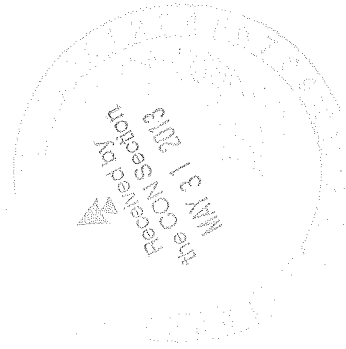

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May 30, 2013

Craig Smith, Section Chief
Certificate of Need Section
Division of Health Services Regulation
N.C. Department of Health and Human Services
809 Ruggles Drive
Raleigh, NC 27603

RE: Advanced Home Care, Brunswick CON, Project ID #O-10118-13
Comments on Competing CON Applications

Dear Mr. Smith:

I am the consultant working with Advanced Home Care on the project referenced above. Please accept these written comments concerning competing Brunswick County home health agency applications.

Thank you for the opportunity to present this information.

Sincerely,

THE STRATEGY HOUSE, INC.

Robert M. Limyansky
Partner

enclosures

COMMENTS ON COMPETING CON APPLICATIONS
MEDICARE-CERTIFIED HOME HEALTH AGENCY
BRUNSWICK COUNTY

Presented by
ADVANCED HOME CARE, INC.
May 30, 2013

Table of Contents

Section ... Page

1. Executive Summary ... 2
2. UniHealth Home Health ... 5
3. NHRMC Home Care ... 14
4. HealthKeeperz of Brunswick ... 22
5. Maxim Healthcare Services ... 32
6. Gentiva Health Services ... 36
7. Continuum Home Care of Brunswick ... 41
8. Comparative Analysis ... 47

Attachments

A. Medicare Home Health Compare – North Carolina Benchmarks
B. Medicare Home Health Compare – United States Benchmarks
C. US Attorney's Office Press Release – Maxim CIA and DPA

1. Executive Summary

Advanced Home Care, Inc. submitted its certificate of need application in response to the projected unmet need identified in the 2013 State Medical Facilities Plan. The following competing applications seek approval for only one new Medicare-certified home health agency for Brunswick County.

Project ID#	Applicant
O-10113-13	UniHealth Home Health
O-10117-13	NHRMC Home Care
O-10118-13	Advanced Home Care
O-10119-13	HealthKeeperz of Brunswick
O-10120-13	Maxim Healthcare Services
O-10121-13	Gentiva Health Services
O-10122-13	Continuum Home Care of Brunswick County

Key evaluation points for each competing applicant are presented below.

UniHealth Home Health

- UniHealth's proposed project will significantly "overserve" patients in Brunswick County while significantly "underserving" patients in New Hanover and Pender counties.
- UniHealth has disclosed *thirty* "civil rights equal access complaints" filed against it or its parent company, in just North Carolina, in the past five years.
- UniHealth projects a first year *loss* of $317,001 and a second year profit of *only* $20,301 (the *lowest* among all *seven* CON applicants). UniHealth does not provide for a financially sustainable project.
- UniHealth has the *lowest* projected second year charity care (by dollars or a percentage of gross revenue) among all *seven* CON applicants.

NHRMC Home Care

- NHRMC Home Care proposes to serve three counties (Bladen, Brunswick and Columbus) with its proposed project. However, NHRMC *already* serves these three counties with its existing home health agency in Pender County.
- The 2013 State Medical Facilities Plan projects a *surplus* of patients in Bladen and Columbus counties. There is no need for additional home health services in two of the three counties proposed to be served by NHRMC.
- Even in Brunswick County, where the SMFP projects a need to serve additional home health patients, NHRMC's 2016 patient projections far exceed its current patient volume plus the projected unmet patient volume. NHRMC's projection that it will essentially *triple* its patient volume in the three-county area from 437 patients in 2012 to 1,233 patients in 2016 is wholly unrealistic.
- Approval of NHRMC's proposed "new" home health agency for the same geographic area it now serves would simply duplicate existing resources. As such, NHRMC's proposed project is neither the least costly nor most effective alternative to meet the need identified in the 2013 State Medical Facilities Plan. NHRMC's proposed project will limit, rather than enhance, competition.
- NHRMC's projected $1.5 million profit in its second year of operation is unreasonable. This projected profit amounts to 43% of projected net revenue and *far* exceeds the 4% - 7% national averages.

- In Brunswick County alone, NHRMC projects its 380 actual patients in 2012 will increase to 1,013 patients in 2016. Yet NHRMC also states in its development schedule that, "Proposed staff to operate the proposed Brunswick County home health agency exists at the NHRMC Home Care Pender County agency. No core staff will be recruited." NHRMC's staffing projections are unrealistic.
- NHRMC proposes to initiate services with five LPNs and two RNs. Additional LPNs only are added in the second year of operation. This emphasis on LPN staffing rather than more highly skilled RN staffing could result in lower patient quality and outcomes. This may be particularly problematic with wound, ostomy and continence nurses (WOCN) and certified infusion nurses (CRNI), where resources appear to be lacking.

HealthKeeperz of Brunswick

- HKZ's proposed project will significantly "overserve" patients in Brunswick County while significantly "underserving" patients in New Hanover County and failing to serve any patients at all in Pender County.
- HKZ's proposal to use contract staffing in *every* service discipline raises serious concerns about staff stability, retention, and familiarity with the patient, care coordination and quality of patient care. Such staffing patterns also do not comply with federal Medicare regulations and guidelines.
- HKZ cites its roots as a pharmacy but does not provide infusion services. HKZ also lacks certified infusion nurses (CRNI) and wound, ostomy and continence nurses (WOCN). HKZ lacks services for ventilator patients and pediatric patients.
- Using either North Carolina or United States benchmarks, HKZ rates *at or near the bottom* of the Medicare home health comparison criteria.

Maxim Healthcare Services

- Maxim entered into both a Corporate Integrity Agreement with the DHHS Office of Inspector General and a Deferred Prosecution Agreement with the US Attorney's Office for the District of New Jersey in September 2011 with an obligation to repay approximately $150 Million. See **Attachment C**. Maxim will need to focus resources on compliance and not development of new agencies.
- Maxim proposes to serve just a *single* county (Brunswick), and is the *only* one of seven applicants proposing to serve just a single county. Maxim's proposed project will significantly "overserve" patients in Brunswick County while *failing* to serve *any* patients at all in New Hanover and Pender counties.
- By projecting to serve only Brunswick County itself and ignoring the unmet need projected in adjacent New Hanover and Pender counties, Maxim is among the *least* effective alternatives proposing to serve the area.
- Maxim's projected first year loss of $470,755 is the *largest* among all seven applicants. Maxim's average net revenue per visit is the *highest* among all applicants ($161.46, compared to $138.63 for Advanced) and is unreasonable. Similarly, Maxim's average administrative costs per visit are the *second highest* among all applicants ($52.58, compared to $37.99 for Advanced) and the *highest* for total operating costs ($138.84, compared to $117.43 for Advanced). For all these reasons, Maxim's pro forma projections are unreasonable and its financial viability is questionable.

Gentiva Health Services

- Gentiva proposes to serve three counties (Brunswick, New Hanover and Pender) but will significantly "underserve" patients in New Hanover and Pender counties.
- Gentiva projects to serve the *fewest* patients of all *seven* applicants.

- Gentiva does not contract with major commercial insurers in North Carolina such as United Healthcare. Thus, it will exclude major payor segments of the population to be served.
- Gentiva projects a first year *loss* of $193,076 and a second year profit of *only* $42,578. This projected second year profit barely achieves the financial breakeven point and does very little to recoup prior losses. Gentiva does not provide for a financially sustainable project, especially if revenues are overstated (bad debt), expenses are understated, payor mix is less profitable, etc.
- Gentiva does not have *any* accredited agencies in North Carolina. This is in sharp contrast to the 67 agencies accredited by the Accreditation Commission for Health Care (ACHC) across the country in various states and the 2 agencies accredited by The Joint Commission. Using either North Carolina or United States benchmarks, Gentiva rates *at or near the bottom* of the Medicare home health comparison criteria.

Continuum Home Care of Brunswick County

- Continuum proposes to serve two counties (Brunswick and New Hanover) but will do nothing to meet the projected unmet need in a third (Pender County). Continuum's proposed project, if approved, will significantly "overserve" patients in Brunswick County while significantly "underserving" patients in New Hanover County and failing to serve any patients at all in Pender County.
- Continuum's average net revenue per unduplicated patient is the *highest* among all applicants ($3,451.56, compared to $2,893.02 for Advanced) and is unreasonable.
- Continuum has the *second lowest* projected second year charity care commitment as measured in total dollars among all *seven* CON applicants.
- Continuum does not provide an accreditation agency listing to document the provision of quality patient care. Using either North Carolina or United States benchmarks, Continuum rates *at or near the bottom* of the Medicare home health comparison criteria.

Detailed comments for each individual competing applicant are presented in the following sections, **Sections 2-7**. Unless otherwise noted, data were taken from the CON application submissions and the 2013 State Medical Facilities Plan (SMFP). Financial comparisons related to patient volumes may be difficult to assess for Gentiva due to possible reporting inconsistencies. For example, at application pages 60 and 64, 391 unduplicated patients (by county) are reported in Year 2. At application page 67, 813 unduplicated patients (by qualifying discipline) are reported in Year 2.

A comparative analysis is presented in **Section 8**. Advanced Home Care's CON application is comparatively superior by:

- Proposing to serve three contiguous counties (Brunswick, New Hanover and Pender) with projected unmet need, consistent with the 2013 SMFP.
- Presenting reasonable volume forecasts, based on historical experience that are consistent with the projected unmet need in these counties.
- Providing a full range of home health agency services and employed staff that will be complementary to Advanced Home Care's existing home medical equipment and infusion services in New Hanover County.
- Maintaining reasonable costs and charges to continue to provide access to a wide variety of payor groups, including Medicare and Medicaid patients.
- Committing to provide the greatest amount of charity care, consistent with historical experience.

- Maintaining quality patient care, using either North Carolina or United States benchmarks, that rates *at or near the top* of the competing applicants using the Medicare home health comparison criteria.

2. UniHealth Home Health

While Advanced Home Care focuses exclusively on home health and equipment services (alternatives to inpatient care), other companies treat home health agency services as a sideline. According to UniHealth's parent company's web site, home health services are "supplemental" to its core post-acute, skilled nursing and assisted living inpatient service lines.

> UHS-Pruitt is a Southeast regional leader in long-term health care. Since its inception in 1969 as the Toccoa Nursing Center, the UHS-Pruitt community of services has grown to encapsulate more than 70 post-acute, skilled nursing and assisted living locations, as well as an array of supplementary resources including home health care, end-of-life care, rehabilitation, veteran care and consultative pharmaceutical services. UHS-Pruitt also offers a variety of business to business services.

Page 172 of the application states that *UHS* is an award winning leader, but any awards received were for nursing home type care. This is validated in the parent company's web site press releases.

General Review Criteria,
G.S. 131E-183(a)

(1) Policies and need. The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.

Comment. UniHealth proposes to serve three counties (Brunswick, New Hanover and Pender) but will essentially meet the projected unmet need in only one (Brunswick).

According to the 2013 State Medical Facilities Plan, these three counties will have a projected 2014 unmet need of 563.93 patients – 324.94 in Brunswick, 186.04 in New Hanover and 52.95 in Pender. However, UniHealth projects to serve 508 patients in Year 3 – 432 in Brunswick, 59 in New Hanover and 17 in Pender.

As indicated in the table below, UniHealth's proposed project will significantly "overserve" patients in Brunswick County while significantly "underserving" patients in New Hanover and Pender counties.

**Inconsistencies between UniHealth Patient Projections
And 2013 State Medical Facilities Plan**

County	2013 SMFP Unmet Need (2014)	UniHealth Projected Patients Served (Year 3)	UniHealth Projected Over/(Under) Served	UniHealth Pct Projected Over/(Under) Served
Brunswick	324.94	432	+107	+32.9%
New Hanover	186.04	59	(127)	(68.3%)
Pender	52.95	17	(36)	(68.0%)
	563.93	508	(56)	(9.9%)

(3) Population to be served. The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

Comment. UniHealth has disclosed *thirty* "civil rights equal access complaints" filed against it or its parent company, in just North Carolina, in the past five years. However, UniHealth has failed to provide details for at least two of the 16 pending complaints.

**UniHealth/UHS Civil Rights Equal Access Complaints
North Carolina, Past Five Years**

Dismissed	Pending	Settled	Total Disclosed
12	16	2	30

These civil rights and equal access complaints are not confined to just one or two locations, but appear to involve a *dozen* separate locations.

This history raises concerns about UniHealth's ability to serve all residents of the area.

In addition, a pediatric support letter is offered even though it appears that UniHealth will not offer services to this segment of the population.

(4) Least costly or most effective alternative. Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.

Comment. UniHealth has not proposed the most effective alternative it could propose because it projects to serve fewer patients in New Hanover and Pender Counties than the need identified in the 2013 SMFP, it has a very low commitment to charity care, it does not explain how it has addressed the history of numerous civil rights complaints and why this will not be a future problem and it proposes to use *all* contract staff to provide *all* therapies.

(5) Availability of funds and reasonable projections of costs and charges. Financial and operational projections for the project shall demonstrate the availability of funds for

capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

Comment. UniHealth projects a first year *loss* of $317,001 and a second year profit of *only* $20,301. This projected second year profit barely achieves the financial breakeven point and does very little to recoup prior losses. UniHealth does not provide for a financially sustainable project, especially if revenues are overstated (bad debt), expenses are understated, payor mix is less profitable, etc.

Furthermore, UniHealth's proposal to buy an existing building (as opposed to leasing space) with such poor projected financial sustainability will lock it into high overhead costs.

(6) Unnecessary duplication. The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.

Comment. UniHealth's proposal unnecessarily duplicates existing health services by proposing to serve 508 patients in Brunswick or 183 more patients than the 324.94 identified as needing home health services in the 2013 State Medical Facilities Plan. This difference means that UniHealth proposes to serve, or unnecessarily duplicate patient volume that is already being served by existing agencies.

(7) Availability of resources, including health manpower. The applicant shall show evidence of the availability of resources, including health manpower and management personnel, for the provision of the services proposed to be provided.

Comment. UniHealth proposes to contract for *all* therapy services – physical therapy, occupational therapy and speech therapy. By relying exclusively on outside resources for these vital services, UniHealth faces increased difficulty with staff stability, retention, familiarity with the patient and care coordination. This, in turn, often results in more difficulty improving patient outcomes and allowing the patient to remain in the home.

As stated previously, UniHealth has disclosed *thirty* "civil rights equal access complaints" filed against it or its parent company, in just North Carolina, in the past five years. However, UniHealth has failed to provide details for at least two of the 16 pending complaints.

UniHealth/UHS Civil Rights Equal Access Complaints
North Carolina, Past Five Years

Dismissed	Pending	Settled	Total Disclosed
12	16	2	30

These civil rights and equal access complaints are not confined to just one or two locations, but appear to involve a *dozen* separate locations.

This history raises concerns about UniHealth's ability to retain quality staff and to provide quality patient care.

(8) Coordination with the existing health care system. The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system.

Comment. Again, UniHealth proposes to contract for *all* therapy services – physical therapy, occupational therapy and speech therapy. By relying on outside resources for these vital services, UniHealth faces increased difficulty with staff stability, retention, familiarity with the patient and care coordination. This, in turn, often results in more difficulty improving patient outcomes and allowing the patient to remain in the home.

UniHealth touts the benefits of its UniGuard program, which is "specifically designed to prevent readmissions to hospitals," as an example of its leadership in care transitions. However, the UHS acute-care hospitalization rates (ACH) reported on the Outcome Concept System (OCS) reports appear to range from 21.7% to 32.6%. This is well above the current North Carolina and United States rates of 17%.

Interestingly, UniHealth states that, "UHC's home health agencies have consistently ranked high among its peers in all client areas surveyed. Please see Exhibit 75." Exhibit 75 contains the Medicare "home health compare" information for one home health agency – United Home Care of North Georgia, located in Gainesville, Georgia. UniHealth states elsewhere that this same agency is one of its two agencies that were honored as a "Top 100" national agency.

(12) Applications involving construction. Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the public of providing health services by other persons, and that applicable energy saving features have been incorporated into the construction plans.

Comment. UniHealth's proposal to buy an existing building (as opposed to leasing space) will lock it into high overhead costs, which it cannot afford. As stated previously, UniHealth projects a first year *loss* of $317,001 and a second year profit of *only* $20,301. This projected second year profit barely achieves the financial breakeven point and does very little to recoup prior losses. In fact, this projected second year profit is the *lowest* among all *seven* CON applicants. UniHealth does not provide for a financially sustainable project, especially if revenues are overstated (bad debt), expenses are understated, payor mix is less profitable, etc.

(13) Medically underserved populations. The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:

a. The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically underserved;

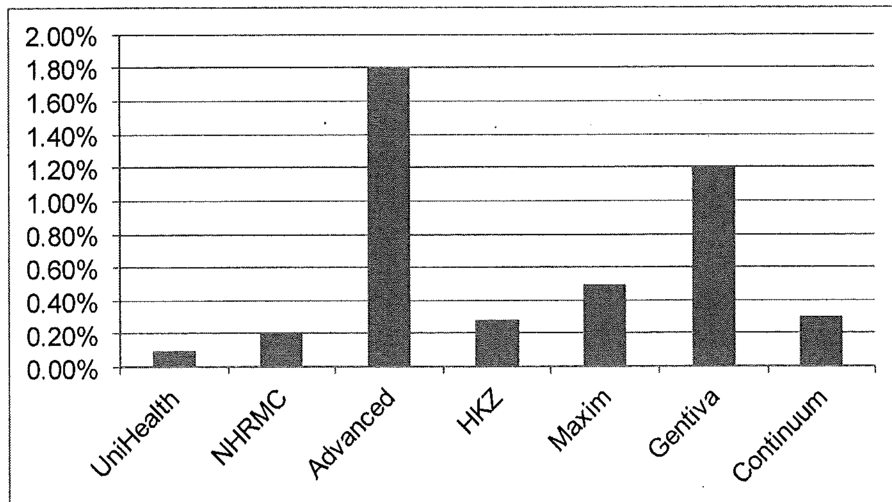
b. Its past performance in meeting its obligation, if any, under any applicable regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal assistance, including the existence of any civil rights access complaints against the applicant;

c. That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services; and

d. That the applicant offers a range of means by which a person will have access to its services. Examples of a range of means are outpatient services, admission by house staff, and admission by personal physicians.

Comment. With a projected first year *loss* of $317,001 and a second year profit of *only* $20,301, UniHealth barely achieves the financial breakeven point and has very few resources to serve medically underserved populations. UniHealth has the *lowest* projected second year charity care (by dollars or a percentage of gross revenue) among all *seven* CON applicants. The commitment is so low as to call into question whether UniHealth will provide access to medically underserved populations.

Year 2 Charity Care as a Percent of Gross Revenue



Year 2 Charity Care as Expressed in Dollars

UniHealth	NHRMC	Advanced	HKZ	Maxim	Gentiva	Continuum
$1,700	$12,174	$33,240	$4,711	$7,737	$14,671	$4,590

UniHealth does not make up for this charity care commitment shortfall by serving substantially more Medicare or Medicaid patients.

Year 2 Duplicated Medicare and Medicaid Patients
As a Percentage of Total Unduplicated Patients

	UniHealth	NHRMC	Advanced	HKZ	Maxim	Gentiva	Continuum
Medicare	76.65%	100.0%*	73.9%	68.4%	71.2%	68.7%	70.94%
Medicaid	17.73%	0.0%	15.6%	17.9%	17.4%	25.5%	18.09%

* As reported in NHRMC Section VI, page 87.

UniHealth's "Category of Home Health Patients" policy states that in order for a patient to be eligible for service they must: have the financial ability to fund the home health services provided if no other funding source is available. This contradicts the response to Section VI. 4 (a).

UniHealth's "Assessments and Reassessments" policy states in #9: If the patient does not have the required face-to-face encounter within the 30 days following the start of care, they will be responsible for all charges for care from the start of care until termination of care. This contradicts Medicare rules (CMS F2F Q&A # 41).

As stated previously, UniHealth has disclosed *thirty* "civil rights equal access complaints" filed against it or its parent company, in just North Carolina, in the past five years. However, UniHealth has failed to provide details for at least two of the 16 pending complaints.

UniHealth/UHS Civil Rights Equal Access Complaints
North Carolina, Past Five Years

Dismissed	Pending	Settled	Total Disclosed
12	16	2	30

These civil rights and equal access complaints are not confined to just one or two locations, but appear to involve a *dozen* separate locations. This history raises concerns about UniHealth's ability to provide access to medically underserved groups.

(18a) Enhanced competition. The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

Comment. UniHealth's project will not have a favorable impact on access because it makes such a low charity care commitment and projects to serve fewer patients in New Hanover and Pender Counties than the need identified in the 2013 SMFP. The history of 30 civil rights complaints against UniHealth also suggests a potential access problem since the complaints were made against multiple different UniHealth agencies.

UniHealth's project will not have a favorable impact on quality since it proposes to contract for *all* therapy services.

UniHealth's high projected loss in Year 1 and very low projected profit in Year 2,indicates that the project will not have a positive impact on cost effectiveness.

(20) Quality. An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.

Comment. Again, UniHealth proposes to contract for *all* therapy services – physical therapy, occupational therapy and speech therapy. By relying on outside resources for these vital services, UniHealth faces increased difficulty with staff stability, retention, familiarity with the patient and care coordination. This, in turn, often results in more difficulty improving patient outcomes and allowing the patient to remain in the home.

UniHealth touts the benefits of its UniGuard program, which is "specifically designed to prevent readmissions to hospitals," as an example of its leadership in care transitions. However, the UHS acute-care hospitalization rates (ACH) reported on the Outcome Concept System (OCS) reports appear to range from 21.7% to 32.6%. This is well above the current North Carolina and United States rates of 17%.

UniHealth's patient care policies submitted with its application have internal review dates from 2005 to 2011. Not only does this contradict statements of "annual" reviews, but appears to be out of compliance with North Carolina Home Care Regulations requiring annual review.

> **10A NCAC 13J .1004 EVALUATION**
> (a) The agency's governing body or its designee shall, at least annually, conduct a comprehensive evaluation of the agency's total operation.
>
> (b) The evaluation shall assure the appropriateness and quality of the agency's services with findings used to verify policy implementation, to identify problems, and to establish problem resolution and policy revision as necessary.
>
> (c) The evaluation shall consist of an overall policy and administration review, including the scope of services offered, arrangements for services with other agencies or individuals, admission and discharge policies, supervision and plan of care, emergency care, service records, personnel qualifications and program evaluation.

Other more specific policy concerns include the following:

- Wound Care policies are outdated (2005) and generically written for "facility" use (e.g., nursing home) as opposed to a home health agency.
- UniHealth caregivers do not provide CPR on patients per "Patients Found in Medical Emergencies" policy. Staff is instructed to maintain an open airway, check skin color and monitor vital signs after calling 911.

- The "Enteral Nutrition" policy puts the burden of obtaining feedings on the patient.

UniHealth's pharmacy does not have access to the patient's electronic medical record (EMR), creating a lapse in the continuum of information flow.

Home Health Regulatory Criteria,
10A NCAC 14C .2002 Information Required of the Applicant

(a) An applicant shall identify:

(1) the counties that are proposed to be served by the new office;

Comment. As explained above, UniHealth proposes to serve three counties (Brunswick, New Hanover and Pender) but will essentially meet the projected unmet need in only one (Brunswick). According to the 2013 State Medical Facilities Plan, these three counties will have a projected 2014 unmet need of 563.93 patients – 324.94 in Brunswick, 186.04 in New Hanover and 52.95 in Pender. However, UniHealth projects to serve 508 patients in Year 3 – 432 in Brunswick, 59 in New Hanover and 17 in Pender.

(2) the proposed types of services to be provided, including a description of each discipline;

Comment. A pediatric support letter is offered even though it appears that UniHealth will not offer services to this segment of the population.

All assumptions, including the specific methodology by which patient utilization and costs are projected, shall be stated.

Comment. UniHealth projects a first year *loss* of $317,001 and a second year profit of *only* $20,301. This projected second year profit barely achieves the financial breakeven point and does very little to recoup prior losses. UniHealth does not provide for a financially sustainable project, especially if revenues are overstated (bad debt), expenses are understated, payor mix is less profitable, etc.

Furthermore, UniHealth's proposal to buy an existing building (as opposed to leasing space) with such poor projected financial sustainability will lock it into high overhead costs.

10A NCAC 14C .2003 Performance Standards

An applicant shall project, in the third year of operation, an annual unduplicated patient caseload for the county in which the facility will be located that meets or exceeds the minimum need used in the applicable State Medical Facilities Plan to justify the establishment of a new home health agency office in that county. An applicant shall not be required to meet this performance standard if the home health agency office need determination in the applicable State Medical Facilities Plan was not based on application of the standard methodology for a Medicare-certified home health agency office.

Comment. As stated previously, UniHealth proposes to serve three counties (Brunswick, New Hanover and Pender) but will essentially meet the projected unmet need in only one (Brunswick). According to the 2013 State Medical Facilities Plan, these three counties will have a projected 2014 unmet need of 563.93 patients – 324.94 in Brunswick, 186.04 in New Hanover and 52.95 in Pender. However, UniHealth projects to serve 508 patients in Year 3 – 432 in Brunswick, 59 in New Hanover and 17 in Pender.

10A NCAC 14C .2005 Staffing and Staff Training

(a) An applicant shall demonstrate that proposed staffing for the home health agency office will meet the staffing requirements as contained in 10A NCAC 13J which is incorporated by reference including all subsequent amendments. A copy of 10A NCAC 13J may be obtained from the Division of Health Service Regulation, Medical Facilities Licensure Section at a cost of two dollars and sixty cents ($2.60).

(b) An applicant shall provide copies of letters of interest, preliminary agreements, or executed contractual arrangements between the proposed home health agency office and each health care provider with which the home health agency office plans to contract for the provision of home health services in each of the counties proposed to be served by the new office.

As stated previously, UniHealth has disclosed *thirty* "civil rights equal access complaints" filed against it or its parent company, in just North Carolina, in the past five years. These civil rights and equal access complaints are not confined to just one or two locations, but appear to involve a *dozen* separate locations. This history raises concerns about UniHealth's ability to retain quality staff and to provide quality patient care.

Separately, UniHealth proposes to contract for *all* therapy services – physical therapy, occupational therapy and speech therapy. By relying on outside resources for these vital services, UniHealth faces increased difficulty with staff stability, retention, familiarity with the patient and care coordination. This, in turn, often results in more difficulty improving patient outcomes and allowing the patient to remain in the home.

Conclusions

- When considered standing alone, the above comments raise questions concerning whether UniHealth's application conforms with Criteria 3, 4, 5, 7, 13(b) and (c) and 18a.
- UniHealth's application:
  - Proposes to use all contract staff to provide all therapies
  - Has questionable financial sustainability
  - Ranks *lowest* in net revenue in year 2
  - Ranks *lowest* in second year charity care (by dollars or a percentage of gross revenue)
  - Reveals a troublesome history of civil rights complaints

3. NHRMC Home Care

NHRMC Home Care proposes to serve three counties (patients in Brunswick and Columbus) with its proposed project. However, NHRMC *already* serves these three counties with its existing home health agency in Pender County. These facts contradict NHRMC's contention that, "The establishment of a home health agency in Brunswick County will allow NHRMC to serve the patients from Brunswick and Columbus counties that it currently cannot serve because they are not within the service area of the NHRMC Home Care Pender County agency."

Furthermore, the 2013 State Medical Facilities Plan projects a *surplus* of patients in Bladen and Columbus counties. There is no need for additional home health services in two of the three counties proposed to be served by NHRMC.

Approval of NHRMC's proposed "new" home health agency for the same geographic area it now serves would simply duplicate existing resources. As such, NHRMC's proposed project is neither the least costly nor most effective alternative to meet the needs identified in the 2013 State Medical Facilities Plan. NHRMC's proposed project will also limit, rather than enhance, competition.

NHRMC's projected $1.5 million profit in its second year of operation is unreasonable. This projected profit amounts to 43% of projected net revenue and *far* exceeds the 4% - 7% national averages. In fact, no other applicant even comes close to this level of profitability.

General Review Criteria,
G.S. 131E-183(a)

(1) Policies and need. The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.

Comment. NHRMC Home Care proposes to serve three counties (Bladen, Brunswick and Columbus) with its proposed project. However, according to the 2013 State Medical Facilities Plan, Table 12A, NHRMC *already* serves patients in these three counties with its existing home health agency in Pender County.

Furthermore, the 2013 State Medical Facilities Plan projects a *surplus* of patients in Bladen and Columbus counties. There is no need for additional home health services in two of the three counties proposed to be served by NHRMC and, in fact, already served by NHRMC.

Inconsistencies between NHRMC Proposed Service Area And 2013 State Medical Facilities Plan Patient Projections for 2014

County	Patient Surplus or (Deficit)
Bladen	70.92
Brunswick	(324.94)
Columbus	58.55

NHRMC's proposed project is not consistent with the need determinations in the 2013 SMFP. Since NHRMC already serves patients from Brunswick County (380 patients in 2012) where there is a projected deficit, approval of NHRMC's proposed "new" home health agency for the same geographic area it now serves would not benefit the service area population.

(3) Population to be served. The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

Comment. As illustrated above, there is no need for additional home health services in two of the three counties proposed to be served by NHRMC and, in fact, already served by NHRMC. The 2013 State Medical Facilities Plan projects a *surplus* of patients in Bladen and Columbus counties.

Even in Brunswick County, where the SMFP projects a need to serve additional home health patients, NHRMC's 2016 patient projections far exceed its current patient volume plus the projected unmet patient volume.

Over-Projection of Need by NHRMC Compared to 2013 SMFP

County	NHRMC Actual 2012 HH Patients	Patient Surplus or (Deficit)	NHRMC Projected 2016 HH Patients	NHRMC Projected Incr 2012-2016
Bladen	21	70.92	45	114%
Brunswick	380	(324.94)	1,013	167%
Columbus	36	58.55	175	386%

NHRMC's projection that it will essentially *triple* its patient volume in the three-county area from 437 patients in 2012 to 1,233 patients in 2016 is unrealistic.

Likewise, NHRMC's projection that it will serve 100.0% Medicare and 0.0% Medicaid duplicated patients in its second year of operation is also unrealistic and does not meet the needs of the population to be served.

(4) Least costly or most effective alternative. Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.

Comment. NHRMC Home Care proposes to serve three counties (Bladen, Brunswick and Columbus) but the 2013 State Medical Facilities Plan projects a *surplus* of patients in Bladen and Columbus counties. There is no need for additional home health services in two of the three counties proposed to be served by NHRMC and, in fact, already served by NHRMC.

Approval of NHRMC's proposed "new" home health agency for the same geographic area it now serves would simply duplicate existing resources. NHRMC's proposed project to serve counties it already serves rather than new counties is neither the least costly nor most effective alternative to meet the needs identified in the 2013 State Medical Facilities Plan.

(5) Availability of funds and reasonable projections of costs and charges. Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

Comment. NHRMC's projected $1.5 million profit in its second year of operation is unreasonable. This projected profit amounts to 43% of projected net revenue, *far* exceeds the 4% - 7% national averages and is unreasonable.

NHRMC's average net revenue per visit is the *second highest* among all applicants and likewise is unreasonable given its overall projected high profitability.

Year 2 Average Net Revenue Per Visit

UniHealth	NHRMC	Advanced	HKZ	Maxim	Gentiva	Continuum
$123.57	$154.84	$138.63	$145.93	$161.46	$142.67	$146.57

NHRMC's average cost per visit is the *lowest* among all applicants and calls into question whether NHRMC is devoting sufficient resources to patient care.

For all these reasons, NHRMC's pro forma projections are unreasonable.

(6) Unnecessary duplication. The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.

Comment. As stated previously, NHRMC Home Care proposes to serve three counties (Bladen, Brunswick and Columbus) with its proposed project. However, according to the 2013 State Medical Facilities Plan, Table 12A, NHRMC *already* serves these three counties with its existing home health agency in Pender County.

Furthermore, the 2013 State Medical Facilities Plan projects a *surplus* of patients in Bladen and Columbus counties. There is no need for additional home health services in

two of the three counties proposed to be served by NHRMC and, in fact, already served by NHRMC.

Approval of NHRMC's proposed "new" home health agency for the same geographic area it now serves would simply duplicate existing resources without offering patients a choice of home health providers or enhancing competition.

(7) Availability of resources, including health manpower. The applicant shall show evidence of the availability of resources, including health manpower and management personnel, for the provision of the services proposed to be provided.

Comment. In Brunswick County alone, NHRMC projects its 380 actual patients in 2012 will increase to 1,013 patients in 2016. NHRMC also states in its development schedule that, "Proposed staff to operate the proposed Brunswick County home health agency exists at the NHRMC Home Care Pender County agency. No core staff will be recruited." NHRMC's staffing projections are unrealistic.

Furthermore, NHRMC proposes to initiate services with five LPNs and two RNs. Additional LPNs only are added in the second year of operation. This emphasis on LPN staffing rather than more highly skilled RN staffing could result in lower patient quality and outcomes.

This may be particularly problematic with wound, ostomy and continence nurses (WOCN) and certified infusion nurses (CRNI), where resources appear to be lacking.

(13) Medically underserved populations. The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:

a. The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically underserved;

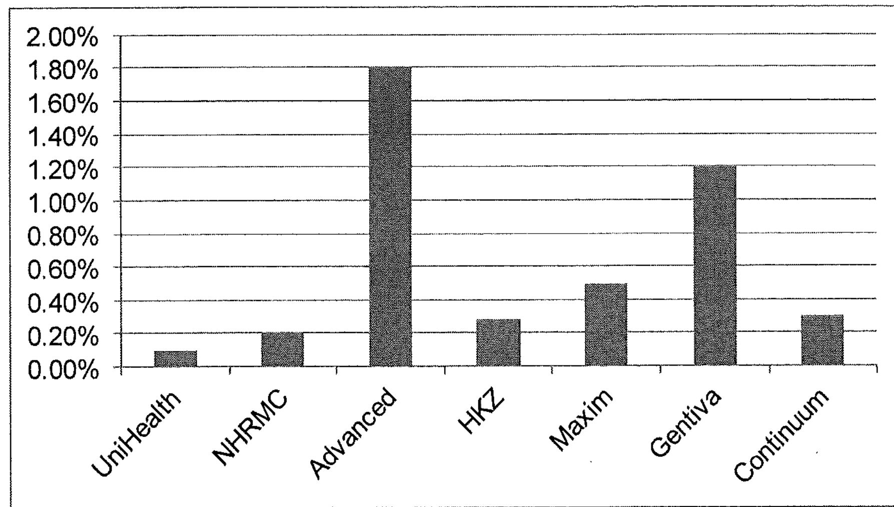
b. Its past performance in meeting its obligation, if any, under any applicable regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal assistance, including the existence of any civil rights access complaints against the applicant;

c. That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services; and

d. That the applicant offers a range of means by which a person will have access to its services. Examples of a range of means are outpatient services, admission by house staff, and admission by personal physicians.

Comment. NHRMC's projected $1.5 million profit in its second year of operation *far exceeds* that of any other applicant. In sharp contrast, however, NHRMC has the *second lowest* projected second year charity care percentage (as measured against gross revenue) among all *seven* CON applicants.

Year 2 Charity Care as a Percent of Gross Revenue



Year 2 Charity Care as Expressed in Dollars

UniHealth	NHRMC	Advanced	HKZ	Maxim	Gentiva	Continuum
$1,700	$12,174	$33,240	$4,711	$7,737	$14,671	$4,590

Given its projected high net profit and non-profit status, NHRMC's does not devote resources to charity care commensurate with the community's needs.

NHRMC's projection that it will serve 100.0% Medicare and 0.0% Medicaid duplicated patients in its second year of operation does not demonstrate a commitment to medically underserved populations.

(18a) Enhanced competition. The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

Comment. As stated previously, NHRMC Home Care proposes to continue to serve three counties (Bladen, Brunswick and Columbus) that it *already* serves with its existing home health agency in Pender County.

Approval of NHRMC's proposed "new" home health agency for the same geographic area it now serves would simply duplicate existing resources, not offer patients a choice of home health providers and not enhance competition.

(20) Quality. An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.

Comment. In Brunswick County alone, NHRMC projects its 380 actual patients in 2012 will increase to 1,013 patients in 2016 but projects to use existing staff and not recruit any new core staff. Additional staff will be required to support this projected patient volume or the quality of patient care will likely suffer.

Furthermore, NHRMC proposes to initiate services with five LPNs and two RNs. Additional LPNs only are added in the second year of operation. This emphasis on LPN staffing rather than more highly skilled RN staffing could result in lower patient quality and outcomes.

This may be particularly problematic with wound, ostomy and continence nurses (WOCN) and certified infusion nurses (CRNI), where resources appear to be lacking.

NHRMC also appears to lack evidence-based programs to monitor and improve clinical quality.

Home Health Regulatory Criteria,
10A NCAC 14C .2002 Information Required of the Applicant

(a) An applicant shall identify:

(1) the counties that are proposed to be served by the new office;

Comment. NHRMC Home Care proposes to serve three counties (Bladen, Brunswick and Columbus) with its proposed project but *already* serves these three counties with its existing home health agency in Pender County. According to the NHRMC CON application, NHRMC also served patients from these three counties in 2012.

These facts contradict NHRMC's contention that, "The establishment of a home health agency in Brunswick County will allow NHRMC to serve the patients from Brunswick and Columbus counties that it currently cannot serve because they are not within the service area of the NHRMC Home Care Pender County agency."

(2) the proposed types of services to be provided, including a description of each discipline;

Comment. NHRMC's emphasis on LPN staffing rather than more highly skilled RN staffing could result in lower patient quality and outcomes. This may be particularly problematic with wound, ostomy and continence nurses (WOCN) and certified infusion nurses (CRNI), where resources appear to be lacking.

(3) the projected total unduplicated patient count of the new office for each of the first two years of operation;

Comment. NHRMC's projection that it will serve 100.0% Medicare and 0.0% Medicaid *duplicated* patients in its second year of operation is unrealistic and calls into question the reliability of NHRMC's payor percentage projections.

(7) the projected average annual cost per visit for each service discipline;

Comment. NHRMC's average cost per visit is the *lowest* among all applicants whether considering administrative costs, $24.69, or direct operating cost, $63.99, or total operating costs, $88.68.

Such low costs apparently contribute to NHRMC's projected $1.5 million profit in its second year of operation, which is unreasonable. This projected profit amounts to 43% of projected net revenue and *far* exceeds the 4% - 7% national averages.

(8) the projected charge by payor source for each service discipline;

Comment. NHRMC's projected $1.5 million profit in its second year of operation, raises questions concerning the reasonableness of its projected charges. , NHRMC's projection that it will serve 100.0% Medicare and 0.0% Medicaid duplicated patients in its second year of operation also calls into question the reliability of NHRMC's payor percentage projections.

10A NCAC 14C .2003 Performance Standards

An applicant shall project, in the third year of operation, an annual unduplicated patient caseload for the county in which the facility will be located that meets or exceeds the minimum need used in the applicable State Medical Facilities Plan to justify the establishment of a new home health agency office in that county. An applicant shall not be required to meet this performance standard if the home health agency office need determination in the applicable State Medical Facilities Plan was not based on application of the standard methodology for a Medicare-certified home health agency office.

Comment. The 2013 State Medical Facilities Plan projects a *surplus* of patients in Bladen and Columbus counties. There is no need for additional home health services in two of the three counties proposed to be served by NHRMC and, in fact, already served by NHRMC.

Inconsistencies between NHRMC Proposed Service Area
And 2013 State Medical Facilities Plan Patient Projections for 2014

County	Patient Surplus or (Deficit)
Bladen	70.92
Brunswick	(324.94)
Columbus	58.55

NHRMC's proposed project is not consistent with the need determinations in the 2013 SMFP. Since NHRMC already serves patients from Brunswick County (380 patients in 2012) where there is a projected deficit, approval of NHRMC's proposed "new" home health agency for the same geographic area it now serves would not benefit the service area population.

10A NCAC 14C .2005 Staffing and Staff Training

(a) An applicant shall demonstrate that proposed staffing for the home health agency office will meet the staffing requirements as contained in 10A NCAC 13J which is incorporated by reference including all subsequent amendments. A copy of 10A NCAC 13J may be obtained from the Division of Health Service Regulation, Medical Facilities Licensure Section at a cost of two dollars and sixty cents ($2.60).

(b) An applicant shall provide copies of letters of interest, preliminary agreements, or executed contractual arrangements between the proposed home health agency office and each health care provider with which the home health agency office plans to contract for the provision of home health services in each of the counties proposed to be served by the new office.

Comment. In Brunswick County alone, NHRMC projects its 380 actual patients in 2012 will increase to 1,013 patients in 2016 yet claims that staff to operate the proposed Brunswick County home health agency already exists at the NHRMC Home Care Pender County agency and no core staff will be recruited." NHRMC's staffing projections are unrealistic and, therefore, not reliable.

Furthermore, NHRMC proposes to initiate services with five LPNs and two RNs. Additional LPNs only are added in the second year of operation. This emphasis on LPN staffing rather than more highly skilled RN staffing could result in lower patient quality and outcomes.

This may be particularly problematic with wound, ostomy and continence nurses (WOCN) and certified infusion nurses (CRNI), where resources appear to be lacking.

Conclusions

- When considered standing alone, the above comments raise questions concerning whether NHRMC's application conforms with Criteria 3, 4, 5, 7, 18a, 20 and 10A NCAC 14C .2005.
- NHRMC's application:
  - Proposes to serve counties where there is a surplus
  - Proposes to duplicate services to counties it already serves from an existing agency
  - Projects an unreasonable increase in patient volume
  - Does not propose sufficient staff or sufficient RNs
  - Projects over $1.5 million in net profit in Year 2
  - Proposes low charity care
  - Does not enhance competition
  - Ranks *highest* in net profit in year 2,
  - Ranks *lowest* on direct operating cost per visit

4. HealthKeeperz of Brunswick

As a matter of procedure, this CON application was accompanied by a Letter of Intent *date-stamped* April 15, 2013 but *dated* July 16, 2012 and otherwise referencing an *entirely different project* – Mecklenburg County home health agency, August 1, 2012. HKZ's application does not appear to satisfy 10A N.C.A.C.14C.0201, which requires an accurate letter of intent.

HKZ's patient projections do not meet the needs identified in the 2013 SMFP. HKZ's proposed project will significantly "overserve" patients in Brunswick County while significantly "underserving" patients in New Hanover County and failing to serve any patients at all in Pender County.

HKZ's proposal to use contract staffing in *every* service discipline raises serious concerns about staff stability, retention, and familiarity with the patient, care coordination and quality of patient care. This, in turn, often results in more difficulty improving patient outcomes and allowing the patient to remain in the home. Even more importantly, such staffing patterns are not consistent with the federal Medicare regulations and guidelines – Medicare Conditions of Participation for Home Health, Section 484.14(a) Standard: Services Furnished, Interpretive Guideline G127.

HKZ cites its roots as a pharmacy but does not provide infusion services. (It appears that HKZ provides only prescribed oral medications.) HKZ also lacks certified infusion nurses (CRNI) and wound, ostomy and continence nurses (WOCN). HKZ lacks services for ventilator patients and pediatric patients.

HKZ's deficiencies, taken together, ultimately are reflected in the performance data from the Medicare "home health compare" web site (for applicants with available data), including average benchmarks for North Carolina and the United States. Using either North Carolina or United States benchmarks, HKZ rates *at or near the bottom* of the Medicare home health comparison criteria.

General Review Criteria,
G.S. 131E-183(a)

(1) Policies and need. The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.

Comment. HKZ proposes to serve two counties (Brunswick and New Hanover) but will do nothing to meet the projected unmet need in a third (Pender County).

According to the 2013 State Medical Facilities Plan, these three counties will have a projected 2014 unmet need of 563.93 patients – 324.94 in Brunswick, 186.04 in New Hanover and 52.95 in Pender. However, HKZ projects to serve 603 patients in Year 3 – 578 in Brunswick, 25 in New Hanover and 0 in Pender.

As indicated in the table below, HKZ's proposed project will significantly "overserve" patients in Brunswick County while significantly "underserving" patients in New Hanover County and failing to serve any patients at all in Pender County.

Inconsistencies between UniHealth Patient Projections And 2013 State Medical Facilities Plan

County	2013 SMFP Unmet Need (2014)	UniHealth Projected Patients Served (Year 3)	UniHealth Projected Over/(Under) Served	UniHealth Pct Projected Over/(Under) Served
Brunswick	324.94	578	+253	+77.8%
New Hanover	186.04	25	(161)	(86.6%)
	510.98	603	92	18.0%
Pender	52.95	0	(53)	(100.0%)

In total, HKZ's patient projections do not address the unmet need identified in the 2013 State Medical Facilities Plan.

(3) Population to be served. The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

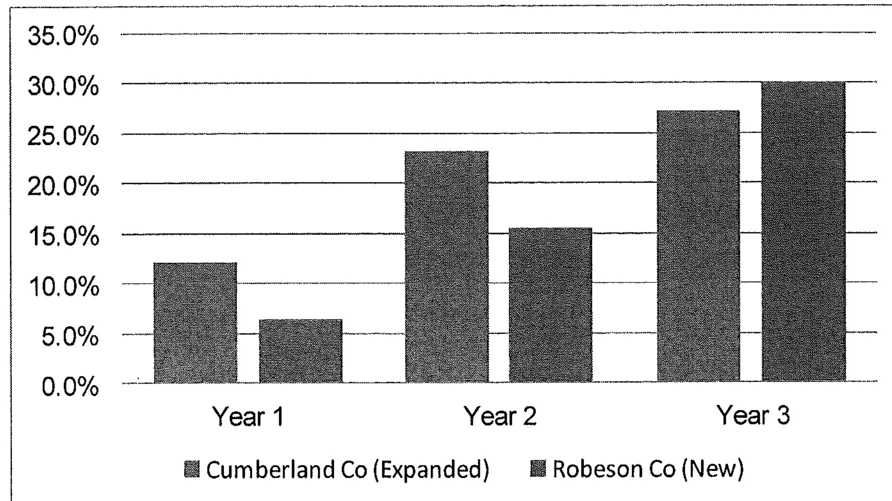
Comment. HKZ's initial patient volume projections are inconsistent with its past experience and are overstated.

As illustrated above, HKZ's projects to significantly "overserve" patients in Brunswick County while significantly "underserving" patients in New Hanover County and failing to serve any patients at all in Pender County.

In fact, HKZ projects to serve more patients than any other applicant except NHRMC, which reports data for its combined existing and proposed operations. As justification for its patient projections (13% market share capture in Brunswick County), HKZ relied upon its market share ramp up for its *expansion* project in Cumberland County rather than its much more conservative market share ramp up for its *new* project in Robeson County.

HKZ Actual 3-Year Market Share Ramp Up Comparison:

Expanded **HHA in Cumberland County**
Versus
New **HHA in Robeson County**



HKZ failed to rely upon its own more conservative market share assumptions for a *new* home health agency start up in Brunswick County. At the same time, HKZ cites numerous examples of the difficulties that a "new entrant" like HKZ encounters in markets with "established relationships" with existing home health agencies and where competing applications are expected from hospital-owned (NHRMC) or hospital-affiliated (Advanced Home Care) home health companies. HKZ ignored its own data and concerns when projecting to overserve patients in Brunswick County.

(4) Least costly or most effective alternative. Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.

Comment. HKZ's plan to use contract staffing in all disciplines is not a less costly or more effective than the alternative of employing at least some staff. Rather than relying upon existing reserves to fund its project, the applicant will take on $250,000 in outside debt (bank line of credit) that is more expensive and riskier for financial feasibility. HKZ's high utilization projections are also not the most effective alternative.

(5) Availability of funds and reasonable projections of costs and charges. Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

Comment. HKZ faces several immediate and long-term hurdles to the financial feasibility of its project.

As stated above, rather than relying upon existing reserves to fund its project, the applicant will take on $250,000 in outside debt (bank line of credit), which is more expensive and increases risk.

As stated previously, HKZ's initial patient volume projections are inconsistent with its past experience and are overstated. HKZ's projects to significantly "overserve" patients in Brunswick County while significantly "underserving" patients in New Hanover County and failing to serve any patients at all in Pender County. HKZ projects to serve more patients than any other applicant except NHRMC, which reports data for its combined existing and proposed operations. HKZ's projected utilization is inconsistent with being a new entrant in the market and its own past more conservative market share assumptions for a *new* home health agency start up. HKZ ignored its own data and concerns when projecting to overserve patients in Brunswick County, thus jeopardizing its project's immediate and long-term financial feasibility.

Furthermore, HKZ's average direct operating cost per visit at $89.21 is not likely to be reliable given its plan to use all contract staffing. For all these reasons, HKZ's pro forma projections are unreasonable.

(6) Unnecessary duplication. The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.

Comment. HKZ's initial patient volume projections are inconsistent with its past experience and are overstated.

As illustrated above, HKZ's projects to significantly "overserve" patients in Brunswick County which results in unnecessary duplication in Brunswick County. HKZ's high volume projections also call into question whether it will be duplicating services already provide by existing home health agencies in order to achieve such volume projections.

(7) Availability of resources, including health manpower. The applicant shall show evidence of the availability of resources, including health manpower and management personnel, for the provision of the services proposed to be provided.

Comment. HKZ's proposal to use contract staffing in *every* service discipline raises serious concerns about staff stability, retention, consistency of patient care, care coordination and quality of patient care. This, in turn, often results in more difficulty improving patient outcomes and allowing the patient to remain in the home.

Even more importantly, such staffing patterns do not comply with federal Medicare regulations and guidelines.

> Medicare Conditions of Participation for Home Health, Section 484.14(a) Standard: Services Furnished, Interpretive Guideline G127:
>
> Part-time or intermittent skilled nursing services and at least one other therapeutic service (physical, speech or occupational therapy; medical social services; or home health aide services) are made available on a visiting basis, in a place of residence used as a patient's home. *An HHA must provide at least one of the qualifying services directly through*

agency employees, but may provide the second qualifying service and additional services under arrangements with another agency or organization. (emphasis added)

(8) Coordination with the existing health care system. The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system.

Comment. HKZ has failed to demonstrate its ability to coordinate its proposed services with the existing health care system. Instead, HKZ cites numerous examples of the difficulties that a "new entrant" like HKZ encounters in markets with "established relationships" with existing home health agencies and where competing applications are expected from hospital-owned (NHRMC) or hospital-affiliated (Advanced Home Care) home health companies.

Like the Letter of Intent for this application, which was *dated* July 16, 2012 and otherwise referencing an *entirely different project* – Mecklenburg County home health agency – HKZ includes two out-of-date support letters from the NC Indian Economic Development Initiative and the Robeson County Finance Department. Neither is relevant to HKZ's proposed project in Brunswick County.

(13) Medically underserved populations. The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:

a. The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically underserved;

b. Its past performance in meeting its obligation, if any, under any applicable regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal assistance, including the existence of any civil rights access complaints against the applicant;

c. That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services; and

d. That the applicant offers a range of means by which a person will have access to its services. Examples of a range of means are outpatient services, admission by house staff, and admission by personal physicians.

Comment. HKZ's Patient Financial Responsibility – Home Health states that: Insurance coverage and patient's responsibility for copay, *if known at time of admission*, will be discussed and presented in writing to the patient/family/caregiver.

Such policies are not consistent with federal Medicare regulations and guidelines, which state that the patient has the right to understand the financial obligation prior to beginning care.

> Medicare Conditions of Participation for Home Health, Section 484.10(e)
> Standard: Patient Liability for Payment
>
> Interpretive Guideline G113
> (1) The patient has the right to be advised, before care is initiated, of the extent to which payment for the HHA services may be expected from Medicare or other sources, and the extent to which payment may be required from the patient.
>
> Interpretive Guideline G114
> Before the care is initiated, the HHA must inform the patient, orally and in writing, of--
> (i) The extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program known to the HHA;
> (ii) The charges for services that will not be covered by Medicare; and
> (iii) The charges that the individual may have to pay.

Similarly, HKZ's admissions policies with respect to use of a walker and homebound status also appear to be in conflict.

Year 2 Charity Care as Expressed in Dollars

UniHealth	NHRMC	Advanced	HKZ	Maxim	Gentiva	Continuum
$1,700	$12,174	$33,240	$4,711	$7,737	$14,671	$4,590

HKZ's projected charity care commitment is also low.

(14) Health training programs. The applicant shall demonstrate that the proposed health services accommodate the clinical needs of health professional training programs in the area, as applicable.

Comment. Like the Letter of Intent for this application, which was *dated* July 16, 2012 and otherwise referencing an *entirely different project* – Mecklenburg County home health agency – HKZ includes a 2012 educational support letter from the University of North Carolina at Pembroke.

(18a) Enhanced competition. The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost effectiveness,

quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

Comment. As stated previously, HKZ has failed to demonstrate its ability to enhance competition with its proposed services but instead cites numerous examples of the difficulties that a "new entrant" like HKZ encounters in markets with "established relationships" with existing home health agencies.

HKZ's proposal will not enhance access since it fails to propose serving any patients from Pender County and projects to significantly "overserve" patients in Brunswick County while significantly "underserving" patients in New Hanover County. HKZ's financial policies are also a deterrent to access.

HKZ's reliance on all contract staffing will not have a favorable impact on quality and makes its cost projections less reliable and effective.

(20) Quality. An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.

Comment. HKZ does not provide an accreditation agency listing to document the provision of quality patient care.

HKZ's proposal to use contract staffing in *every* service discipline raises serious concerns about staff stability, retention, consistency of patient care, care coordination and quality of patient care. This, in turn, often results in more difficulty improving patient outcomes and allowing the patient to remain in the home. As documented previously, such staffing patterns are not consistent with federal Medicare regulations and guidelines.

HKZ lacks evidence-based programs that promote collaboration of patient care between disciplines and drive positive outcomes.

HKZ does not mention the provision of health coaching or any type of program/certification to care for the chronically ill.

HKZ cites its roots as a pharmacy but does not provide infusion services. (It appears that HKZ provides only prescribed oral medications.) HKZ also lacks certified infusion nurses (CRNI) and wound, ostomy and continence nurses (WOCN). HKZ lacks services for ventilator patients and pediatric patients.

HKZ references Lean Six Sigma but does not offer any concrete examples of processes that have been improved as a result of its use. Furthermore, it is very difficult to commit to Lean Six Sigma with old fashioned charts housed in a record room as opposed to an electronic medical record system.

Ultimately, these deficiencies are reflected in the performance data from the Medicare "home health compare" web site[1] (for applicants with available data), including average

[1] Medicare's Home Health Compare, found at www.medicare.gov has information about the quality of care provided by "Medicare-certified" home health agencies throughout the nation. The information on Home Health Compare helps individuals learn how well home health agencies care for their patients, shows how often each agency used

benchmarks for North Carolina and the United States. Please refer to **Attachment A** and **Attachment B**.

Medicare "Home Health Compare"
Quality of Patient Care – Indicator Summary
***North Carolina* Benchmarks**

	UniHealth	NHRMC	Advanced*	HKZ*	Gentiva*	Continuum
Indicators >= N.C. Avg Benchmarks	15	22	20	14	14	13
Indicators < N.C. Avg Benchmarks	9	5	7	13	13	14
Indicators Not Available	3	0	0	0	0	0
Total Indicators Reviewed	24	27	27	27	27	27
Percent of Indicators >= N.C. Avg Benchmarks Available	62.5%	81.5%	74.1%	51.9%	51.9%	48.1%
Number of Completed Surveys	99	371	2,873	409	7,244	154

* Average of the provider agencies in North Carolina

Medicare "Home Health Compare"
Quality of Patient Care – Indicator Summary
***United States* Benchmarks**

	UniHealth	NHRMC	Advanced*	HKZ*	Gentiva*	Continuum
Indicators >= U.S. Avg Benchmarks	15	21	20	13	10	15
Indicators < U.S. Avg Benchmarks	9	6	7	14	17	12
Indicators Not Available	3	0	0	0	0	0
Total Indicators Reviewed	24	27	27	27	27	27
Percent of Indicators >= U.S. Avg	62.5%	77.8%	74.1%	48.1%	37.0%	55.6%

best practices when caring for its patients and whether patients improved in certain important areas of care, and shows what other patients said about their recent home health care experience.

Benchmarks Available						
Number of Completed Surveys	99	371	2,873	409	7,244	154

* Average of the provider agencies in North Carolina

Using either North Carolina or United States benchmarks, HKZ rates *at or near the bottom* of the Medicare home health comparison criteria.

Home Health Criteria,
10A NCAC 14C .2002 Information Required of the Applicant

(a) An applicant shall identify:

(1) the counties that are proposed to be served by the new office;

Comment. HKZ's proposed project will significantly "overserve" patients in Brunswick County while significantly "underserving" patients in New Hanover County and failing to serve any patients at all in Pender County.

(2) the proposed types of services to be provided, including a description of each discipline;

Comment. HKZ cites its roots as a pharmacy but does not provide infusion services. HKZ also lacks certified infusion nurses (CRNI) and wound, ostomy and continence nurses (WOCN). HKZ lacks services for ventilator patients and pediatric patients.

(3) the projected total unduplicated patient count of the new office for each of the first two years of operation;

Comment. HKZ's initial patient volume projections are inconsistent with its past experience and are overstated. In fact, HKZ projects to serve more patients than any other applicant except NHRMC, which reports data for its combined existing and proposed operations. As justification for its patient projections (13% market share capture in Brunswick County), HKZ relied upon its market share ramp up for its *expansion* project in Cumberland County rather than its much more conservative market share ramp up for its *new* project in Robeson County.

(7) the projected average annual cost per visit for each service discipline;

Comment. HKZ's average direct operating cost per visit of $89.21 is likely not reliable given its complete reliance on contract staffing.

(9) the names of the anticipated sources of referrals; and

(10) documentation of attempts made to establish working relationships with the sources of referrals.

Comment. HKZ has failed to demonstrate its ability to coordinate its proposed services with anticipated sources of referrals and instead cites numerous examples

of the difficulties that a "new entrant" like HKZ encounters in markets where there are already "established relationships" with existing home health agencies.

10A NCAC 14C .2003 Performance Standards

An applicant shall project, in the third year of operation, an annual unduplicated patient caseload for the county in which the facility will be located that meets or exceeds the minimum need used in the applicable State Medical Facilities Plan to justify the establishment of a new home health agency office in that county. An applicant shall not be required to meet this performance standard if the home health agency office need determination in the applicable State Medical Facilities Plan was not based on application of the standard methodology for a Medicare-certified home health agency office.

Comment. HKZ's proposed project will significantly "overserve" patients in Brunswick County while significantly "underserving" patients in New Hanover County and failing to serve any patients at all in Pender County. HKZ's initial high patient volume projections and market share assumptions are inconsistent with its past projections as a new entrant in Robeson County and are overstated.

10A NCAC 14C .2005 Staffing and Staff Training

(a) An applicant shall demonstrate that proposed staffing for the home health agency office will meet the staffing requirements as contained in 10A NCAC 13J which is incorporated by reference including all subsequent amendments. A copy of 10A NCAC 13J may be obtained from the Division of Health Service Regulation, Medical Facilities Licensure Section at a cost of two dollars and sixty cents ($2.60).

(b) An applicant shall provide copies of letters of interest, preliminary agreements, or executed contractual arrangements between the proposed home health agency office and each health care provider with which the home health agency office plans to contract for the provision of home health services in each of the counties proposed to be served by the new office.

Comment. HKZ's proposal to use contract staffing in *every* service discipline raises serious concerns about with staff stability, retention, consistency of patient care, care coordination and quality of patient care. This, in turn, often results in more difficulty improving patient outcomes and allowing the patient to remain in the home.

Even more importantly, such staffing patterns do not comply with the federal Medicare regulations and guidelines – Medicare Conditions of Participation for Home Health, Section 484.14(a) Standard: Services Furnished, Interpretive Guideline G127.

Conclusions

- When considered standing alone, the above comments raise questions concerning whether HKZ's application conforms with Criteria 3, 4, 5, 6, 7, 8, 13(b) and (c) 18a, 20 and 10A NCAC 14C .2005.
- HKZ's application:
    - Does not propose any services to meet the unmet need in Pender County
    - Projects to serve fewer patients in New Hanover County than the need identified in the 2013 SMFP

- Projects unrealistically high volume for a new entrant in a market that is inconsistent with its own past much more conservative market share ramp up for its *new* project in Robeson County
- Relies wholly on contract staffing, which does not comply with Medicare Conditions of Participation for Home Health, Section 484.14(a) Standard: Services Furnished, Interpretive Guideline G127.
- Has financial policies that do not satisfy applicable Medicare requirements
- Has a low charity care commitment whether measured in total dollars or as a percentage of gross revenue.
- Does not propose infusion services and lacks certified infusion nurses (CRNI) and wound, ostomy and continence nurses (WOCN) as well as services for ventilator patients and pediatric patients.
- Using either North Carolina or United States benchmarks, rates *at or near the bottom* of the Medicare home health comparison criteria.

5. Maxim Healthcare Services

Maxim entered into both a Corporate Integrity Agreement with the DHHS Office of Inspector General and a Deferred Prosecution Agreement with the US Attorney's Office for the District of New Jersey in September 2011. According to the US Attorney's Office press release, "Maxim Healthcare Services Charged With Fraud, Agrees To Pay Approximately $150 Million, Enact Reforms after False Billings Revealed As Common Practice." Please refer to **Attachment C**. Maxim will need to focus its resources on payback and compliance efforts and is unlikely to be able to devote time, effort and resources to developing another new home health agency in North Carolina.

Since its Wake County and Mecklenburg County home health agency CON projects are under appeal, Maxim does not have any experience with Medicare-certified home health agencies in North Carolina. Maxim does not focus on home health but treats home health agency services as part of a diverse portfolio of business lines including home care, non-medical care, medical facility staffing, flu and wellness, and autism and applied behavioral analysis (ABA) therapy. (See www.maximhealthcare.com)

Maxim proposes to serve just a *single* county (Brunswick), and is the *only* one of seven applicants proposing to serve just a single county.

General Review Criteria,
G.S. 131E-183(a)

(1) Policies and need. The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.

Comment. Maxim proposes to serve just a *single* county (Brunswick), and is the *only* one of seven applicants proposing to serve just a single county.

According to the 2013 State Medical Facilities Plan, Brunswick County will have a projected 2014 unmet need of 324.94 patients. Maxim projects to serve 387 patients in

Year 1, 503 patients in Year 2 and 516 patients in Year 3. Maxim does *not* propose to serve a *single* patient from either adjacent New Hanover or Pender counties despite a projected unmet need of 186.04 patients in New Hanover and 52.95 in Pender.

As indicated in the table below, Maxim's proposed project will significantly "overserve" patients in Brunswick County while *failing* to serve *any* patients at all in New Hanover and Pender counties.

Inconsistencies between Maxim Patient Projections
And 2013 State Medical Facilities Plan

County	2013 SMFP Unmet Need (2014)	Maxim Projected Patients Served (Year 3)	Maxim Projected Over/(Under) Served	Maxim Pct Projected Over/(Under) Served
Brunswick	324.94	516	+191	+58.8%
New Hanover	186.04	0	(186)	(100.0%)
Pender	52.95	0	(53)	(100.0%)

(3) Population to be served. The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

Comment. Maxim seeks to serve *only* Brunswick County itself, ignoring the unmet need projected in adjacent New Hanover and Pender counties.

(4) Least costly or most effective alternative. Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.

Comment. By projecting to serve only Brunswick County itself and ignoring the unmet need projected in adjacent New Hanover and Pender counties, Maxim has proposed a less effective alternative.

(5) Availability of funds and reasonable projections of costs and charges. Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

Comment. Maxim's projects a large first year loss of $470,755, the *largest* among all seven applicants. Maxim also projects high net revenue in Year 2, which seems difficult to accomplish given the large first year loss. If the high net revenue were to be accomplished in Year 2, then Maxim would not appear to be devoting an appropriate level of resources to patient care. Maxim's high average administrative

costs per visit and high total operating costs raise questions about its efficiency and balance of resources allocated to patient care rather than overhead. For all these reasons, Maxim's pro forma projections are unreasonable.

(8) the projected charge by payor source for each service discipline;

Comment. Maxim's high average net revenue per visit appears to be unreasonable.

(13) Medically underserved populations. The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:

a. The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically underserved;

b. Its past performance in meeting its obligation, if any, under any applicable regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal assistance, including the existence of any civil rights access complaints against the applicant;

c. That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services; and

d. That the applicant offers a range of means by which a person will have access to its services. Examples of a range of means are outpatient services, admission by house staff, and admission by personal physicians.

Comment. Maxim's ability to meet the needs of underserved groups will be dependent on its ability to satisfy the conditions of its CIA and Deferred Prosecution Agreement. Please refer to **Attachment C**. Maxim also does not project to provide access to any underserved groups in Pender or New Hanover Counties where there is a need.

(18a) Enhanced competition. The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

Comment. By projecting to serve only Brunswick County and ignoring the unmet need projected in adjacent New Hanover and Pender counties, Maxim will not enhance

competition throughout the area nor will it have a positive impact upon the cost effectiveness, quality, and access to the services proposed.

(20) Quality. An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.

Comments. *All but one* policy provided in Maxim's CON application is out of date. This suggests that Maxim is not doing the annual review of policies required under 10A NCAC 13J .1004 EVALUATION.

Home Health Criteria,
10A NCAC 14C .2002 Information Required of the Applicant

(a) An applicant shall identify:

(1) the counties that are proposed to be served by the new office;

Comment. Maxim proposes to serve just a *single* county (Brunswick. According to the 2013 State Medical Facilities Plan, Brunswick County will have a projected 2014 unmet need of 324.94 patients. Maxim projects to serve 387 patients in Year 1, 503 patients in Year 2 and 516 patients in Year 3. Maxim does *not* propose to serve a *single* patient from either adjacent New Hanover or Pender counties despite a projected unmet need of 186.04 patients in New Hanover and 52.95 in Pender.

As indicated in the table below, Maxim's proposed project will significantly "overserve" patients in Brunswick County while *failing* to serve *any* patients at all in New Hanover and Pender counties.

Inconsistencies between Maxim Patient Projections And 2013 State Medical Facilities Plan

County	2013 SMFP Unmet Need (2014)	Maxim Projected Patients Served (Year 3)	Maxim Projected Over/(Under) Served	Maxim Pct Projected Over/(Under) Served
Brunswick	324.94	516	+191	+58.8%
New Hanover	186.04	0	(186)	(100.0%)
Pender	52.95	0	(53)	(100.0%)

(7) the projected average annual cost per visit for each service discipline;

Comment. Maxim's high average administrative costs per visit and high total operating costs raise questions about its efficiency and commitment of resources to patient care.

(8) the projected charge by payor source for each service discipline;

Comment. Maxim's high average net revenue per visit appears to be unreasonable.

10A NCAC 14C .2003 Performance Standards

An applicant shall project, in the third year of operation, an annual unduplicated patient caseload for the county in which the facility will be located that meets or exceeds the minimum need used in the applicable State Medical Facilities Plan to justify the establishment of a new home health agency office in that county. An applicant shall not be required to meet this performance standard if the home health agency office need determination in the applicable State Medical Facilities Plan was not based on application of the standard methodology for a Medicare-certified home health agency office.

Comment. Maxim proposes to serve just a *single* county, Brunswick, and does *not* propose to serve a *single* patient from either adjacent New Hanover or Pender counties despite a projected unmet need of 186.04 patients in New Hanover and 52.95 in Pender.

Conclusions

- When considered standing alone, the above comments raise questions concerning whether Maxim's application conforms with Criteria 3, 4, 5, 13(c), 18a, and 10A NCAC 14C .2003.
- Maxim will need to focus its resources on compliance with its Corporate Integrity Agreement and Deferred Prosecution Agreement and will likely have difficulty developing and integrating new agencies especially since it also has been approved to develop two new home health agencies in other counties in North Carolina that are not yet operational. Please refer to **Attachment C**.
- Maxim's application:
    - Proposes to serve just a *single* county, Brunswick, while *failing* to serve *any* patients at all in New Hanover and Pender counties.
    - Projects a first year loss of $470,755 that is large and the *largest* among all seven applicants
    - Projects average net revenue per visit of $161.46, which appears to be unreasonable
    - Proposes high average administrative costs per visit of $52.58
    - Projects high total operating costs of $138.84.

6. Gentiva Health Services

Note: Financial comparisons related to patient volumes may be difficult to assess for Gentiva due to possible reporting inconsistencies. For example, at application pages 60 and 64, 391 unduplicated patients (by county) are reported in Year 2. At application page 67, 813 unduplicated patients (by qualifying discipline) are reported in Year 2.

Gentiva proposes to serve three counties (Brunswick, New Hanover and Pender) but will significantly "underserve" patients in New Hanover and Pender counties. In fact, based on its own projections, Gentiva will actually serve the *fewest* patients of all *seven* applicants.

Gentiva does not contract with major commercial insurers in North Carolina such as United Healthcare. Thus, it will exclude major payor segments of the population to be served.

Gentiva projects a first year *loss* of $193,076 and a second year profit of *only* $42,578. This projected second year profit barely achieves the financial breakeven point and does very little to recoup prior losses. In fact, this projected second year profit is the *second lowest* among all *seven* CON applicants. Gentiva does not provide for a financially sustainable project, especially if revenues are overstated (bad debt), expenses are understated, payor mix is less profitable, etc.

Gentiva does not have *any* accredited agencies in North Carolina. This is in sharp contrast to the 67 agencies accredited by the Accreditation Commission for Health Care (ACHC) across the country in various states and the 2 agencies accredited by The Joint Commission. Using either North Carolina or United States benchmarks, Gentiva rates *at or near the bottom* of the Medicare home health comparison criteria.

General Review Criteria,
G.S. 131E-183(a)

(1) Policies and need. The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.

Comment. Gentiva proposes to significantly "underserve" patients in New Hanover and Pender counties. Gentiva will actually serve the *fewest* patients of all *seven* applicants.

According to the 2013 State Medical Facilities Plan, these three counties will have a projected 2014 unmet need of 563.93 patients – 324.94 in Brunswick, 186.04 in New Hanover and 52.95 in Pender. However, Gentiva projects to serve 391 patients in Year 2 – 313 in Brunswick, 59 in New Hanover and 20 in Pender.

Inconsistencies between Gentiva Patient Projections And 2013 State Medical Facilities Plan

County	2013 SMFP Unmet Need (2014)	Gentiva Projected Patients Served (Year 2)	Gentiva Projected Over/(Under) Served	Gentiva Pct Projected Over/(Under) Served
Brunswick	324.94	313	(12)	(3.7%)
New Hanover	186.04	59	(127)	(68.3%)
Pender	52.95	20	(33)	(62.3%)
	563.93	391	(173)	(30.5%)

(3) Population to be served. The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

Comment. As explained above, Gentiva will not meet the unmet need identified in the 2013 SMFP for Brunswick, New Hanover or Pender Counties. Gentiva also does not contract with major commercial insurers in North Carolina such as United Healthcare. Thus, it will exclude major payor segments of the population to be served.

(4) Least costly or most effective alternative. Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.

Comment. As explained above, Gentiva will not meet the unmet need identified in the 2013 SMFP for Brunswick, New Hanover or Pender Counties. Gentiva also does not contract with major commercial insurers in North Carolina such as United Healthcare, which will exclude major payor segments of the population to be served. Gentiva also projects to serve a low volume of patients, which is more costly and less effective because overhead costs are incurred with less benefit offered to the community. Gentiva did not propose the least costly or most effective alternative available to it to propose.

(5) Availability of funds and reasonable projections of costs and charges. Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

Comment. Gentiva projects a first year *loss* of $193,076 and a second year profit of *only* $42,578. This projected second year profit barely achieves the financial breakeven point and does very little to recoup prior losses. Gentiva does not provide for a financially sustainable project, especially if revenues are overstated (bad debt), expenses are understated, payor mix is less profitable, etc.

(18a) Enhanced competition. The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

Comment. Gentiva's proposal will not have a positive impact on competition because it does not contract with major commercial insurers in North Carolina such as United Healthcare, and will not compete for this business. Gentiva's proposal will also not have a positive impact on access because it will serve fewer patients and not serve patients covered by certain insurance plans. Gentiva's application is less cost effective because it will incur overhead to establish the agency but serve fewer patients.

(20) Quality. An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.

Comment. Gentiva does not have *any* accredited agencies in North Carolina. This is in sharp contrast to the 67 agencies accredited by the Accreditation Commission for Health Care (ACHC) across the country in various states and the 2 agencies accredited by The Joint Commission.

Medicare "Home Health Compare"[2]
Quality of Patient Care – Indicator Summary
***North Carolina* Benchmarks**

	UniHealth	NHRMC	Advanced*	HKZ*	Gentiva*	Continuum
Indicators >= N.C. Avg Benchmarks	15	22	20	14	14	13
Indicators < N.C. Avg Benchmarks	9	5	7	13	13	14
Indicators Not Available	3	0	0	0	0	0
Total Indicators Reviewed	24	27	27	27	27	27
Percent of Indicators >= N.C. Avg Benchmarks Available	62.5%	81.5%	74.1%	51.9%	51.9%	48.1%
Number of Completed Surveys	99	371	2,873	409	7,244	154

* Average of the provider agencies in North Carolina

Medicare "Home Health Compare"
Quality of Patient Care – Indicator Summary
***United States* Benchmarks**

	UniHealth	NHRMC	Advanced*	HKZ*	Gentiva*	Continuum
Indicators >= U.S. Avg Benchmarks	15	21	20	13	10	15
Indicators < U.S. Avg Benchmarks	9	6	7	14	17	12

[2] Medicare's Home Health Compare, found at www.medicare.gov has information about the quality of care provided by "Medicare-certified" home health agencies throughout the nation. The information on Home Health Compare helps individuals learn how well home health agencies care for their patients, shows how often each agency used best practices when caring for its patients and whether patients improved in certain important areas of care, and shows what other patients said about their recent home health care experience.

Indicators Not Available	3	0	0	0	0	0
Total Indicators Reviewed	24	27	27	27	27	27
Percent of Indicators >= U.S. Avg Benchmarks Available	62.5%	77.8%	74.1%	48.1%	37.0%	55.6%
Number of Completed Surveys	99	371	2,873	409	7,244	154

* Average of the provider agencies in North Carolina

Using either North Carolina or United States benchmarks, Gentiva rates *at or near the bottom* of the Medicare home health comparison criteria.

Home Health Criteria,
10A NCAC 14C .2002 Information Required of the Applicant

(a) An applicant shall identify:

(1) the counties that are proposed to be served by the new office;

Comment. Gentiva significantly "underserve" patients in New Hanover and Pender counties. Gentiva will actually serve the *fewest* patients of all *seven* applicants.

According to the 2013 State Medical Facilities Plan, these three counties will have a projected 2014 unmet need of 563.93 patients – 324.94 in Brunswick, 186.04 in New Hanover and 52.95 in Pender. However, Gentiva projects to serve 391 patients in Year 2 – 313 in Brunswick, 59 in New Hanover and 20 in Pender.

Inconsistencies between Gentiva Patient Projections
And 2013 State Medical Facilities Plan

County	2013 SMFP Unmet Need (2014)	Gentiva Projected Patients Served (Year 2)	Gentiva Projected Over/(Under) Served	Gentiva Pct Projected Over/(Under) Served
Brunswick	324.94	313	(12)	(3.7%)
New Hanover	186.04	59	(127)	(68.3%)
Pender	52.95	20	(33)	(62.3%)
	563.93	391	(173)	(30.5%)

All assumptions, including the specific methodology by which patient utilization and costs are projected, shall be stated.

Comment. Gentiva projects a first year *loss* of $193,076 and a second year profit of *only* $42,578. This projected second year profit barely achieves the financial breakeven point

and does very little to recoup prior losses. Gentiva does not provide for a financially sustainable project, especially if revenues are overstated (bad debt), expenses are understated, payor mix is less profitable, etc.

10A NCAC 14C .2003 Performance Standards

An applicant shall project, in the third year of operation, an annual unduplicated patient caseload for the county in which the facility will be located that meets or exceeds the minimum need used in the applicable State Medical Facilities Plan to justify the establishment of a new home health agency office in that county. An applicant shall not be required to meet this performance standard if the home health agency office need determination in the applicable State Medical Facilities Plan was not based on application of the standard methodology for a Medicare-certified home health agency office.

Comment. As explained above, Gentiva proposes to significantly "underserve" patients in New Hanover and Pender counties.

Conclusions

- When considered standing alone, the above comments raise questions concerning whether Gentiva's application conforms with Criteria 3, 4, 5, 18a, 20 and 10A NCAC 14C .2003.

- Gentiva's application:

  - Proposes to significantly "underserve" patients in New Hanover and Pender counties.
  - Proposes to serve the *fewest* patients of all *seven* applicants.
  - Does not propose to contract with major commercial insurers in North Carolina such as United Healthcare.
  - Projects a first year *loss* of $193,076 and a second year profit of *only* $42,578 that barely achieves the financial breakeven point and does very little to recoup prior losses.
  - Does not have the support of *any* accredited agencies in North Carolina.

7. Continuum Home Care of Brunswick County

Continuum proposes to serve two counties (Brunswick and New Hanover) but will do nothing to meet the projected unmet need in a third (Pender County). Continuum's proposed project, if approved, will significantly "overserve" patients in Brunswick County while significantly "underserving" patients in New Hanover County and failing to serve any patients at all in Pender County. Advanced Home Care presents a superior alternative to Continuum's proposed project.

Continuum's average net revenue per unduplicated patient is the *highest* among all applicants ($3,451.56, compared to $2,893.02 for Advanced) and is unreasonable.

Continuum has the *second lowest* projected second year charity care commitment as measured in total dollars among all *seven* CON applicants. Continuum's projected charity care commitment falls far short of the amounts projected by Advanced.

Continuum does not provide an accreditation agency listing to document the provision of quality patient care. Continuum does not provide dates on its policies to signify regular review and updates. These deficiencies are consistent with Continuum's performance in data from the Medicare "home health compare" web site (for applicants with available data), including average benchmarks for North Carolina and the United States. Using either North Carolina or United States benchmarks, Continuum rates *at or near the bottom* of the Medicare home health comparison criteria.

General Review Criteria,
G.S. 131E-183(a)

(1) Policies and need. The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.

Comment. Continuum proposes to serve two counties (Brunswick and New Hanover) but will do nothing to meet the projected unmet need in a third (Pender County).

According to the 2013 State Medical Facilities Plan, these three counties will have a projected 2014 unmet need of 563.93 patients – 324.94 in Brunswick, 186.04 in New Hanover and 52.95 in Pender. However, Continuum projects to serve 474 patients in Year 2 – 453 in Brunswick, 21 in New Hanover and 0 in Pender.

As indicated in the table below, Continuum's proposed project will significantly "overserve" patients in Brunswick County while significantly "underserving" patients in New Hanover County and failing to serve any patients at all in Pender County.

Inconsistencies between Continuum Patient Projections And 2013 State Medical Facilities Plan

County	2013 SMFP Unmet Need (2014)	Continuum Projected Patients Served (Year 2)	Continuum Projected Over/(Under) Served	Continuum Pct Projected Over/(Under) Served
Brunswick	324.94	453	+128	+39.4%
New Hanover	186.04	21	(165)	(88.7%)
	510.98	474	(37)	(7.2%)
Pender	52.95	0	(53)	(100.0%)

(3) Population to be served. The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

Comment. Although Continuum is proposing to serve New Hanover County, the number of patients projected is so low as to render this application irrelevant as an alternative for the unmet need projected for New Hanover County. Continuum also projects to serve no patients in Pender County and, therefore, does not project to meet the need identified in the 2013 SMFP for New Hanover and Pender Counties.

(4) Least costly or most effective alternative. Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.

Comment. As explained above, Continuum will not meet the unmet need identified in the 2013 SMFP for New Hanover or Pender Counties. Continuum's high average net revenue per unduplicated patient and low charity care do not present the least costly or most effective alternative for patients or the health care system. Continuum did not propose the least costly or most effective alternative available to it to propose.

(5) Availability of funds and reasonable projections of costs and charges. Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

Comment. Continuum's high average net revenue per unduplicated patient, which is the *highest* among all applicants at $3,451.56, appears to be unreasonable.

Year 2 Average Net Revenue Per Unduplicated Patient

UniHealth	NHRMC	Advanced	HKZ	Maxim	Gentiva	Continuum
$2,815.95	$2,684.35	$2,893.02	$2,741.77	$3,018.92	$1,352.27	$3,451.56

(6) Unnecessary duplication. The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.

Comment. Continuum projects to significantly "overserve" patients in Brunswick County which results in unnecessary duplication in Brunswick County. Continuum's high volume projections in Brunswick County compared to the need identified in the 2013 SMFP call into question whether it will be duplicating services already provide by existing home health agencies in order to achieve such volume projections.

(13) Medically underserved populations. The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:

a. The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically underserved;

b. Its past performance in meeting its obligation, if any, under any applicable regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal assistance, including the existence of any civil rights access complaints against the applicant;

c. That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services; and

d. That the applicant offers a range of means by which a person will have access to its services. Examples of a range of means are outpatient services, admission by house staff, and admission by personal physicians.

Comment. Continuum has low charity care, which is the *second lowest* projected second year charity care commitment as measured in total dollars among all *seven* CON applicants.

Year 2 Charity Care as Expressed in Dollars

UniHealth	NHRMC	Advanced	HKZ	Maxim	Gentiva	Continuum
$1,700	$12,174	$33,240	$4,711	$7,737	$14,671	$4,590

Continuum's projected charity care commitment is not likely to meet the needs of the population projected to be served.

(18a) Enhanced competition. The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

Comment. By projecting to serve so few patients in New Hanover County and ignoring the unmet need projected in adjacent Pender County, and making a low commitment to charity care, Continuum will not enhance access or competition throughout the area. By proposing such high net revenue Continuum's proposal will not have a positive impact upon the cost effectiveness of the services proposed. Continuum's low Medicare Compare ranking also suggests that its proposal will not have a positive impact on competition with regard to quality.

(20) Quality. An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.

Comment. Continuum does not provide an accreditation agency listing to document the provision of quality patient care.

Continuum does not provide dates on its policies to signify regular review and updates.

These deficiencies are consistent with Continuum's performance in data from the Medicare "home health compare" web site[3] (for applicants with available data), including average benchmarks for North Carolina and the United States. Please refer to **Attachment A** and **Attachment B**.

Medicare "Home Health Compare"
Quality of Patient Care – Indicator Summary
***North Carolina* Benchmarks**

	UniHealth	NHRMC	Advanced*	HKZ*	Gentiva*	Continuum
Indicators >= N.C. Avg Benchmarks	15	22	20	14	14	13
Indicators < N.C. Avg Benchmarks	9	5	7	13	13	14
Indicators Not Available	3	0	0	0	0	0
Total Indicators Reviewed	24	27	27	27	27	27
Percent of Indicators >= N.C. Avg Benchmarks Available	62.5%	81.5%	74.1%	51.9%	51.9%	48.1%
Number of Completed Surveys	99	371	2,873	409	7,244	154

* Average of the provider agencies in North Carolina

Medicare "Home Health Compare"
Quality of Patient Care – Indicator Summary
***United States* Benchmarks**

	UniHealth	NHRMC	Advanced*	HKZ*	Gentiva	Continuum
Indicators >= U.S. Avg Benchmarks	15	21	20	13	10	15
Indicators < U.S. Avg Benchmarks	9	6	7	14	17	12
Indicators Not	3	0	0	0	0	0

[3] Medicare's Home Health Compare, found at www.medicare.gov has information about the quality of care provided by "Medicare-certified" home health agencies throughout the nation. The information on Home Health Compare helps individuals learn how well home health agencies care for their patients, shows how often each agency used best practices when caring for its patients and whether patients improved in certain important areas of care, and shows what other patients said about their recent home health care experience.

Available						
Total Indicators Reviewed	24	27	27	27	27	27
Percent of Indicators >= U.S. Avg Benchmarks Available	62.5%	77.8%	74.1%	48.1%	37.0%	55.6%
Number of Completed Surveys	99	371	2,873	409	7,244	154

* Average of the provider agencies in North Carolina

Using either North Carolina or United States benchmarks, Continuum rates *at or near the bottom* of the Medicare home health comparison criteria.

Home Health Criteria,
10A NCAC 14C .2002 Information Required of the Applicant

(a) An applicant shall identify:

(1) the counties that are proposed to be served by the new office;

Comment. As explained above, Continuum proposes to serve two counties (Brunswick and New Hanover) but will do nothing to meet the projected unmet need in a third (Pender County).

10A NCAC 14C .2003 Performance Standards

An applicant shall project, in the third year of operation, an annual unduplicated patient caseload for the county in which the facility will be located that meets or exceeds the minimum need used in the applicable State Medical Facilities Plan to justify the establishment of a new home health agency office in that county. An applicant shall not be required to meet this performance standard if the home health agency office need determination in the applicable State Medical Facilities Plan was not based on application of the standard methodology for a Medicare-certified home health agency office.

Comment. As explained above, Continuum proposes to serve two counties (Brunswick and New Hanover) but will do nothing to meet the projected unmet need in a third (Pender County).

Conclusions

- When considered standing alone, the above comments raise questions concerning whether Continuum's application conforms with Criteria 3, 4, 5, 6, 13(c), 18a, 20 and 10A NCAC 14C .2003.
- Continuum's application:
  - Does nothing to meet the projected unmet need in Pender County
  - Projects low charity care

- Ranks *highest* for average net revenue per unduplicated patient at $3,451.56 appears to be unreasonable
- Ranks *second lowest* for projected second year charity care.
- Ranks *at or near the bottom* of the Medicare home health comparison criteria.

8. Comparative Analysis

Geographic Access

Maxim is the least effective since it proposes to serve only Brunswick County. NHRMC is also not effective since it proposes to serve the counties it already serves, two of which have a surplus—Bladen and Columbus Counties---and does not project to serve any patients in Pender County. Advanced is the most effective since it best projects to meet the need identified in Brunswick, New Hanover and Pender Counties and does not project to serve a county where a surplus exists.

Operating Costs

Year 2 Average Administrative Costs Per Visit

UniHealth	NHRMC	Advanced	HKZ	Maxim	Gentiva	Continuum
$34.09	$24.69	$37.99	$42.99	$52.58	$59.99	$32.35

Gentiva's and Maxim's average administrative costs per visit are the *first and second highest* among all applicants and significantly higher than the other applicants.

Year 2 Average Direct Operating Costs Per Visit

UniHealth	NHRMC	Advanced	HKZ	Maxim	Gentiva	Continuum
$87.73	$63.99	$79.44	$89.21	$86.26	$77.15	$98.19

NHRMC is the lowest and least effective in proposed direct operating costs. Continuum's significantly higher proposed direct operating costs raise questions about whether its projections are realistic and reasonable.

Year 2 Average Total Operating Costs Per Visit

UniHealth	NHRMC	Advanced	HKZ	Maxim	Gentiva	Continuum
$121.82	$88.68	$117.43	$132.20	$138.84	$137.14	$130.44

NHRMC's significantly lower projected total operating costs appear to be unreasonable especially since it projected not to add any new staff to serve substantial new patient volume. Advanced's projected total operating costs are *second lowest* and are realistic. Maxim's and Gentiva's high projected total operating costs appear to be unreasonable or at least not as effective.

Net Revenue

Year 2 Average Net Revenue Per Unduplicated Patient

UniHealth	NHRMC	Advanced	HKZ	Maxim	Gentiva	Continuum
$2,815.95	$2,684.35	$2,893.02	$2,741.77	$3,018.92	$1,352.27	$3,451.56

Continuum's average net revenue per unduplicated patient is the *highest* among all applicants and appears to be unreasonable or at least not as effective especially in light of its projected high direct operating costs.

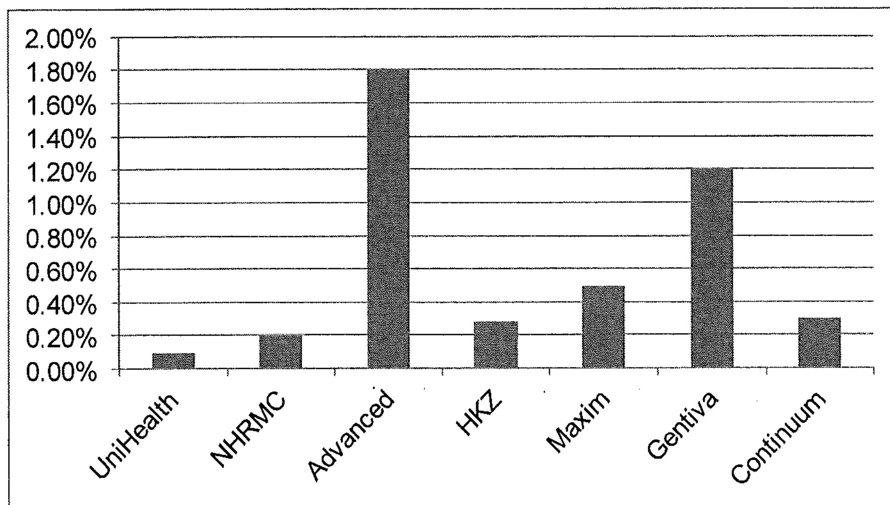
Year 2 Average Net Revenue Per Visit

UniHealth	NHRMC	Advanced	HKZ	Maxim	Gentiva	Continuum
$123.57	$154.84	$138.63	$145.93	$161.46	$142.67	$146.57

Maxim's average net revenue per visit is the *highest* among all applicants at $161.46 and appears to be unreasonable.

Charity Care

Year 2 Charity Care as a Percent of Gross Revenue



Advanced projects the highest and UniHealth projects the lowest charity care commitment.

Quality Care

Advanced Home Care analyzed a broad representation of performance data from the Medicare "home health compare" web site[4] for applicants with available data, including average benchmarks for North Carolina and the United States. Please refer to **Attachment A** and **Attachment B**.

[4] Medicare's Home Health Compare, found at www.medicare.gov has information about the quality of care provided by "Medicare-certified" home health agencies throughout the nation. The information on Home Health Compare helps individuals learn how well home health agencies care for their patients, shows how often each agency used best practices when caring for its patients and whether patients improved in certain important areas of care, and shows what other patients said about their recent home health care experience.

Medicare "Home Health Compare"
Quality of Patient Care – Indicator Summary
***North Carolina* Benchmarks**

	UniHealth	NHRMC	Advanced*	HKZ*	Gentiva*	Continuum
Indicators >= N.C. Avg Benchmarks	15	22	20	14	14	13
Indicators < N.C. Avg Benchmarks	9	5	7	13	13	14
Indicators Not Available	3	0	0	0	0	0
Total Indicators Reviewed	24	27	27	27	27	27
Percent of Indicators >= N.C. Avg Benchmarks Available	62.5%	81.5%	74.1%	51.9%	51.9%	48.1%
Number of Completed Surveys	99	371	2,873	409	7,244	154

* Average of the provider agencies in North Carolina

Medicare "Home Health Compare"
Quality of Patient Care – Indicator Summary
***United States* Benchmarks**

	UniHealth	NHRMC	Advanced*	HKZ*	Gentiva*	Continuum
Indicators >= U.S. Avg Benchmarks	15	21	20	13	10	15
Indicators < U.S. Avg Benchmarks	9	6	7	14	17	12
Indicators Not Available	3	0	0	0	0	0
Total Indicators Reviewed	24	27	27	27	27	27
Percent of Indicators >= U.S. Avg Benchmarks Available	62.5%	77.8%	74.1%	48.1%	37.0%	55.6%
Number of Completed Surveys	99	371	2,873	409	7,244	154

* Average of the provider agencies in North Carolina

Using either North Carolina or United States benchmarks, NHRMC and Advanced are the most effective overall and Continuum is the least effective in North Carolina and Gentiva is the least effective in the U.S. among the competing applicants. Advanced also accomplished higher Medicare Compare rankings while operating multiple locations compared to NHRMC, which has one existing agency.

UniHealth Home Health

- While Advanced Home Care focuses exclusively on home medical and equipment services (alternatives to inpatient care), other companies treat home health agency services as a sideline. According to UniHealth's parent company's web site, home health services are "supplemental" to its core post-acute, skilled nursing and assisted living inpatient service lines.
- UniHealth's proposed project will significantly "overserve" patients in Brunswick County while significantly "underserving" patients in New Hanover and Pender counties.
- UniHealth has disclosed *thirty* "civil rights equal access complaints" filed against it or its parent company, in just North Carolina, in the past five years. These civil rights and equal access complaints are not confined to just one or two locations, but appear to involve a *dozen* separate locations. This history raises concerns about UniHealth's ability to serve all residents of the area, to retain quality staff and to provide quality patient care.
- UniHealth projects a first year *loss* of $317,001 and a second year profit of *only* $20,301. This projected second year profit barely achieves the financial breakeven point and does very little to recoup prior losses. In fact, this projected second year profit is the *lowest* among all *seven* CON applicants. UniHealth does not provide for a financially sustainable project, especially if revenues are overstated, expenses are understated, payor mix is less profitable, etc.
- UniHealth barely achieves the financial breakeven point in its second year and has very few resources to serve medically underserved populations. In fact, UniHealth has the *lowest* projected second year charity care (by dollars or a percentage of gross revenue) among all *seven* CON applicants.
- UniHealth does not make up for this charity care commitment shortfall by serving substantially more Medicare or Medicaid patients. In fact, UniHealth's Medicare and Medicaid patient mix is within two or three percentage points of Advanced Home Care yet Advanced Home Care has (and has the ability) to make a much greater commitment to charity care.

NHRMC Home Care

- NHRMC Home Care proposes to serve three counties (Bladen, Brunswick and Columbus) with its proposed project. However, NHRMC *already* serves these three counties with its existing home health agency in Pender County.

- Furthermore, the 2013 State Medical Facilities Plan projects a *surplus* of patients in Bladen and Columbus counties. There is no need for additional home health services in two of the three counties proposed to be served by NHRMC.

- Approval of NHRMC's proposed "new" home health agency for the same geographic area it now serves would simply duplicate existing resources. As such, NHRMC's proposed project is neither the least costly nor most effective alternative to meet the needs identified in the 2013 State Medical Facilities Plan. NHRMC's proposed project will limit, rather than enhance, competition.

- NHRMC's projected $1.5 million profit in its second year of operation is unreasonable. This projected profit amounts to 43% of projected net revenue and *far* exceeds the 4% - 7% national averages. In fact, no other applicant even comes close to this level of profitability.

HealthKeeperz of Brunswick

- As a matter of procedure, this CON application was accompanied by a Letter of Intent *date-stamped* April 15, 2013 but *dated* July 16, 2012 and otherwise referencing an *entirely different project* – Mecklenburg County home health agency, August 1, 2012.

- HKZ's proposed project will significantly "overserve" patients in Brunswick County while significantly "underserving" patients in New Hanover County and failing to serve any patients at all in Pender County.

- HKZ's proposal to use contract staffing in *every* service discipline raises serious concerns about staff stability, retention, consistency of patient care, care coordination and quality of patient care and does not comply with federal Medicare regulations and guidelines – Medicare Conditions of Participation for Home Health, Section 484.14(a) Standard: Services Furnished, Interpretive Guideline G127.

- HKZ does not propose infusion services. HKZ also lacks certified infusion nurses (CRNI) and wound, ostomy and continence nurses (WOCN). HKZ lacks services for ventilator patients and pediatric patients.

- Using either North Carolina or United States benchmarks, HKZ rates *at or near the bottom* of the Medicare home health comparison criteria.

Maxim Healthcare Services

- Maxim will need to focus resources on compliance with its Corporate Integrity Agreement and Deferred Prosecution Agreement rather than developing and integrating a new agency. Please refer to **Attachment C**.

- Maxim proposes to serve just a *single* county (Brunswick), and is the *only* one of seven applicants proposing to serve just a single county. Maxim's proposed project will significantly "overserve" patients in Brunswick County while *failing* to serve *any* patients at all in New Hanover and Pender counties.

- By projecting to serve only Brunswick County itself and ignoring the unmet need projected in adjacent New Hanover and Pender counties, Maxim is among the *least* effective alternatives proposing to serve the area.
- Maxim's projected first year loss of $470,755 is the *largest* among all seven applicants. Maxim's average net revenue per visit is the *highest* among all applicants and is unreasonable.
- Maxim's average administrative costs per visit are the *second highest* among all applicants and the *highest* for total operating costs.

Gentiva Health Services

- Gentiva will significantly "underserve" patients in New Hanover and Pender counties.
- Gentiva will actually serve the *fewest* patients of all *seven* applicants. .
- Gentiva does not contract with major commercial insurers in North Carolina such as United Healthcare. Thus, it will exclude major payor segments of the population to be served.
- Gentiva projects a first year *loss* of $193,076 and a second year profit of *only* $42,578. This projected second year profit barely achieves the financial breakeven point and does very little to recoup prior losses. UniHealth does not provide for a financially sustainable project
- Gentiva does not have *any* accredited agencies in North Carolina. Using either North Carolina or United States benchmarks, Gentiva rates *at or near the bottom* of the Medicare home health comparison criteria.

Continuum Home Care of Brunswick County

- Continuum's projects to significantly "overserve" patients in Brunswick County while significantly "underserving" patients in New Hanover County and failing to serve any patients at all in Pender County.
- Continuum's average net revenue per unduplicated patient is the *highest* among all applicants and is unreasonable.
- Continuum has the *second lowest* projected second year charity care commitment as measured in total dollars among all *seven* CON applicants.
- Continuum does not provide an accreditation agency listing to document the provision of quality patient care. Continuum does not provide dates on its policies to signify regular review and updates.
- Using either North Carolina or United States benchmarks, Continuum rates *at or near the bottom* of the Medicare home health comparison criteria.

For reasons set forth below, Advanced Home Care's project is comparatively superior and can *best* meet the needs of the population identified in the 2013 SMFP as needing services.

Advanced Home Care

- Advanced proposes to serve three contiguous counties (Brunswick, New Hanover and Pender) with projected unmet need, consistent with the 2013 SMFP.
- Advanced presents reasonable volume forecasts, based on historical experience that are consistent with the projected unmet need in these counties.
- Advanced provides a full range of home health agency services and employed staff that will be complementary to Advanced Home Care's existing home medical equipment and infusion services in New Hanover County.
- Advanced maintains reasonable costs and charges to continue to provide access to a wide variety of payor groups, including Medicare and Medicaid patients.
- Advanced commits to provide the greatest amount of charity care, consistent with historical experience.
- Advanced has a history of offering quality patient care, using either North Carolina or United States benchmarks, that rates Advanced *at or near the top* of the Medicare home health comparison criteria.

Attachment A

Medicare Home Health Compare – North Carolina Benchmarks

January-December 2012

Provider Name	North Carolina Average	Advanced Home Care*	Gentiva*	Unihealth Home Inc	NHRMC Home Care	Health Keeperz*	Continuum Home Care and Hospice
Offers Nursing Care Services		✓	✓	✓	✓	✓	✓
Offers Physical Therapy Services		✓	✓	✓	✓	✓	✓
Offers Occupational Therapy Services		✓	✓	✓	✓	✓	X
Offers Speech Pathology Services		✓	✓	✓	✓	✓	✓
Offers Medical Social Services		✓	✓	✓	✓	✓	✓
Offers Home Health Aide Services		✓	✓	✓	✓	✓	✓
How often the home health team began their patients' care in a timely manner	91	96	89	99	95	75	97
How often the home health team taught patients (or their family caregivers) about their drugs	89	94	81	95	99	92	91
How often the home health team checked patients' risk of falling	91	97	89	100	92	98	79

January-December 2012

Provider Name	North Carolina Average	Advanced Home Care*	Gentiva*	Unihealth Home Inc	NHRMC Home Care	Health Keeperz*	Continuum Home Care and Hospice
How often the home health team checked patients for depression	97	98	97	98	100	97	91
How often the home health team determined whether patients received a flu shot for the current flu season	71	76	66	78	78	58	76
How often the home health team determined whether their patients received a pneumococcal vaccine (pneumonia shot)	70	75	62	86	80	64	80
With diabetes, how often the home health team got doctor's orders, gave foot care, and taught patients about foot care	92	93	89	62	99	97	75
How often the home health team checked patients for pain	98	99	98	100	100	99	99

January-December 2012

Provider Name	North Carolina Average	Advanced Home Care*	Gentiva*	Unihealth Home Inc	NHRMC Home Care	Health Keeperz*	Continuum Home Care and Hospice
How often the home health team treated their patients' pain	97	98	97	97	100	98	95
How often the home health team treated heart failure (weakening of the heart) patients' symptoms	97	98	95		99	95	100
How often the home health team took doctor-ordered action to prevent pressure sores (bed sores)	94	94	93		96	95	75
How often the home health team included treatments to prevent pressure sores (bed sores) in the plan of care	95	98	96	94	100	97	83
How often the home health team checked patients for the risk of developing pressure sores (bed sores)	99	99	99	99	100	99	96
How often patients got better at walking or moving around	58	57	59	68	56	51	59

January-December 2012

Provider Name	North Carolina Average	Advanced Home Care*	Gentiva*	Unihealth Home Inc	NHRMC Home Care	Health Keeperz*	Continuum Home Care and Hospice
How often patients got better at getting in and out of bed	56	55	52	65	52	49	49
How often patients got better at bathing	62	60	61	57	65	57	60
How often patients had less pain when moving around	65	62	66	50	69	69	71
How often patients' breathing improved	66	64	68	70	66	68	65

January-December 2012

Provider Name	North Carolina Average	Advanced Home Care*	Gentiva*	Unihealth Home Inc	NHRMC Home Care	Health Keeperz*	Continuum Home Care and Hospice
How often patients' wounds improved or healed after an operation	88	88	85		89	92	93
How often patients got better at taking their drugs correctly by mouth	46	42	48	36	42	46	40
How often patients receiving home health care needed urgent, unplanned care in the ER without being admitted	12	11	13	16	12	10	10
How often home health patients had to be admitted to the hospital	17	17	17	13	16	19	20
HH CAHPS							

January-December 2012

Provider Name	North Carolina Average	Advanced Home Care*	Gentiva*	Unihealth Home Inc	NHRMC Home Care	Health Keeperz*	Continuum Home Care and Hospice
Percent of patients who reported that their home health team gave care in a professional way	90	90	90	91	90	86	89
Percent of patients who reported that their home health team communicated well with them	87	88	88	82	88	83	89
Percent of patients who reported that their home health team discussed medicines, pain, and home safety with them	84	82	86	83	84	81	89
Percent of patients who gave their home health agency a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	87	87	88	88	85	79	87
Percent of patients who reported YES, they would definitely recommend the home health agency to friends and family	82	82	81	76	81	74	80

January-December 2012

Provider Name	North Carolina Average	Advanced Home Care*	Gentiva*	Unihealth Home Inc	NHRMC Home Care	Health Keeperz*	Continuum Home Care and Hospice
Number of completed Surveys		2873	7244	99	371	409	154

* indicates that the numbers shown are an average of the provider agencies in NC.

	Met or exceeds NC Average
	Below NC Average

Attachment B

Medicare Home Health Compare – United States Benchmarks

January-December 2012

Provider Name	National Average	Advanced Home Care*	Gentiva*	Unihealth Home Inc	NHRMC Home Care	HealthKeeperz*	Continuum Home Care and Hospice
Offers Nursing Care Services		✓	✓	✓	✓	✓	✓
Offers Physical Therapy Services		✓	✓	✓	✓	✓	✓
Offers Occupational Therapy Services		✓	✓	✓	✓	✓	X
Offers Speech Pathology Services		✓	✓	✓	✓	✓	✓
Offers Medical Social Services		✓	✓	✓	✓	✓	✓
Offers Home Health Aide Services		✓	✓	✓	✓	✓	✓
How often the home health team began their patients' care in a timely manner	92	96	89	99	95	75	97
How often the home health team taught patients (or their family caregivers) about their drugs	92	94	81	95	99	92	91
How often the home health team checked patients' risk of falling	94	97	89	100	92	98	79
How often the home health team checked patients for depression	97	98	97	98	100	97	91
How often the home health team determined whether patients received a flu shot for the current flu season	69	76	66	78	78	58	76
How often the home health team determined whether their patients received a pneumococcal vaccine (pneumonia shot)	68	75	62	86	80	64	80

January-December 2012

Provider Name	National Average	Advanced Home Care*	Gentiva*	Unihealth Home Inc	NHRMC Home Care	HealthKeeperz*	Continuum Home Care and Hospice
With diabetes, how often the home health team got doctor's orders, gave foot care, and taught patients about foot care	93	93	89	62	99	97	75
How often the home health team checked patients for pain	99	99	98	100	100	99	99
How often the home health team treated their patients' pain	98	98	97	97	100	98	95
How often the home health team treated heart failure (weakening of the heart) patients' symptoms	98	98	95		99	95	100
How often the home health team took doctor-ordered action to prevent pressure sores (bed sores)	95	94	93		96	95	75
How often the home health team included treatments to prevent pressure sores (bed sores) in the plan of care	96	98	96	94	100	97	83
How often the home health team checked patients for the risk of developing pressure sores (bed sores)	98	99	99	99	100	99	96
How often patients got better at walking or moving around	59	57	59	68	56	51	59

January-December 2012

Provider Name	National Average	Advanced Home Care*	Gentiva*	Unihealth Home Inc	NHRMC Home Care	HealthKeeperz*	Continuum Home Care and Hospice
How often patients got better at getting in and out of bed	55	55	52	65	52	49	49
How often patients got better at bathing	66	60	61	57	65	57	60
How often patients had less pain when moving around	67	62	66	50	69	69	71
How often patients' breathing improved	64	64	68	70	66	68	65
How often patients' wounds improved or healed after an operation	89	88	85		89	92	93
How often patients got better at taking their drugs correctly by mouth	49	42	48	36	42	46	40

January-December 2012

Provider Name	National Average	Advanced Home Care*	Gentiva*	Unihealth Home Inc	NHRMC Home Care	HealthKeeperz*	Continuum Home Care and Hospice
How often patients receiving home health care needed urgent, unplanned care in the ER without being admitted	11	11	13	16	12	10	10
How often home health patients had to be admitted to the hospital	17	17	17	13	16	19	20
HH CAHPS							
Percent of patients who reported that their home health team gave care in a professional way	88	90	90	91	90	86	89
Percent of patients who reported that their home health team communicated well with them	85	88	88	82	88	83	89
Percent of patients who reported that their home health team discussed medicines, pain, and home safety with them	83	82	86	83	84	81	89
Percent of patients who gave their home health agency a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	84	87	88	88	85	79	87

January-December 2012

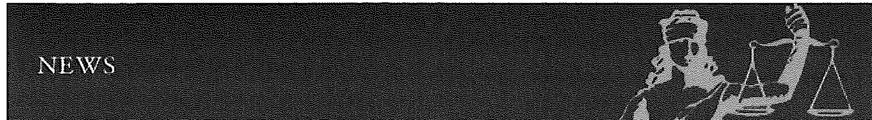
Provider Name	National Average	Advanced Home Care*	Gentiva*	Unihealth Home Inc	NHRMC Home Care	HealthKeeperz*	Continuum Home Care and Hospice
Percent of patients who reported YES, they would definitely recommend the home health agency to friends and family	79	82	81	76	81	74	80
Number of completed Surveys		2873	7244	99	371	409	154

* indicates that the numbers shown are an average of the provider agencies in NC.

(light shading)	Met or exceeds NC Average
(dark shading)	Below NC Average

Attachment C

US Attorney's Office Press Release – Maxim CIA and DPA



Maxim Healthcare Services Charged With Fraud, Agrees To Pay Approximately $150 Million, Enact Reforms After False Billings Revealed As Common Practice

FOR IMMEDIATE RELEASE September 12, 2011

Nine, Including Senior Managers, Have Pleaded Guilty to Felony Charges for Related Conduct

NEWARK, N.J. – Maxim Healthcare Services, Inc. ("Maxim") – one of the nation's leading providers of home healthcare services – has entered into a settlement to resolve criminal and civil charges relating to a nationwide scheme to defraud Medicaid programs and the Veterans Affairs program of more than $61 million. J. Gilmore Childers, Acting New Jersey U.S. Attorney; Tony West, Assistant Attorney General of the Civil Division of the Department of Justice; Tom ODonnell, Special Agent in Charge of the Health and Human Services Office of Inspector General (HHS OIG) region covering New Jersey; Michael B. Ward, Special Agent in Charge of the FBI's Newark Field Office; and Jeffrey Hughes, Special Agent in Charge of the U.S. Department of Veterans Affairs, Office of the Inspector General (VA OIG), Northeast Field Office, announced the developments today.

Maxim was charged today in a criminal Complaint with conspiracy to commit health care fraud, and has entered into a Deferred Prosecution Agreement ("DPA") with the Department of Justice. The agreement will allow Maxim to avoid a health care fraud conviction on the charges if it complies with the DPA's requirements. As required by the DPA, which will expire in 24 months if the company meets all of its reform and compliance requirements, Maxim has agreed to pay a criminal penalty of $20 million and to pay approximately $130 million in civil settlements in the matter, including to settle federal False Claims Act claims.

To date, nine individuals – eight former Maxim employees, including three senior managers, and the parent of a former Maxim patient – have pleaded guilty to felony charges arising out of the submission of fraudulent billings to government health care programs, the creation of fraudulent documentation associated with government program billings, or false statements to government health care program officials regarding Maxim's activities.

The criminal Complaint accuses Maxim – a privately-held company based in Columbia, Md., with hundreds of offices throughout the United States – of submitting more than $61 million in fraudulent billings to government health care programs for services not rendered or otherwise not reimbursable. The investigation revealed that the submission of false bills to government health care programs was a common practice at Maxim from 2003 through 2009. During that time period, Maxim received more than $2 billion in reimbursements from government health care programs in 43 states based on billings submitted by Maxim.

"Maxim, including senior executives, defrauded a system providing needed services to turn money meant for patient care into corporate profits," said Acting U.S. Attorney Childers. "We will continue to prove our commitment to investigating and prosecuting both companies and individuals whose misconduct robs our nation's health care programs and those who count on them. It is our hope that Maxim, in cleaning up its own house, will be a lighthouse influencing best practices across the industry."

"Fraudulent billing for services not rendered uses patients as pawns in a game of corporate greed that puts cash over care and wastes precious taxpayer dollars," said Tony West, Assistant Attorney General for the Civil Division of the Department of Justice. "At a time when we're all looking for ways to reduce public expenditures, settlements like this one recapture taxpayer dollars lost to fraud and abuse, and help ensure that funds are available for the vital health care programs and services that people depend on day in and day out."

UNITED STATES ATTORNEYS' OFFICES
HOMEPAGE

UNITED STATES ATTORNEYS' OFFICES
BRIEFING ROOM

FEMA
Federal Emergency Management Agency (FEMA) announced that federal disaster aid has been made available to the State of New Jersey.

FEMA is now accepting applications from residents and business owners who sustained losses in Atlantic County, Cape May County, Essex County, Hudson County, Middlesex County, Monmouth County, Ocean County and Union County.

Register online at Www.disasterassistance.gov , by web-enabled mobile device atm.fema.gov or by calling 1-800-621-FEMA (3362) or 1-800-462-7585 (TTY) for the hearing and speech impaired. The toll-free telephone numbers will operate from 7 a.m. to 10 p.m. EDT seven days a week until further notice.

Community Outreach

Giving Back to the Community through a variety of venues & initatives.

LAW ENFORCEMENT COORDINATING COMMITTEE

Training and seminars for Federal, State, and Local Law Enforcement Agencies.

Civil Rights Enforcement

"Companies scheming to profit by deceiving patients and defrauding taxpayer-funded government health care programs can expect close scrutiny and aggressive investigation," said HHS OIG Special Agent in Charge ODonnell. "We will continue to carefully guard the nation's vital health programs against those who put greed over patient care."

"Health care fraud is a considerable problem in New Jersey with residents being victimized by an estimated $7.5 billion in care-related frauds in 2010," said FBI Special Agent in Charge Ward. "The criminal conduct by Maxim in this instance was significant and systemic, which resulted in both the company and individuals being liable for their actions. The Newark Division of the FBI is committed to its stance of being among the most aggressive offices in pursuit and ultimate prosecution of Health Care Fraud offenders."

"Today's announcement demonstrates the Department of Veterans Affairs Office of Inspector General's commitment to focus investigative resources on companies that choose to pursue profit over the public's health," said VA OIG Special Agent in Charge Hughes. "VA OIG applauds the hard work of the Department of Justice and our law enforcement counterparts in bringing about this successful conclusion by aggressively pursuing and prosecuting those who committed fraud against our nation's federal healthcare programs, including VA's."

As part of the DPA, Maxim has stipulated to a Statement of Facts which mirrors the language of the criminal Complaint. In the event that Maxim fails to comply with the provisions of the DPA, Maxim has agreed that the U.S. Attorney's Office may proceed with its prosecution of Maxim and use the agreed-upon Statement of Facts against it in the prosecution.

As detailed in the criminal Complaint, Maxim, through its former officers and employees, falsely and fraudulently submitted billings to government health care programs for services not rendered or otherwise not reimbursable by government health care programs from 2003 through 2009. In order to conceal the fraud, Maxim's former officers and employees engaged in various conduct during that time period, including creating or modifying time sheets to support billings to government health care programs for services not rendered. They also submitted billings through licensed offices for care actually supervised by offices which operated without licenses and whose existence was concealed from government health care program auditors and investigators. Additionally, they created or modified documentation relating to required administrative functions associated with billings submitted to government health care programs, including documentation reflecting required training and qualifications of caregivers.

The DPA obliges Maxim to continue cooperating in the government's ongoing federal and state criminal investigation of former Maxim executives and employees responsible for the alleged conduct at issue, and to develop and operate an effective corporate compliance and governance program that includes adequate internal controls to prevent the recurrence of any improper or illegal activities.

The DPA requires Maxim's acceptance and acknowledgment of full responsibility for the conduct that led to the government's investigation.

The settlement requires payment of approximately $130 million to Medicaid programs and the Veterans Affairs program to resolve False Claims Act liability for false home healthcare billings to Medicaid programs and the Veterans Administration under civil agreements relating to this matter. The settlement resolves allegations that Maxim billed for services that were not rendered, services that were not properly documented, and services performed by 13 unlicensed offices. Maxim has agreed to pay approximately $70 million to the federal government and approximately $60 million to 42 states – including more than $2.7 million to be paid to the state of New Jersey.

Also included in the settlement is Corporate Integrity Agreement with HHS OIG, which requires additional reforms and monitoring under HHS OIG supervision.

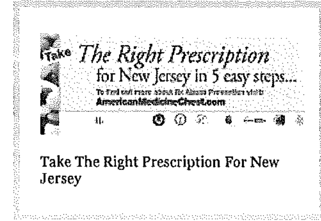
In addition, the company must also retain and pay an independent monitor, who will review Maxim's business operations and regularly report concerning the company's compliance with all federal and state health care laws, regulations, and programs. The monitor was selected by the U.S. Attorney's Office, consistent with U.S. Department of Justice guidelines, after a review of monitor candidates and in consultation with the company. Maxim will be monitored by Peter Keith of the law firm Gallagher, Evelius & Jones, which is headquartered in Baltimore, Md.

Prosecution of Individuals

According to documents filed in these cases and statements made in Trenton federal court:

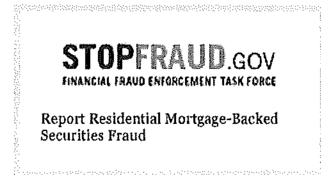
Gregory Munzel, 35, of Charleston, S.C., was employed as a regional account manager, reporting directly to a vice president, responsible for Maxim offices throughout the southeastern United States. He pleaded guilty on December 4, 2009, to one count of making false statements relating to health care fraud matters. During his plea hearing, Munzel admitted that he was aware individuals he supervised were submitting time cards for work that had not actually been done – a practice Munzel said was in response to pressure from Maxim superiors to increase revenue. Munzel also acknowledged forging caregiver credentials such as CPR cards throughout his time at Maxim, in order to make it appear that the caregivers were properly credentialed, when they were not. Munzel indicated he learned the practice from his supervisors when he first joined Maxim, and that those under him engaged in the practice when he took on a leadership role with the company. Munzel is currently scheduled to be sentenced September 29, 2011.

Bryan Lee Shipman, 38, of Athens, Ga., worked for Maxim for 13 years – the last eight as a regional account manager, reporting directly to a vice president. He pleaded guilty on June 17, 2010, to one count of



Take The Right Prescription For New Jersey

Report Health Care Fraud:
FBI Newark's Ad Campaign



Report Residential Mortgage-Backed Securities Fraud

health care fraud. During his plea hearing, Shipman acknowledged that Maxim's Gainesville, Ga., office operated without a license from 2008 through 2009, and that he and others directed billings from that office to be submitted as if they were from another, licensed office to be approved for reimbursement by the Medicaid program. At one point, when Maxim employees believed a state regulator would be visiting the office, lower-level employees were directed to provide false information to the state regulator in an effort to prevent the Medicaid program from learning about the unlicensed operation of the office. Shipman said his superiors demanded levels of growth based "not on any market analysis, but simply on a belief that dramatic growth was necessary regardless of market conditions." Shipman is currently scheduled to be sentenced November 16, 2011.

Matthew Skaggs, 39, was employed as a regional account manager, reporting directly to a vice president, responsible for Maxim's offices in Texas. He pleaded guilty on September 23, 2010, to making false statements relating to health care fraud matters. During his plea hearing, Skaggs acknowledged having knowingly made false statements to a surveyor from Texas' Medicaid Program, who was investigating the operation of an unlicensed Maxim office in Houston. Skaggs was sentenced on June 10, 2011, to a three-year term of probation and ordered to pay a $4,000 fine.

Andrew Sabbaghzadeh, 29, of Clay, N.Y., was employed as an account manager; and Jason Bouche, 27, of Paradise Valley, Ariz., was employed as a recruiter at Maxim's Tempe, Ariz. office. They pleaded guilty to health care fraud on November 4, 2009, and April 23, 2010, respectively. During their plea hearings, Sabbaghzadeh and Bouche acknowledged creating fraudulent time cards in order to bill government programs. They acknowledged that in some instances, Maxim employees cut signatures from legitimate time cards and pasted them onto forged time cards in order to submit them for reimbursement. Sabbaghzadeh is currently scheduled to be sentenced on September 26, 2011; Bouche is currently scheduled to be sentenced on November 17, 2011.

Donna Ocansey, 49, of Medford, N.J., was employed as a director of clinical services (supervising nurse) in Maxim's Cherry Hill, N.J., office. She pleaded guilty on May 28, 2010, to making false statements relating to health care fraud matters. Ocansey, a Registered Nurse, had responsibility for, among other things, ensuring that Medicaid-required supervisory visits of patients were conducted periodically – meaning that a Registered Nurse periodically visited each patient to check each patient's condition and the care the patient was receiving from Maxim Home Health Aides, who lack the skills and training of Registered Nurses. During her plea hearing, Ocansey acknowledged that she fabricated documentation in order to make it appear that other nurses had conducted Medicaid-mandated supervisory visits, when in fact they had not. Ocansey stated that she fabricated documentation in response to pressure from her superiors at Maxim, who expected her to make sure that all supervisory visits were completed without providing adequate resources for her to do so. Ocansey is currently scheduled to be sentenced September 20, 2011.

Mary Shelly Janvier-Pierre, 42, of Lake Worth, Fla., and Sandy Cave, 39, of West Palm Beach, Fla., pleaded guilty to health care fraud on February 1, 2010, and June 21, 2010, respectively. During their plea hearings, Janvier-Pierre, who had been employed by Maxim's West Palm Beach office as a Licensed Practical Nurse; and Cave, the mother of a former pediatric patient of Maxim, admitted to their roles in a scheme to fraudulently bill Medicaid, through Maxim, for services that were not rendered. Janvier-Pierre and Cave acknowledged that they agreed to submit billings as if Janvier-Pierre was taking care of Cave's child, when in reality she was not. Janvier-Pierre and Cave then split the money Janvier-Pierre received for purportedly providing the care. As a result of the scheme, Maxim was paid more than $70,000 by Florida's Medicaid program. Janvier-Pierre and Cave are scheduled to be sentenced on September 21, 2011, and October 24, 2011, respectively.

Marion Morton, 45, of North Charleston, S.C., was employed as a home health aide and personal care assistant by Maxim's Charleston, S.C., office. He pleaded guilty on May 3, 2010, to one count of making false statements relating to health care fraud matters. During his plea hearing, Morton acknowledged that, at the instruction of Maxim employees, he fabricated timecards reflecting work he had not done. On multiple occasions, Maxim submitted bills to Medicaid based on timecards which showed he worked more than 24 hours on certain days. Morton was sentenced on May 24, 2011, to a three-year term of probation and ordered to pay a $5,000 fine.

All of the defendants pleaded guilty before U.S. District Judge Anne E. Thompson in Trenton federal court.

The health care fraud charge to which Shipman, Sabbaghzadeh, Bouche, Janvier-Pierre, and Cave pleaded guilty carries a maximum penalty of 10 years in prison and a maximum fine of $250,000, or twice the amount of loss caused by their offenses. The false statements relating to health care fraud matters charge to which defendants Munzel, Skaggs, Ocansey, and Morton pleaded guilty carries a maximum penalty of five years in prison and a maximum fine of $250,000, or twice the amount of loss caused by their offenses.

Maxim's Remedial Actions

The government's willingness to enter into a DPA with Maxim is due, in significant part, to the company's cooperation and the reforms and remedial actions the Company has taken – beginning particularly in May 2009 – including significant personnel changes: terminating senior executives and other employees the Company identified as responsible for the misconduct; establishing and filling of positions of Chief Executive Officer, Chief Compliance Officer, Chief Operations Officer/Chief Clinical Officer, Chief Quality Officer/Chief Medical Officer, Chief Culture Officer, Chief Financial and Strategy Officer, and Vice President of Human Resources; and hiring a new General Counsel.

The company has identified and disclosed to law enforcement the misconduct of former Maxim employees, including providing information which has been critical in obtaining the convictions of some of the

individuals who have pleaded guilty to date. The company has also significantly increased the resources allocated to its compliance program.

* * *

The settlement arises from a lawsuit filed under the False Claims Act. Under the qui tam, or whistleblower, provisions of the Act, private citizens may file actions on behalf of the United States and share in any recovery. The whistleblower will receive approximately $15.4 million as his share of the recoveries from the federal government and the states.

Acting U.S. Attorney Childers noted that the criminal Complaint, DPA, civil settlement agreement, and guilty pleas are the culmination of a multi-year investigation conducted jointly by special agents and investigators from HHS/OIG, under the direction of Special Agent in Charge ODonnell; FBI, under the direction of Special Agent in Charge Ward; and VA OIG, under the direction of Special Agent in Charge Hughes. He also thanked the National Association of Medicaid Fraud Control Units (NAMFCU), with assistance from the Medicaid Fraud Control Units of the New Jersey, Virginia, and Massachusetts Attorney General's Offices, for their help in coordinating the settlements with the various states.

The government is represented in the prosecution of the criminal case by Assistant U.S. Attorney Jacob T. Elberg of the U.S. Attorney's Office Health Care and Government Fraud Unit in Newark; and in the civil agreement by Assistant U.S. Attorney Alex Kriegsman of the Office's Civil Division and Sara McLean of the Department of Justice's Commercial Litigation Branch, Frauds Section.

11-356

Defense counsel:

Maxim: Laura Laemmle-Weidenfeld Esq.; Robert Luskin, Esq., Washington
Gregory Munzel: John Lacey Esq., Roseland, N.J.
Bryan Lee Shipman: Peter Bennett Esq., Middletown, N.J.
Matthew Skaggs: David Sellinger Esq., Florham Park, N.J.
Andrew Sabbaghzadeh: James Hopkins Esq., Syracuse, N.Y.
Jason Bouche: Chester Keller Esq., Assistant Federal Public Defender, Newark
Donna Ocansey: Jeffrey Carney Esq., Hackensack, N.J.
Mary Shelly Janvier Pierre: Michael Salnick Esq., West Palm Beach, Fla.
Sandy Cave: Chester Keller Esq., Assistant Federal Public Defender, Newark
Marion Morton: John Renner Esq., Marlton, N.J.

Maxim Criminal Complaint
Maxim Deferred Prosecution Agreement
Maxim Corporate Integrity Agreement
Maxim Civil Settlement Agreement

Return To Top