public.

In addition, AHH would offer a unique service that helps transition patients from HHCPs to hospice care called AIM. The AIM program provides these options by using experts specifically trained in understanding the challenges and needs of those facing life-limiting illness. This team includes Hospice certified physicians, licensed nurses, certified nurse assistants, medical social workers and chaplains. They offer the patients expert care in the symptoms associated with their illness, treatment strategy and guidance, social services, emotional and spiritual support, as well as support for the family. With this focus, palliative care can improve the quality of care and reduce the costs associated with more expensive medical services.[39] By offering this unique service, the AIM program gives those with life-limiting illnesses the option, guidance, education about the services available to them.

[36] https://www.usnews.com/news/articles/2014/09/30/is-home-health-a-solution-to-rising-health-costs
[37] http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch9_sec.pdf?sfvrsn=0 at 251.
[38] https://www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf at 20. Figure 20.
[39] Temel JS, Greer JA, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *NEJM*. 2010;363:733–42. 734.

V. DESCRIBE COMMUNITY REACTION TO THE PROJECT

Letters of Support from the following are attached as "Exhibit 6"

a. Montgomery City Councilmember Clay McInnis, District 7.

VI. NON-PATIENT CARE

If appropriate, describe any non-patient care objectives of the facility, i.e., professional training programs, access by health professional schools and behavioral research projects which are designed to meet a national need.

None. AHH would be all patient care.

VII. MULTI-AREA PROVIDER

If the applicant holds itself as a multi-area provider, describe those factors that qualify it as such, including the percentage of admissions which resides outside the immediate health service area in which the facility is located.

In this case, AHH does not meet the limited definition of multi-are provider set by CON Rules and Regulations. HHCPs in Alabama are limited to the county in which their CON is granted. However, under the Contiguous County Rule, they can apply to operate in any contiguous county after a year of operation.

VIII. HEALTH MAINTENANCE ORGANIZATION

If the proposal is by or on behalf of a health maintenance organization (HMO), address the rules regarding HMOs, and show that the HMO is federally qualified.

Not applicable.

IX. ENERGY-SAVING MEASURES

Discuss as applicable the principal energy-saving measures included in this project.

Energy saving measures would be incorporated in renovation of any existing space consistent with state and federal requirements.

X. OTHER FACTORS

Describe any other factor(s) that will assist in understanding and evaluating the proposed project, including the applicable criteria found at 410-1-6 of the Alabama Certificate of Need Program Rules and Regulations which are not included elsewhere in the application.

Over the last few weeks, much attention has been given to projections that hospitals across America run the possibility of being inundated with patients suffering form COVID-19. What has received less notice is what occurs when patients recuperate (even high risk). They will still require post-acute care that might be unavailable due to a lack of not just capacity, but capability to properly treat patients.

Post-acute services include palliative care, which is provided by HHCPs, following a hospital stay.[40] Due to the pandemic nature of this crisis, data is limited in regards to COVID-19 patients requiring post-acute care. However, Medicare's historical data, in regards to sepsis (similar inpatient mortality rate associated with COVID-19), indicates that 20% require home healthcare.[41]

In order to free up hospital beds, Medicare has already relaxed the "3 Day Rule" that requires beneficiaries to spend three days in the hospital to be eligible for post-acute benefits.[42] However discharge of a potentially contagious patient complicates and paces an undue amount of strain on the American health care system. As one recent journal article posited, "What steps can policy makers and health care organizations take to ensure safe and appropriate post-acute care services in the coming weeks and month?"[43]

In light of these post-acute issues, it is pertinent to point out that AHH (through CHN), will offer a "Home Vent" service as a part of its home healthcare package. This service offers oxygen therapy through a ventilator that controls the flow of oxygen in the patient's home. It is used by those suffering from COPD and other respiratory illnesses, including COVID-19. It is our understanding that no other HHCP is offering this service in the State.

Considering the issues associated with isolation in inpatient care, it will be important to treat patients in their home.[44] This service is currently provided by HHCPs. In order to meet the need, Montgomery County will need another HHCP, and AHH is prepared to get to work immediately with their novel approach to fighting COVID-19.

PART THREE: CONSTRUCTION OR RENOVATION ACTIVITIES

Complete the following if construction/renovation is involved in this project. Indicate N/A for any questions not applicable.

I. ARCHITECT N/A

Firm N/A

Address N/A

[40] Report to Congress: Medicare payment policy—skilled nursing facility services. News release. Medicare Payment Advisory Commission. Published March 15, 2019. Accessed March 20, 2020. http://www.medpac.gov/docs/default-source/reports/mar19_medpac_entirereport_sec.pdf

[41] Buchman TG, Simpson SQ, Sciarretta KL, et al. Sepsis among Medicare beneficiaries, 2: the trajectories of sepsis, 2012-2018. *Crit Care Med*. 2020;48(3):289-301.

[42] Emergency declaration press call remarks by CMS Administrator Seema Verma. News release. US Centers for Medicare and Medicaid Services. March 13, 2020. Accessed March 20, 2020. https://www.cms.gov/newsroom/press-releases/emergency-declaration-press-call-remarks-cms-administrator-seema-verma

[43] Grabowski DC, Joynt Maddox KE. Postacute Care Preparedness for COVID-19: Thinking Ahead. *JAMA.* Published online March 25, 2020. doi:10.1001/jama.2020.4686

[44] *Id*.

City/State/Zip N/A

Contact Person N/A

Telephone N/A

Architect's Project Number N/A

II. ATTACH SCHEMATICS AND THE FOLLOWING INFORMATION

A. *Describe the proposed construction/renovation*
N/A

B. Total gross square footage to be constructed/renovated N/A

C. Net useable square footage (not including stairs, elevators, corridors, toilets) N/A

D. Acres of land to be purchased or leased N/A

E. Acres of land owned on site N/A

F. Anticipated amount of time for construction or renovations N/A

G. Cost per square foot $ N/A

H. Cost per bed (if applicable) $ N/A

PART FOUR: UTILIZATION DATA AND FINANCIAL INFORMATION

This part should be completed for projects under $500,000.00 and/or those projects for ESRD and home health. If this project is not one of the items listed above, please omit Part Four and complete Part Five. Indicate N/A for any questions not applicable.

I. UTILIZATION	CURRENT		PROJECTED
Years: 2019	2020	2020	2021
A. ESRD			
# Patients _____	_____	_____	_____
# Procedures _____	_____	_____	_____
B. Home Health Agency			
# Patients 0	0	90	150
# of Visits _____	_____	_____	_____

C. New Equipment
Patients _____ _____ _____ _____

Procedures _____ _____ _____ _____

D. Other
Patients _____ _____ _____ _____

Procedures _____ _____ _____ _____

II. PERCENT OF GROSS REVENUE

	Historical			Projected	
Source of Payment	**2019**	**2020**	**2020**	**2020**	**2021**
ALL Kids					
Blue Cross/Blue Shield				5%	5%
Champus/Tricare				2%	2%
Charity Care (see note below)				1%	1%
Medicaid				8%	8%
Medicare				66%	66%
Other commercial insurance				15%	15%
Self pay				1%	1%
Other					
Veterans Administration				2%	2%
Workers' Compensation					
TOTAL	%	%	%	%	%

Note: Refer to the Healthcare Financial Management Association (HFMA) Principles and Practices Board Statement Number 15, Section II.

III. CHARGE INFORMATION

A. *List schedule of current charges related to this project.*

Not Applicable

B. *List schedule of proposed charges after completion of this project. Discuss the impact of project cost on operational costs and charges of the facility or service.*

Visit	Charge
Skilled Nursing	$160
Physical Therapy	$160
Occupational Therapy	$160
Speech Pathologist	$160
Medical Social Worker	$160
Home Health Aide	$70

In regards to the impact of the project cost on operational costs and charges, the answer is there will be very little impact. The majority of the revenue generated by HHCPs are based on preset intermittent visit rates. Very few insurers negotiate visit rates or look for discounted rates, as a result, the charges are of minimal value. The operational costs associated with this project will largely be personnel, rent, and supplies. The project costs will be low because the little equipment is required, and the procurement of any equipment will be funded as reflected in the operational budget above.

PART FIVE: UTILIZATION DATA AND FINANCIAL INFORMATION

This part should be completed for projects which cost over $500,000.00 or which propose a substantial change in service, or which would change the bed capacity of the facility in excess of ten percent (10%), or which propose a new facility. ESRD, home health, and projects that are under $500,000.00 should omit this part and complete Part Four.

I. PERCENT OF GROSS REVENUE

	Historical			**Projected**	
Source of Payment	**20___**	**20___**	**20___**	**20___**	**20___**
ALL Kids					
Blue Cross/Blue Shield					
Champus/Tricare					
Charity Care (see note below)					
Medicaid					
Medicare					
Other commercial insurance					
Self pay					
Other					
Veterans Administration					
Workers' Compensation					
TOTAL	%	%	%	%	%

II. CHARGE INFORMATION

C. List schedule of current charges related to this project.

D. List schedule of proposed charges after completion of this project. Discuss the impact of
project cost on operational costs and charges of the facility or service.

III. INPATIENT UTILIZATION DATA

A. Historical Data
Give information for last three (3) years for which complete data is available.

OCCUPANCY DATA

Occupancy	**Number of Beds**			**Admissions or Discharges**			**Total Patient Days**			**Percentage (%)**		
	Yr ___	Yr ___	Yr__ _	Yr__ _	Yr__ _	Yr__ _	Yr__ _	Yr__ _	Yr__ _	Yr__ _	Yr___	Yr___
Medicine & Surgery												
Obstetrics												
Pediatrics												
Psychiatry												
Other												
TOTALS												

B. Projected Data
Give information to cover the first two (2) years of operation after completion of project.

OCCUPANCY DATA

Occupancy	**Number of Beds**		**Admissions or Discharges**		**Total Patient Days**		**Percentage (%)**	
	1st Year	2nd Year	1st Year	2nd Year	1st Year	2nd Year	1st Year	2nd Year
Medicine & Surgery								
Obstetrics								

Pediatrics								
Psychiatry								
Other								
TOTALS								

IV. OUTPATIENT UTILIZATION DATA

A. HISTORICAL DATA

	Number of Outpatient Visits			**Percentage of Outpatient Visits**		
	Yr_____	Yr_____	Yr_____	Yr_____	Yr_____	Yr_____
Clinical						
Diagnostic						
Rehabilitation						
Surgical						

B. PROJECTED DATA

	Number of Outpatient Visits		**Percentage of Outpatient Visits**	
	1st year	2nd year	1st year	2nd year
Clinical				
Diagnostic				
Rehabilitation				
Surgical				

V. A. ORGANIZATION FINANCIAL INFORMATION[45]

STATEMENT OF INCOME AND EXPENSE	**HISTORICAL DATA** (Give information for last 3 years for which complete data are available)			**PROJECTED DATA** (First 2 years after completion of project)	
	20___ (Total)	20___ (Total)	20___ (Total)	20___ (Total)	20___ (Total)
Revenue from Services to Patients					
Inpatient Services					
Routine (nursing service areas)					
Other					
Outpatient Services					
Emergency Services					
Gross Patient Revenue					
Deductions from Revenue					
Contractual Adjustments					
Discount/Miscellaneous Allowances					
Total Deductions					
NET PATIENT REVENUE (Gross patient revenue less deductions)					
Other Operating Revenue					
NET OPERATING REVENUE					
OPERATING EXPENSES					
Salaries, Wages, and Benefits					
Physician Salaries and Fees					
Supplies and other					
Uncompensated Care (less recoveries) per State Health Plan 410-2-2-.06(d)					
Other Expenses					
Total Operating Expenses					
NON-OPERATING EXPENSES					
Taxes					

[45] It is the position of counsel that this section is a part of "Part Five," and as result does not apply to projects with under $500,000 (such as this one). This position was further evidenced by previous Home Health CON applications.

Depreciation					
Interest (other than mortgage)					
Existing Capital Expenditures				N/A	N/A
Interest				N/A	N/A
Total Non-Operating Expenses					
TOTAL EXPENSES (Operating & Capital)					
Operating Income (Loss)					
Other Revenue (Expense) -- Net					
NET INCOME (Loss)					
Projected Capital Expenditure	N/A	N/A	N/A		
Interest	N/A	N/A	N/A		

B. PROJECT SPECIFIC FINANCIAL INFORMATION[46]

STATEMENT OF INCOME AND EXPENSE	**HISTORICAL DATA** (Give information for last 3 years for which complete data are available)			**PROJECTED DATA** (First 2 years after completion of project)	
	20___ (Total)	20___ (Total)	20___ (Total)	20___ (Total)	20___ (Total)
Revenue from Services to Patients					
Inpatient Services					
Routine (nursing service areas)					
Other					
Outpatient Services					
Emergency Services					
Gross Patient Revenue					
Deductions from Revenue					
Contractual Adjustments					
Discount/Miscellaneous Allowances					
Total Deductions					
NET PATIENT REVENUE(Gross patient revenue less deductions)					
Other Operating Revenue					
NET OPERATING REVENUE					
OPERATING EXPENSES					
Salaries, Wages, and Benefits					
Physician Salaries and Fees					
Supplies and other					

[46] It is the position of counsel that this section is a part of "Part Five," and as result does not apply to projects with under $500,000 (such as this one). This position was further evidenced by previous Home Health CON applications.

Uncompensated Care (less recoveries) per State Health Plan 410-2-2-.06(d)					
Other Expenses					
Total Operating Expenses					
NON-OPERATING EXPENSES					
Taxes					
Depreciation					
Interest (other than mortgage)					
Existing Capital Expenditures				N/A	N/A
Interest				N/A	N/A
Total Non-Operating Expenses					
TOTAL EXPENSES (Operating & Capital)					
Operating Income (Loss)					
Other Revenue (Expense) – Net					
NET INCOME (Loss)					
Projected Capital Expenditure	N/A	N/A	N/A		
Interest	N/A	N/A	N/A		

STATEMENT OF COMMUNITY PARTNERSHIP FOR EDUCATION AND REFERRALS

A. This section is declaration of those activities your organization performs outside of inpatient and outpatient care in the community and for the underserved population. Please indicate historical and projected data by expenditures in the columns specified below.

Services and/or Programs	**Historical Data (total dollars spent in last 3 years)**			**Projected Data (total dollars budgeted for next 2 years)**	
	Year	Year	Year 2019	Year 2020	Year 2021
Health Education (nutrition, fitness, etc.)			N/A	N/A	N/A
Community Events and Education			15,000	15,000	20,000
Health screenings			20,000	20,000	20,000

Other: Carpenter Health for Life Wellness			25,000	30,000	35,000
TOTAL			60,000	65,000	75,000

B. Please describe how the new services specified in this project application will be made available to and address the needs of the underserved community. If the project does not involve new services, please describe how the project will address the underserved population in your community.

Please briefly describe some of the current services or programs presented to the underserved in your community.

1. CHN has a partnership with LHCC Medicaid in Louisiana to provide Home Health in Louisiana. They are currently pursuing similar contract in state of Alabama.

2. CHN provides a wellness program to 15,000 patients throughout 6 states. This includes bimonthly proactive checkups by Nurse Practitioners to curb Hospitalization rates. They will also serve indigent and Medicaid populations.

PART SIX: ACKNOWLEDGEMENT AND CERTIFICATION BY THE APPLICANT

I. ACKNOWLEDGEMENT

In submitting this application, the applicant understands and acknowledges that:

A. The rules, regulations and standards for health facilities and services promulgated by the SHPDA have been read, and the applicant will comply with same.

B. The issuance of a certificate of need will depend on the approval of the CON Review Board, and no attempt to provide the service or incur an obligation will be made until a bona fide certificate of need is issued.

C. The certificate of need will expire in twelve (12) months after date of issuance, unless an
extension is granted pursuant to the applicable portions of the SHPDA rules and regulations.

D. The certificate of need is not transferrable, and any action to transfer or assign the certificate will render it null and void.

E. The applicant will notify the State Health Planning and Development Agency when a project is started, completed or abandoned.

F. The applicant shall file a progress report on each active project every six (6) months until the project is completed.

G. The applicant must comply with all state and local building codes, and failure to comply will render the certificate of need null and void.

H. The applicants and their agents will construct and operate in compliance with appropriate state licensure rules, regulations, and standards.

I. Projects are limited to the work identified in the Certificate of Need as issued.

J. Any expenditure in excess of the amount approved on the Certificate of Need must be reported to the State Health Planning and Development Agency and may be subject to review.

K. The applicant will comply with all state statutes for the protection of the environment.

L. The applicant is not presently operating with a probational (except as may be converted by this application) or revoked license.

II. CERTIFICATION

The information contained in this application is true and correct to the best of my knowledge and belief.

Signature of Applicant

Patrick T. Mitchell, CEO

Applicant's Name and Title
(Type or Print)

13TH day of May, 2020

Notary Public (Affix seal on Original)

BRETT DANIEL SANDIFER
NOTARY PUBLIC
State of Louisiana
Notary # 92784
My Commission is for Life

Author: Alva M. Lambert
Statutory Authority: §§ 22-21-267, -271, -275, Code of Alabama, 1975
History: Amended: March 19, 1996; July 25, 2002; Filed: July 22, 2013; effective August 26, 2013.

EXHIBIT

1

exhibitsticker.com

Exhibit 2

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

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

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

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

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

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

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

Our analysis is outlined as follows. First, as CON regulations restrict the flow of labor and capital into the home health sector, we employ data on the size of the home health sector in U.S. counties to quantify the impact of the state's regulations. Our statistical analysis reveals that Alabama counties are well below average in the size of the home health sector: home health employment in Alabama is about 24% below the natural average. Second, we determine whether a CON should be granted for Montgomery County by constructing a model of future demand for home health services. We conclude that the need for home health services in Montgomery County is large enough to support an additional home health provider. Third, we demonstrate why SHPDA's methodology for determining "need" is inconsistent with the underlying basis of CON regulations.

I. Home Health Services in Alabama

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

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

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

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

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

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

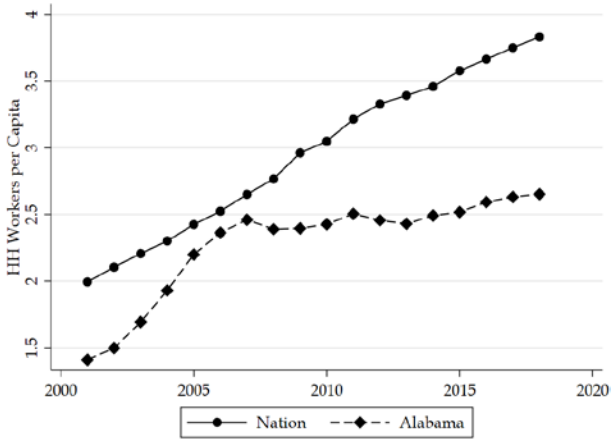
[4] The Alabama counties are: Baldwin, Calhoun, Cullman, Etowah, Houston, Jefferson, Lauderdale, Madison, Marengo, Mobile, Montgomery, Morgan, Tuscaloosa, and Walker.

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

The R^2 for the regression is 0.72, so the model explains 72% of the variation in the dependent variable. Of the six variables in the model (ignoring the fixed effects, λ_t), all are statistically significant at the 10% level or better. The number of home health workers in a county is nearly proportional to population ($\beta_1 = 0.94$) and the t-statistic is very large. Population is the dominant determinant of home health employment. The share of homes with a single resident is positively related to the number of home health workers ($\beta_2 = 1.7$). Workers are negatively related to income ($\beta_3 = -0.13$), but the coefficient is small; a 10% increase in per-capita income reduces the number of workers only by about 1%. The number of home health workers is positively related to the share of Black population ($\beta_4 = 0.45$) and a 10-percentage point increase in Black population increases home health employment by nearly 5%. As expected, home health employment is positively related to persons age 65 or older ($\beta^5 = 0.76$), with a 10-percentage point increase in older population increasing such workers by nearly 8%.

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

Figure 1. Per-Capita Home Health Workers



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

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

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

Table 1. Demographic Comparisons

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

Alabama's counties, relative to the nation, have lower incomes, much higher proportions of African Americans, higher proportions of persons living alone, and a more aged population—all factors that point to a greater need for home health services in the state relative to the nation. As such, we conclude that home health care is substantially underprovided in Alabama. Also, observed utilization rates of home health services in Alabama are thus inaccurate indicators of the true need for home health services in Alabama.

II. Forecast Need for Montgomery County

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

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

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

$$S_{i,t} \equiv u_{i,t} \cdot N_{i,t} \tag{2}$$

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

$$S_{t+1} \equiv u_{t+1} \cdot N_{t+1}, \tag{3}$$

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

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

where g_i is the growth in utilization between periods and $\hat{S}$ and $\hat{N}$ are forecast values. Given the information available to us at this time, we forecast the number of persons requiring home health services in 2022 based on utilization rates from 2017, the last year for which we have data. (We have requested more data from SHPDA, but as of yet, we have not received it). We do not have data on the growth in

home health utilization directly, but we do know that employment in the sector is growing 3.5% annually and expenditures on home health are expected to grow by 6.8% in the future.[8]

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

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

where T is the threshold. This threshold should have some economic meaning. We set the threshold T equal the median number of home health patients served per provider across the counties, since this figure represents the typical size of a home health provider in the state. In satisfying Expression (5), the median number of patients served by existing providers today is not diminished by additional entry in the future. In 2017, the median sized provider served 600 patients, so we set $T = 600$.

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

Table 2. Projections of Need for Montgomery County

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

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

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

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

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

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

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

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

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

We note also that these forecasts do not account for the fact that Alabama is rated high among states as a best place to retire.[11] Alabama has a relatively low cost of living, relatively low taxes, and does not tax Social Security Benefits. As the American population ages, it seems likely that the number of older persons, many of whom are in need of home health services, will rise faster in some Alabama counties over the next decade than forecasted (since such forecasts rely largely on observed history). The lower cost of home health services makes such services particularly attractive to the older population and could materially cut the costs of both public and private health care providers. In light of the growing demand for and lower costs of home health, the expansion of home health care services in Alabama should be encouraged—not restricted—by state health officials.

III. A Review of SHPDA's Method

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

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

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

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

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

IV. Conclusion

Under conservative assumptions, we estimate the increase in home health patients in Montgomery County between 2017 and 2022 to be greater than 2,000 persons. With the median number of patients served by a home health provider in the state at 600 persons, the increased need for home health services

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

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

in Montgomery County is more than adequate to permit an additional provider of home health services without redundancy.

Technical Appendix

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

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

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

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

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

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

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

and the total predicted served for county i is:

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

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

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

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

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

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

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

The county projected patients per-capita is:

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

Expanding terms, the determination of need is computed using:

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

which simplifies to:

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

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

Coverage and Payment Related to COVID-19
Medicare

Original Medicare

Diagnostic Tests

Medicare Part B, which includes a variety of outpatient services, covers medically necessary clinical diagnostic laboratory tests when a doctor or other practitioner orders them. Medically necessary clinical diagnostic laboratory tests are generally not subject to coinsurance or deductible.

Medicare Part B also covers medically necessary imaging tests, such as computed tomography (CT) scans, as needed for treatment purposes for lung infections (not for screening asymptomatic patients). For those imaging tests paid by Part B, beneficiary coinsurance and deductible would apply.

If the Part B deductible ($198 in 2020) applies to the Part B services, beneficiaries must pay all costs (up to the Medicare-approved amount) until the beneficiary meets the yearly Part B deductible. After the beneficiary's deductible is met, Medicare pays its share and beneficiaries typically pay 20% of the Medicare-approved amount of the service (except laboratory tests), if the doctor or other health care provider accepts assignment. There's no yearly limit for what a beneficiary pays out-of-pocket.

CMS issued a public health news alert on February 13[1], which has additional information about the new Healthcare Common Procedure Coding System (HCPCS) code (U0001) for health care providers and laboratories to bill for a laboratory testing patients for SARS-CoV-2. HCPCS is a standardized coding system that Medicare and other health insurers use to submit claims for services provided to patients. This code will allow those laboratories conducting the tests to bill for the specific test instead of using an unspecified code, which means better tracking of the public health response for this particular strain of the coronavirus to help protect people from the spread of this infectious disease.

There are two new HCPCS codes for healthcare providers who need to test patients for Coronavirus. Providers using the Centers for Disease Control and Prevention (CDC) 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel may bill for that test using the newly created HCPCS code (U0001). A second new HCPCS code (U0002) can be used by laboratories and healthcare facilities to bill Medicare as well as by other health insurers that choose to

[1] https://www.cms.gov/newsroom/press-releases/public-health-news-alert-cms-develops-new-code-coronavirus-lab-test

adopt this new code for such tests. HCPCS code (U0002) generally describes 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19) using any technique, multiple types or subtypes (includes all targets). The Medicare claims processing system will be able to accept these codes on April 1, 2020 for dates of service on or after February 4, 2020.

Vaccines

Medicare Part B pays for certain preventive vaccines (influenza, pneumococcal, and Hepatitis B) and coinsurance and deductible do not apply to preventive vaccines. Medicare Part B also pays for other vaccines directly related to medically necessary treatment of an injury or direct exposure to a disease or condition. For example, Medicare would cover a tetanus vaccine for a beneficiary who steps on a rusty nail. For these other medically necessary vaccines, beneficiary coinsurance and deductible would apply.

Inpatient Hospital Care Services

Medicare Part A covers medically necessary inpatient hospital care. This coverage includes semi-private rooms, meals, general nursing, imaging, drugs as well as other hospital services and supplies as part of inpatient hospital treatment. Inpatient hospital treatment includes care from acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and inpatient mental health care given in a psychiatric hospital or psychiatric unit within a hospital.

Medicare beneficiaries may pay a deductible for hospital services. Under Original Medicare, for hospital inpatient services, beneficiaries pay a deductible of $1,408 and no coinsurance for days 1– 60 of each benefit period. Beneficiaries pay a coinsurance amount of $352 per day for days 61– 90 of each benefit period. There is a coinsurance amount per “lifetime reserve day” after day 90 of each benefit period (up to 60 days over a beneficiary’s lifetime). Beneficiaries pay all costs for each day after all the lifetime reserve days are used. In addition, inpatient psychiatric care in a freestanding psychiatric hospital is limited to 190 days in a beneficiary’s lifetime.

Inpatient Hospital Quarantines

There may be times when beneficiaries with the virus need to be quarantined in a hospital private room to avoid infecting other individuals. These patients may not meet the need for acute inpatient care any longer but may remain in the hospital for public health reasons. Hospitals having both private and semiprivate accommodations may not charge the patient a differential for a private room if the private room is medically necessary. Patients who would have been otherwise discharged from the hospital after an inpatient stay but are instead remaining in the hospital under quarantine would not have to pay an additional deductible for quarantine in a hospital.

If a Medicare beneficiary is a hospital inpatient for medically necessary care, Medicare will pay hospitals the diagnosis-related group (DRG) rate and any cost outliers for the entire stay, including any the quarantine time when the patient does not meet the need for acute inpatient care, until the Medicare patient is discharged. The DRG rate (and cost outliers as applicable) includes the payments for when a patient needs to be isolated or quarantined in a private room.

Ambulatory Services in a Hospital or Other Location

Medicare Part B covers medically necessary ambulatory services, including doctors' services, hospital outpatient department services, home health services, durable medical equipment, mental health services, and other medical services. Coinsurance and deductible would generally apply depending on the service.

In the event a patient is quarantined in an ambulatory setting, the existing Medicare payments for medically necessary services apply.

Telehealth and Other Communication-Based Technology Services

Beneficiaries can communicate with their doctors or certain other practitioners without necessarily going to the doctor's office in person for a full visit.

Since 2018, Medicare pays for "virtual check-ins" for patients to connect with their doctors without going to the doctor's office. These brief, virtual check-in services are for patients with an established relationship with a physician or certain practitioners where the communication is not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours (or soonest appointment available). The patient must verbally consent to using virtual check-ins and the consent must be documented in the medical record prior to the patient using the service. The Medicare coinsurance and deductible would apply to these services.

Doctors and certain practitioners may bill for these virtual check-in services furnished through several communication technology modalities, such as telephone (HCPCS code G2012) or captured video or image (HCPCS code G2010).

Medicare also pays for patients to communicate with their doctors without going to the doctor's office using online patient portals. The individual communications, like the virtual check ins, must be initiated by the patient; however, practitioners may educate beneficiaries on the availability of this kind of service prior to patient initiation. The communications can occur over a 7-day period. The services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G206, as applicable. The Medicare coinsurance and deductible would apply to these services.

In addition, Medicare beneficiaries living in rural areas may use communication technology to have full visits with their physicians. The law requires that these visits take place at specified sites of service, known as telehealth originating sites, and receive services using a real-time audio and video communication system at the site to communicate with a remotely located doctor or certain other types of practitioners. Medicare pays for many medical visits through this telehealth benefit. Certain beneficiaries, such as those needing a monthly end-stage renal disease visit or those needing treatment for substance use disorders or co-occurring mental health disorder may access telehealth services from their home without traveling to an originating site. The Medicare coinsurance and deductible would apply to these services.

Medicare also pays doctors for certain non-face-to-face care management services and remote patient monitoring services. The Medicare coinsurance and deductible would apply to these services.

Requests for Prescription Refills

For Part B drugs, when considering whether to pay for a greater-than-30-day-supply of drugs, in general, Medicare and its contractors, known as Medicare Administrative Contractors or MACs, will, on a case-by-case, basis, consider each request and make decisions locally.

In general, local Medicare contractors will take into account the nature of the particular Part B drug (including Part B immunosuppressive drugs), the patient's diagnosis, the extent and likely duration of disruptions to the drug supply chain during an emergency, and other relevant factors that would be applicable when making a determination as to whether, on the date of service, an extended supply of the drug was reasonable and necessary.

Emergency Ambulance Transportation

Medicare covers ground ambulance transportation when beneficiaries need to be transported to a hospital, critical access hospital, or skilled nursing facility for medically necessary services when transportation in any other vehicle could endanger the beneficiary's health. A ground ambulance emergency transportation may temporarily stop at a doctor's office without affecting the coverage status of the transport in certain circumstances, however, in general the physician's office is not a covered destination. Medicare may pay for emergency ambulance transportation in an airplane or helicopter to a hospital if the beneficiaries needs immediate and rapid ambulance transportation that ground transportation can't provide.

Should a facility which would normally be the nearest appropriate facility be unavailable during an emergency, Medicare may pay for transportation to another facility so long as that facility is the nearest facility that is available and equipped to provide the needed care for the illness or injury involved.

In some cases, Medicare may pay for limited, medically necessary, nonemergency ambulance transportation if the doctor writes an order stating that ambulance transportation is medically necessary. For example, beneficiaries may need a medically necessary nonemergency ambulance transport to a dialysis facility when they have End-Stage Renal Disease. There is a current Medicare model testing prior authorization for individuals receiving scheduled, non-emergency ambulance transportation for 3 or more round trips in a 10-day period or at least once a week for 3 weeks or more in certain states.

The Medicare coinsurance and deductible would apply to these Part B services.

Medicare pays for ambulance transports under the Ambulance Fee Schedule. This payment amount includes a base rate payment (level of service provided) plus a separate payment for mileage to the nearest appropriate facility and also cover both the transport of the beneficiary to the nearest appropriate facility and all medically necessary covered items and services (such as oxygen, drugs, extra attendants, and electrocardiogram testing) associated with the transport.

Medicare Advantage (Part C) and Part D

Medicare Advantage (also known as "Part C") is an "all in one" alternative to Original Medicare. Medicare Advantage plans cover Medicare Part A and Part B services, and usually prescription drugs covered under Medicare Part D. These plans also may offer extra benefits Original Medicare doesn't cover. Medicare Part D, also called the Medicare prescription drug benefit, is an optional federal-government program to help Medicare beneficiaries pay for prescription drugs not covered under Part B through prescription drug insurance.

Medicare Advantage Coverage

Medicare Advantage plans must cover all medically necessary Part A and B services covered under Original Medicare for all enrollees. Medicare Advantage plans can also cover items and services beyond those covered by Original Medicare, such as vision, dental, and over-the-counter products, among other things. These items and services are typically referred to as "supplemental benefits."

Medicare Advantage Cost Sharing - "Surprise Billing"

Medicare Advantage plan enrollees are generally protected from "surprise billing" which is when an enrollee receives unexpected bills from out-of-network providers. Surprise billing most commonly occurs when patients either receive care from an out-of-network provider they had reasonably assumed was in-network or received out-of-network care in an emergency when they had limited, if any, ability to choose their provider. When Medicare Advantage enrollees obtain plan-covered services (e.g., covered under the plan's normal rules, or when an HMO

arranges for or directs out of network care) in an HMO, PPO, or Regional PPO, they may not be charged or held liable for more than plan-allowed cost-sharing.

Additionally, CMS advises Medicare Advantage (MA) organizations that they may waive or reduce enrollee cost-sharing for Novel Coronavirus (COVID-19) laboratory tests effective immediately provided that MA organizations waive or reduce cost-sharing for all plan enrollees on a uniform basis. Specifically, CMS will exercise its enforcement discretion regarding the administration of MA organizations benefit packages as approved by CMS in conjunction with implementing a voluntary waiver or reduction of cost-sharing for COVID-19 laboratory tests as described. CMS consulted with the Office of Inspector General (OIG) and OIG advised that should an MA organization choose to voluntarily waive or reduce enrollee cost-sharing for COVID-19 laboratory tests, as approved by CMS in this advisory, such waivers or reductions would satisfy the safe harbor to the Federal anti-kickback statute set forth at 42 CFR 1001.952(l).

Nothing in this guidance speaks to the arrangements between MA organizations and their contracted providers or facilities.

Telehealth and other Communication Based Technology Services

Medicare Advantage plans may provide their enrollees with access to Medicare Part B services via telehealth in any geographic area and from a variety of places, including beneficiaries' homes. With this flexibility, it is possible that beneficiaries in Medicare Advantage plans can receive clinically appropriate services for treatment of COVID-19 via telehealth.

Part D Coverage

Each Part D Sponsor that offers prescription drug coverage must provide a standard level of coverage to ensure beneficiaries have adequate access to Part D drugs. Many Part D Sponsors offer plans with different levels of coverage many of which exceed CMS's minimum requirements.

Vaccines

Under current law, once a vaccine becomes available for COVID-19, Medicare will cover the vaccine under Part D. All Part D plans will be required to cover the vaccine.

Prior Authorization

Consistent with flexibilities available to Medicare Advantage Organizations and Part D Sponsors with respect to other items and services, MAOs and Part D Sponsors may choose to waive plan prior authorization requirements that otherwise would apply to tests or services related to COVID-19.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

March 12, 2020

FAQs on Essential Health Benefit Coverage and the Coronavirus (COVID-19)

Q1. Do the Essential Health Benefits (EHB) currently include coverage for the diagnosis and treatment of COVID-19?

A1. Yes. EHB generally includes coverage for the diagnosis and treatment of COVID-19. However, the exact coverage details and cost-sharing amounts for individual services may vary by plan, and some plans may require prior authorization before these services are covered. Non-grandfathered health insurance plans purchased by individuals and small employers, including qualified health plans purchased on the Exchanges, must provide coverage for ten categories of EHB.[1] These ten categories of benefits include, among other things, hospitalization and laboratory services. Under current regulation, each state and the District of Columbia generally determines the specific benefits that plans in that state must cover within the ten EHB categories. This standard set of benefits determined by the state is called the EHB-benchmark plan. All 51 EHB-benchmark plans currently provide coverage for the diagnosis and treatment of COVID-19.[2]

Many health plans have publicly announced that COVID-19 diagnostic tests are covered benefits and will be waiving any cost-sharing that would otherwise apply to the test. Furthermore, many states are encouraging their issuers to cover a variety of COVID-19 related services, including testing and treatment, without cost-sharing, while several states have announced that health plans in the state must cover the diagnostic testing of COVID-19 without cost-sharing and waive any prior authorization requirements for such testing.

Q2. Is isolation and quarantine for the diagnosis of COVID-19 covered as EHB?

A2. All EHB-benchmark plans cover medically necessary hospitalizations. Medically necessary isolation and quarantine required by and under the supervision of a medical provider during a hospital admission are generally covered as EHB. The cost-sharing and specific coverage limitations associated with these services may vary by plan. For example, some plans may require prior authorization before these services are covered or may apply other limitations. Quarantine outside of a hospital setting, such as a home, is not a medical benefit, nor is it required as EHB. However, other medical benefits that occur in the home that are required by and under the supervision of a medical provider, such as home health care or telemedicine, may be covered as EHB, but may require prior authorization or be subject to cost-sharing or other limitations.

[1] Grandfathered health plans are health plans that were in existence as of March 23, 2010, the date of enactment of Patient Protection and Affordable Care Act (PPACA), and that are only subject to certain provisions of PPACA, as long as they maintain status as grandfathered health plans under the applicable rules.
[2] For information on the EHB-benchmark plans, see: https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.

Q3. When a COVID-19 vaccine is available, will it be covered as EHB, and will issuers be permitted to require cost-sharing?

A3. A COVID-19 vaccine does not currently exist. However, current law and regulations require specific vaccines to be covered as EHB without cost-sharing, and before meeting any applicable deductible, when the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) recommends them. Under current regulations, if ACIP recommends a new vaccine, plans are not required to cover the vaccine until the beginning of the plan year that is 12 months after ACIP issues the recommendation. However, plans may voluntarily choose to cover a vaccine for COVID-19, with or without cost-sharing, prior to that date.

In addition, as part of a plan's responsibility to cover prescription drugs as EHB, as described above to cover ACIP-recommended vaccines, if a plan does not provide coverage of a vaccine (or other prescription drugs) on the plan's formulary enrollees may use the plan's drug exceptions process to request that the vaccine be covered under their plan, pursuant to 45 CFR 156.122(c).

To: Ms. Emily T. Marsal, Executive Director, State Health Planning & Development Agency
From: Clay McInnis, Montgomery City Council, District 7.
Date: May 11th, 2020
In re: Emergency CON Application on behalf of Alabama Home Healthcare, LLC.

Dear Ms. Marsal,

I am writing to express my support for Alabama Home Healthcare's (AHH) Emergency Certificate of Need (CON) application as an additional home health provider in Montgomery County, Alabama. As you know, the novel Coronavirus (COVID-19) pandemic has resulted in emergency declarations from both the President of the United States and Governor Kay Ivey. The goals of which are to contain and prevent the spread of the virus by relaxing regulations to promote flexibility in handling this crisis.

Furthermore, America's population aged 65 and older, as well as those suffering from respiratory illnesses, are particularly at risk for COVID-19. Montgomery County's Senior citizen population, and those suffering from COPD are both over the state and national average. As a result, Montgomery County is particularly vulnerable during this crisis.

In light of this, AHH has adopted a novel approach to attacking this emergency. They are prepared to provide COVID-19 tests to any home health patients showing symptoms. This approach serves several purposes. First, it will provide better access to testing by giving the test to the patient in the home. Second, it will help contain the virus, as the test is administered in the patient's home as opposed to a clinic or hospital. Third, it will reduce hospital beds by identifying the most at risk patients before they require costly inpatient care.

In addition to being preventative, cost effective and proactive, home health provides a great educational opportunity. Along with their COVID-19 testing system, AHH utilizes the unique AIM program in their operation. This program seeks to break the pyscho-social barriers in some communities associated with palliative care. They train each member of their staff that goes into the home to educate patients and family members about overall healthcare and the options available. In conclusion, I heartily support AHH's Emergency CON application.

Sincerely,

Clay McInnis
City Council District -7