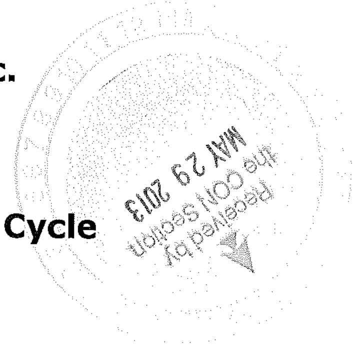
Comments in Opposition from
HKZ Group, LLC
Regarding a Certificate of Need Application
Submitted by Maxim Healthcare Services, Inc.
in Response to a Need Determination for
One Home Health Agency in the
Brunswick County Service Area
Submitted April 15, 2013 for May 1, 2013 Review Cycle



I. Introduction

In accordance with N.C.G.S. Section 131E-185(a1)(1), HKZ Group, LLC submits the following comments regarding a Certificate of Need Application submitted by Maxim Healthcare Services, Inc. (Maxim) in response to a need determination for one Home Health Agency in the Brunswick County Service Area for the May 1, 2013 review cycle.

The following seven CON applications were submitted in response to a need determination for one home health agency in the Brunswick County Service Area in the *2013 State Medical Facilities Plan* (*2013 SMFP*):

- O-10113-13: United Home Care, Inc. d/b/a UniHealth Home Health, Inc. d/b/a UniHealth Home Health and Brunswick County Healthcare Properties, Inc.
- O-10117-13: NHRMC Home Care
- O-10118-13: Advanced Home Care, Inc. d/b/a Advanced Home Care
- O-10119-13: HKZ Group, LLC
- O-10120-13: Maxim Healthcare Services, Inc.
- O-10121-13: Tar Heel Health Services, LLC d/b/a Gentiva Health Services
- O-10122-13: Continuum II Home Care and Hospice, Inc. d/b/a Continuum Home Care of Brunswick County.

II. Comparative Analysis

The Comparative Analysis in Attachment 1 shows that **HKZ** is the most effective alternative for a new Medicare-certified home health agency in Brunswick County.

III. Maxim Healthcare Services, Inc. CON Application

Maxim Healthcare Services, Inc. (Maxim) does not operate a Medicare-certified home health agency in Brunswick. It does, however, operate a licensed home care agency in New Hanover County that serves patients from Brunswick County. Maxim's licensed home care agency in New Hanover County provides hourly Medicaid services, hourly and intermittent managed care services, and private pay services. Maxim's licensed home care agency in Wilmington has provided care to 258 patients from Brunswick County; approximately 27% of patient census served by the Wilmington home care agency is comprised of Brunswick County patients.

Maxim proposes to lease existing medical office space in Shallotte for its proposed Medicare-certified home health agency in Brunswick County.

IV. CON Review Criteria

The following comments are submitted based upon the CON Review Criteria found at G.S.131E-183. While some issues impact multiple Criteria, they are discussed under the most relevant review Criteria and referenced in others to which they apply.

G.S. 131E-183 (1)

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.

There is one *State Medical Facilities Plan* (*SMFP*) Policy applicable to the review of Brunswick County Home Health Agencies:

- Policy GEN-3: Basic Principles.

As will be discussed in the context of CON Review Criteria (3), (4), (5), (6), (7), (8), (13c), and (18a), Maxim does not demonstrate:

- A need for the proposed project;
- That the proposed project will promote equitable access; and
- That the proposed project will maximize health care value for resources expended.

As a result, the Maxim CON Application does not conform to Policy GEN-3 and CON Review Criterion (1).

G.S. 131E-183 (3) and (13c)

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.

A. Ratio of Duplicated to Unduplicated Patients is Unreasonable

The following table shows a range of duplicated: unduplicated patient ratios used by the seven applicants.

Brunswick County Home Health Agency CON Applications
Ratio of Duplicated to Unduplicated Patients: PYs 1 & 2

Project ID	Applicant	PY 1	PY 2
O-10113-13	UniHealth	1.2	1.3
O-10117-13	NHRMC	4.2	4.5
O-10118-13	Advanced	1.0	1.0
O-10119-13	HKZ	2.7	2.7
O-10120-13	**Maxim**	**4.8**	**5.2**
O-10121-13	Gentiva	2.2	2.7
O-10122-13	Continuum	3.1	2.7

As shown in the previous table, Maxim's ratio of duplicated to unduplicated patients is the highest among the seven applicants.

Maxim proposes a service area consisting of Brunswick County only. Maxim's duplicated to unduplicated patient ratio exceeds the ratio reported by existing Brunswick County Medicare-certified home health agencies in FY 2012, as shown in the following table.

Brunswick County Existing Home Health Agencies
Ratio of Duplicated to Unduplicated Patients: FY 2012

Brunswick Average	Brunswick High	Brunswick Low
2.7	3.7	1.8

Source: 2013 Home Health Agency Annual Data Supplement to License Application
*Unduplicated patients as per Home Health Services Reporting Instructions on page 2 of the Annual Data Supplement
**Total Clients as per Home Health Staffing Table (Table E, page 7 of Annual Data Supplement)

Maxim chose to use a ratio in PY 1 that is **128%** (4.8/3.7) higher than the existing home health agencies in Brunswick County high in FY 2012, and **141%** (5.2/3.7) higher in PY 2 without any explanation. In the absence of an explanation offered in support of its ratio assumption, it is reasonable to assume that Maxim's duplicated: unduplicated patient ratio is unreasonable. Maxim's use of an unreasonable ratio results in overstated projected duplicated patients and visits.

B. Lowest Visits per Duplicated Patients

The following table shows a range of duplicated visits per duplicated patient ratios used by the seven applicants.

Brunswick County Home Health Agency CON Applications
Visits per Duplicated Patient: PYs 1 & 2

Project ID	Applicant	PY 1	PY 2
O-10113-13	UniHealth	15.7	17.0
O-10117-13	NHRMC	3.9	3.8
O-10118-13	Advanced	20.8	20.9
O-10119-13	HKZ	7.1	7.1
O-10120-13	**Maxim**	**3.6**	**3.6**
O-10121-13	Gentiva	9.0	7.3
O-10122-13	Continuum	8.8	8.8

As shown in the previous table, Maxim proposes the lowest visits per duplicated patient ratio of all applicants. As discussed in Section A., Maxim's ratio of duplicated to unduplicated patients is the highest of all applicants. Maxim must use an unreasonably low visit per duplicated patient ratio to offset its unreasonably high duplicated to unduplicated patient ratio. The net effect of those disparate assumptions is that Maxim's duplicated patients are overstated, while its patient visits are understated.

Maxim proposes single county service area of Brunswick County. Maxim's visits per duplicated patient ratio is lower than the lowest ratios reported by existing Brunswick County Medicare-certified home health agencies in FY 2012, as shown in the following table.

Brunswick County Existing Home Health Agencies
Ratio of Duplicated to Unduplicated Patients: FY 2012

Brunswick Average	Brunswick High	Brunswick Low
5.5	8.1	3.7

Source: 2013 Home Health Agency Annual Data Supplement to License Application, Home Health Staffing Table (Table E, page 7)

Maxim does not explain why it chose to use a ratio that differs from existing home health agencies in Brunswick County.

C. Unreasonable Ratios = Unreasonable Projections

As discussed in Sections A. and B., Maxim used (1) an unreasonably low duplicated to unduplicated patient ratio and (2) an unreasonably high visits to duplicated patient ratio. Those unreasonable ratios result in unreasonable projections for duplicated patients and duplicated patient visits.

1. Highest Projected Duplicated Patients

The following table shows a range of duplicated patients projected by the seven applicants.

Brunswick County Home Health Agency CON Applications
Duplicated to Unduplicated Patients: PYs 1 & 2

Rank	Applicant	PY 1	PY 2
1	NHRMC*	4,176	5,990
2	**Maxim**	**1,863**	**2,595**
3	HKZ	1,117	1,543
4	Continuum	392	1,264
5	Gentiva	515	1,059
6	UniHealth	254	679
7	Advanced	316	533

* As discussed in HKZ's Comments in Opposition, NHRMC erroneously relied on "Projected Utilization in 2014," instead of home health patient deficit, which resulted in NHRMC's overstating significantly the unduplicated and duplicated home health patients in each Project Year.

Maxim projected the second highest number of duplicated patients, as shown in the previous table. For comparison purposes, Maxim's projected duplicated patients in PY 2 are **168% higher** (2,595/1,543) than the duplicated patients proposed by **HKZ.** Maxim's projected duplicated patients in PY 2 are **487% higher** (2,595/533) than the lowest duplicated patients proposed by Advanced.

2. Second Lowest Projected Patient Visits

The following table shows a range of patient visits projected by the seven applicants.

Brunswick County Home Health Agency CON Applications
Patient Visits: PYs 1 & 2

Rank	Applicant	PY 1	PY 2
1	NHRMC*	16,115	23,022
2	UniHealth	3,982	11,576
3	Continuum	3,455	11,162
4	Advanced	6,577	11,123
5	HKZ	7,918	10,935
6	**Maxim**	**6,746**	**9,405**
7	Gentiva	4,638	7,706

* As discussed in HKZ's Comments in Opposition, NHRMC erroneously relied on "Projected Utilization in 2014," instead of home health patient deficit, which resulted in NHRMC's overstating significantly the unduplicated and duplicated home health patients in each Project Year.

Maxim projected the second lowest number of patient visits, as shown in the previous table. For comparison purposes, Maxim's projected patient visits in PY 2 are **123% lower** (11,576/9,405) than the second highest patient visits proposed by UniHealth. Maxim's projected patient visits in PY 2 are **116% lower** (10,935/9,405) than the patient visits proposed by **HKZ.**

3. Unreasonable Projections Infect Metrics of Comparison

Maxim's unreasonable duplicated patient and patient visit volume infects each of the following metrics of comparison discussed in the Comparative Analysis (Attachment 1):

- Projected Access by Medicare Recipients
- Projected Access of Medicaid Recipients
- Average Number of Visits per Unduplicated Patient
- Average Net Patient Revenue per Visit
- Average Net Patient Revenue per Unduplicated Patient
- Average Total Operating Cost per Visit
- Average Direct Care Operating Cost per Visit
- Average Administrative Operating Cost per Visit
- Ratio of Average Net Revenue per Visit to Average Total Operating Cost per Visit
- Average Direct Care Operating Cost per Visit as a Percentage of Average Total Operating Cost per Visit.

The entirety of Maxim's staffing and financial projections are rendered unreliable by the unreasonableness of its unduplicated patient volume, duplicated patient volume, and duplicated patient visits.

D. Projected Duplicated Medicare Recipients are Significantly Overstated

For each applicant in this review, the following table compares: (a) the total number of duplicated patients in PY 2; (b) the number of duplicated Medicare recipients in PY 2; and (c) duplicated Medicare recipients as a percentage of total duplicated patients. Generally, the application proposing the higher number of Medicare recipients is the more effective alternative with regard to this comparative factor. The applications are listed in the following table in decreasing order of effectiveness based on the number of Medicare recipients projected to be served.

Brunswick County Home Health Agency CON Applications
Projected Access by Medicare Recipients: PY 2

PY 2				
Rank	**Applicant**	**Total Number of Duplicated Patients**	**Number of Duplicated Medicare Recipients**	**Duplicated Medicare Recipients as a Percentage of Total Duplicated Patients**
1	**Maxim**	**2,595**	**1,848**	**71.20%**
2	HKZ	1,543	1,055	68.40%
3	Continuum	1,264	897	70.94%
4	Gentiva	1,059	728	68.70%
5	UniHealth	679	520	76.65%
6	Advanced	533	394	73.90%
7	NHRMC	5,990	unable to determine without percentage in VI.12.	no percentage included in VI.12.

Overstated duplicated patients result in Maxim's projecting the highest number of duplicated Medicare recipients, despite projecting a percentage of Medicare recipients (71.2%) slightly below the average (71.63%) of the applicants in PY 2, as shown in the previous table.

Maxim's CON Application cannot be considered the more effective alternative with regard to projected Medicare access because it relies on overstated projections.

For comparison purposes, Maxim's projected Medicare duplicated recipients in PY 2 are **175% higher** (1,848/1,055) than the Medicare duplicated recipients proposed by **HKZ.** Maxim's projected Medicare duplicated recipients in PY 2 are **204% higher** (1,848/907) than the average Medicare duplicated recipients proposed by the seven applicants (907).

E. Projected Duplicated Medicaid Recipients are Significantly Overstated

For each applicant in this review, the following table compares: (a) the total number of duplicated patients in PY 2; (b) the number of duplicated Medicaid recipients in PY 2; and (c) duplicated Medicaid recipients as a percentage of total duplicated patients. Generally, the application proposing the higher number of Medicaid recipients is the more effective alternative with regard to this comparative factor. The applications are listed in the following table in decreasing order of effectiveness based on the number of Medicaid patients projected to be served.

Brunswick County Home Health Agency CON Applications
Projected Access by Medicaid Recipients: PY 2

PY 2				
Rank	Applicant	Total Number of Duplicated Patients	Number of Duplicated Medicaid Recipients	Duplicated Medicaid Recipients as a Percentage of Total Duplicated Patients
1	**Maxim**	**2,595**	**452**	**17.40%**
2	HKZ	1,543	276	17.90%
3	Gentiva	1,059	270	25.50%
4	Continuum	1,264	229	18.09%
5	UniHealth	679	120	17.73%
6	Advanced	533	83	15.60%
7	NHRMC	5,990	unable to determine without percentage in VI.12.	no percentage included in VI.12.

Overstated duplicated patients also result in Maxim's projected the highest number of duplicated Medicaid recipients, despite having projected a percentage of Medicare recipients (17.4%) slightly below the average (18.7%) of the applicants in PY 2, as shown in the previous table. Maxim's CON Application cannot be considered the more effective alternative with regard to projected Medicaid access because it relies on overstated projections.

For comparison purposes, Maxim's projected Medicaid duplicated recipients in PY 2 are **163% higher** (452/276) than the Medicare duplicated recipients proposed by **HKZ.** Maxim's projected Medicaid duplicated patients in PY 2 are **190% higher** (452/238) than the average Medicaid duplicated recipients proposed by the seven applicants (238).

F. September 2011 Settlement Agreement to Resolve Criminal and Civil Charges related to a Nationwide Scheme to Defraud Medicaid and Veterans Affairs Program

In September 2011, Maxim, one of the nation's leading providers of home health care services, entered into a settlement agreement 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. Maxim was charged in a criminal complaint with conspiracy to commit health care fraud, and entered into a Deferred Prosecution Agreement (DPA) with the United States Department of Justice. The Agreement allows Maxim to avoid a health care fraud conviction on the charges if it complies with the DPA's requirements. Please see Attachment 2 for additional details.

As reflected in Attachment 2, Maxim billed to the Medicaid and Veterans Affairs program for services that were not delivered to Medicaid recipients and veterans, which resulted in limiting access to necessary Medicare-certified home health services by underserved patients. If Maxim relied on historical utilization and past experience as the basis for their projections the projections are overstated due to the problems associated with these charges.

G. In November 2011, Eight Former Maxim Employees, Including Three Senior Managers, Sentenced to Felony Charges arising out of the Submission of Fraudulent Bills to Government Health Care Programs

Eight former Maxim employees, including three senior managers plead guilty to and were sentenced on 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. Among the Maxim employees who have pleaded guilty is Gregory Munzel, who was regional account manager of Maxim's Charleston, South Carolina office from 2001 to 2005. At his plea hearing in December 2009, Mr. Munzel acknowledged fabricating documentation to make it appear that caregivers were properly credentialed when, in fact, they were not. Mr. Munzel said he did so in response to sales pressure from his superiors to generate more revenue. Mr. Munzel also said such falsifications were a common practice by employees in his office. Please see Attachment 3 for additional details.

As reflected in Attachment 3, in order to conceal the fraud, Maxim employees falsified time sheets and covertly submitted bills for services delivered by unlicensed offices, which resulted in limiting access to necessary Medicare-certified home health services to underserved patients. If Maxim relied on historical utilization and past experience as the basis for their projections the projections are overstated due to the problems associated with these charges.

For the reasons set forth above, the Maxim CON Application does not conform to CON Review Criteria (3) and (13c) and should be denied.

G.S. 131E-183 (4)

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.

The following table shows the project cost, working capital, and total capital expenditure proposed by each of seven applicants.

Brunswick County Home Health Agency CON Applications
Project Cost + Working Capital = Total Capital Expenditure

Project ID	Applicant	Project Cost	Working Capital	Grand Total
O-10113-13	UniHealth and Brunswick County Healthcare Properties	$318,967	$580,437	$899,404
O-10117-13	NHRMC	$80,190	$50,764	$130,954
O-10118-13	Advanced	$70,000	$3,000	$73,000
O-10119-13	HKZ	$62,400	$123,326	$185,726
O-10120-13	**Maxim**	**$90,000**	**$525,000**	**$615,000**
O-10121-13	Gentiva	$107,500	$497,884	$605,384

Maxim's project cost is **144% higher** ($90,000/$62,400) than the lowest project cost proposed by **HKZ.** Maxim's working capital is **175% higher** ($525,000/$3,000) than the lowest working capital proposed by Advanced.

For those reasons, Maxim fails to demonstrate that it is the least costly or most effective alternative proposed, which demonstrates non-conformity with CON Review Criteria (4).

G.S. 131E-183 (5)

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.

As discussed in the context of CON Review Criterion (3), Maxim's PY 2 projections are unreasonable due to its use of (1) an unreasonably low duplicated to unduplicated patient ratio and (2) an unreasonably high duplicated visits to duplicated patient ratio.

HKZ does not reasonably believe any of the Maxim's financial metrics can be used as a basis for comparison with the six other applicants.

For purposes of the analysis of financial projections and comparative financial metrics, **HKZ** presents metrics as they are presented in Maxim's CON Application.

A. Analysis of Financial Projections

Maxim's financial projections do not reflect true expenses necessary for the development of the proposed Brunswick County Medicare-certified home health agency, as shown in the following table.

Financial Projection/Cost	Page Reference	Comment
Amortization cost is $0 per year	Form B Page 124 (start-up costs)	• Amortization cost is understated • Had Maxim amortized the start-up cost ($50,000) for 10 years, the amortization cost would be $5,000 per year.
Data process cost is $0 per year for Software and computer cost	Form B	• Data processing costs are understated

The items set forth in the previous table demonstrate that Maxim's financial projections are incomplete and not based upon reasonable projections of the costs for providing Medicare-certified home health services.

B. Medicare Revenue is Overstated

In Section X., Question 7., subsection (b), each applicant is required to provide all assumptions and the methodology used to develop the projected Statement of Revenues and Expenses (Form B), including the following assumptions regarding Medicare reimbursement.

The following table summarizes Maxim's response to Section X., Question 7, subsection (b) on page 132 for PY 2, respectively, shown the component assumptions of its projected Medicare reimbursement.

Maxim
Total Medicare Reimbursement: PY 2

Assumptions regarding Medicare Reimbursement (page 132)	PY 2
Total Episode Payments	$1,132,506
Total LUPA Payments	$32,523
Total PEP Payments	$1,488
Total Outlier Payments	$8,632
Total Medicare Reimbursement	$1,175,149

Maxim's projected Medicare revenue for PY 2 in Form B is shown in the following table.

Maxim
Medicare Revenue: PY 2

Form B	PY 2
Medicare Revenue	$1,273,815

The previous two tables show a discrepancy in the total Medicare reimbursement (page 132) and Medicare revenue (Form B). Those projections should be the same because the assumptions regarding Medicare reimbursement are the basis for projecting Medicare revenue.

When the Medicare reimbursement (page 132) is compared to the Medicare revenue (Form B), there is a difference, as shown in the following table.

Maxim
Medicare Revenue (page 132 v Form B): PY 2

	PY 2
Form B: Medicare Revenue	$1,273,815
Page 132: Total Medicare Reimbursement	$1,175,149
Difference	**$98,666**

Medicare revenue (Form B) is greater than the total Medicare reimbursement (page 132), as shown in the previous table. That difference is an overstatement in the revenue projection of Maxim in PY 2.

C. Proposed Staffing does not Support Volume

The following table shows that Maxim has not projected sufficient staff to perform all of the visits projected in PY 1.

Maxim
Proposed Staffing for Projected Visits: PY 1

	Visits Per Day	Visits Per FTE	Yr 2 FTEs (Visits per day X Visits per FTE)	Total Possible Visits by Staff	Projected Visits	Projected Visits for which Staff is Insufficient	Percent Difference	Contract Staff per Visit	Understated Cost
RN	5	1,200	3.5	4200	3,836	364	Covered		
HHA	5.2	1,248	0.4	499.2	545	-45.8	-8.4%	$38.00	$1,740.40
PT	5	1,200	1.4	1,680	1,785	-105	-5.9%	$75.00	$7,875.00
OT	5	1,200	0.3	360	385	-25	-6.5%	$75.00	$1,875.00
ST	5	1,200	0.1	120	131	-11	-8.4%	$75.00	$825.00
MSW	3.5	840	0.1	84	64	20	Covered		
				6,943.2					$12,315.40

Source: CON Application O-10120-13, pages 76, 77, 109, 110, Tables IV.2, VII.2
Average Annual Days Worked per Year = (48 weeks x 5 days = 240 days) - 10 vacations, 5 holidays, 5 sick days

Total visits by staff are calculated when visits per day are multiplied by FTEs and that product is multiplied by 240 days. Total visits by staff should be greater than projected visits. As shown in

the previous table, Maxim's total visits by staff are lower than projected visits for home health aides, physical therapists, occupational therapists, and speech therapists in PY 1.

When there is a staff shortfall for projected visits, contract staff can provide needed coverage. On page 114, Maxim states clearly that "Maxim does not propose to contract for personnel to provide direct patient care services for its Brunswick County Medicare-certified home health agency."

The previous table shows that Maxim's staffing shortfall for projected visits in PY 1 results in an understatement of direct care costs of $12,315.30 had it proposed to use contract staff. Please note that the understated direct care costs in PY 1 would be higher had Maxim projected salaried staff sufficient to provide all projected visits.

The following table shows that Maxim has not projected sufficient staff to perform all of the visits projected in PY 2.

Maxim
Proposed Staffing for Projected Visits: PY 2

	Visits Per Day	Visits Per FTE	Yr 2 FTEs (Visits per day X Visits per FTE)	Total Visits by Staff	Projected Visits	Projected Visits for which Staff is Insufficient	Percent Difference	Contract Staff per Visit	Understated Cost
RN	5	1,200	4.6	5,520	5,348	172		Covered	
HHA	5.2	1,248	0.6	748.8	760	-11.2	-1.5%	$38.00	$425.60
PT	5	1,200	2	2,400	2,488	-88	-3.5%	$75.00	$6,600.00
OT	5	1,200	0.45	540	537	3		Covered	
ST	5	1,200	0.15	180	183	-3	-1.6%	$75.00	$225.00
MSW	3.5	840	0.1	84	89	-5	-5.6%	$38.00	$190.00
Total				**9,472.8**					$7,440.60

Source: CON Application O-10120-13, pages 76, 77, 109, 110, Tables IV.2, VII.2
Average Annual Days Worked per Year = (48 weeks x 5 days = 240 days) - 10 vacations, 5 holidays, 5 sick days

Total visits by staff are calculated when visits per day are multiplied by FTEs and that product is multiplied by 240 days. Total visits by staff should be greater than projected visits. As shown it the previous table, Maxim's total visits by staff are lower than projected visits for registered home health aides, physical therapists, speech therapists, and medical social workers in PY 2.

When there is a staff shortfall for projected visits, contract staff can provide needed coverage. On page 114, Maxim states clearly that "Maxim does not propose to contract for personnel to provide direct patient care services for its Brunswick County Medicare-certified home health agency."

The previous table shows that Maxim's staffing shortfall for projected visits in PY 2 results in an understatement of direct care costs of $7,440.60 had it proposed to use contract staff. Please note that the understated direct care costs in PY 2 would be higher had Maxim projected salaried staff sufficient to provide all projected visits.

E. Highest Average Net Revenue per Visit

Average net revenue per visit in PY 2 was calculated by dividing projected net revenue from Form B by the projected number of visits from Section IV., as shown in the following table. Generally, the application proposing the lowest average net revenue per visit is the more effective alternative with regard to this comparative factor. The applications are listed in the following table in decreasing order of effectiveness.

Brunswick County Home Health Agency CON Applications
Average Net Revenue per Visit: PY 2

PY 2				
Rank	Applicant	Total Number of Visits	Net Patient Revenue	Average Net Patient Revenue per Visit
1	UniHealth	11,756	$1,430,501	$122
2	Advanced	11,123	$1,541,982	$139
3	Gentiva	7,706	$1,099,399	$143
4	HKZ	10,935	$1,595,709	$146
5	Continuum	11,162	$1,636,041	$147
6	NHRMC	23,022	$3,564,820	$155
7	**Maxim**	**9,405**	**$1,518,518**	**$161**

As shown in the previous table, Maxim proposes the highest net revenue per visit of the seven applicants, which makes its CON Application the least effective alternative with regard to that comparative factor.

F. Second Highest Average Net Revenue per Unduplicated Patient

Average net revenue per unduplicated patient in PY 2was calculated by dividing projected net revenue from Form B by the projected number of unduplicated patients from Section IV., as shown in the following table. Generally, the application proposing the lowest average net revenue per unduplicated patient is the more effective alternative with regard to this comparative factor. The applications are listed in the following table in decreasing order of effectiveness.

Brunswick County Home Health Agency CON Applications
Average Net Revenue per Unduplicated Patient: PY 2

PY 2				
Rank	Applicant	Number of Unduplicated Patients	Net Patient Revenue	Average Net Patient Revenue per Unduplicated Patient
1	NHRMC	1,328	$3,564,820	$2,684
2	HKZ	582	$1,595,709	$2,742
3	Gentiva	391	$1,099,399	$2,812
4	UniHealth	508	$1,430,501	$2,816
5	Advanced	533	$1,541,982	$2,893
6	**Maxim**	**503**	**$1,518,518**	**$3,019**
7	Continuum	474	$1,636,041	$3,452

As shown in the previous table, Maxim proposes the second highest net revenue per unduplicated patient of the seven applicants, which makes its CON Application the second least effective alternative with regard to that comparative factor.

G. Highest Average Total Administrative Operating Cost per Visit

The average total operating cost per visit in PY 2 was calculated by dividing projected operating costs from Form B by the total number of visits from Section IV., as shown in the following table. Generally, the application proposing the lowest average total operating cost per visit is the more effective alternative with regard to this comparative factor. The applications are listed in the following table in decreasing order of effectiveness.

Brunswick County Home Health Agency CON Applications
Average Total Administrative Operating Cost per Visit: PY 2

PY 2				
Rank	Applicant	Total Number of Visits	Total Operating Cost	Average Total Operating Cost per Visit
1	NHRMC	23,022	$2,041,650	$89
2	Advanced	11,123	$1,306,201	$117
3	UniHealth	11,756	$1,410,200	$120
4	Continuum	11,162	$1,455,998	$130
5	HKZ	10,935	$1,445,606	$132
6	Gentiva	7,706	$1,057,821	$137
7	**Maxim**	**9,405**	**$1,305,747**	**$139**

As shown in the previous table, Maxim proposes the highest average total operating cost per visit of the seven applicants, which makes its CON Application the least effective alternative with regard to that comparative factor.

H. Second Highest Average Total Administrative Operating Cost per Visit

The average total operating cost per visit in PY 2 was calculated by dividing projected administrative expenses from Form B by the total number of visits from Section IV., as shown in the following table. Generally, the application proposing the lowest average administrative operating cost per visit is the more effective alternative with regard to this comparative factor. The applications are listed in the following table in decreasing order of effectiveness.

Brunswick County Home Health Agency CON Applications
Average Total Administrative Operating Cost per Visit: PY 2

PY 2				
Rank	**Applicant**	**Total Number of Visits**	**Total Administrative Operating Cost**	**Average Total Administrative Operating Cost per Visit**
1	NHRMC	23,022	$568,428	$25
2	Continuum	11,162	$360,009	$32
3	UniHealth	11,756	$394,629	$34
4	Advanced	11,123	$422,560	$38
5	HKZ	10,935	$470,098	$43
6	**Maxim**	**9,405**	**$494,488**	**$53**
7	Gentiva	7,706	$463,305	$60

As shown in the previous table, Maxim has the second highest average total administrative operating cost per visit, which makes its CON Application the second least effective alternative with regard to that comparative factor.

I. Third Highest Ratio of Net Revenue to Average Total Operating Cost per Visit

The ratios in the following table were calculated by dividing the average net revenue per visit in PY 2 by the average total operating cost per visit in PY 2. Generally, the application proposing the lowest ratio is the more effective alternative with regard to this comparative factor. The ratio must equal one or greater in order for a proposal to be financially feasible. The applications are listed in the following table in decreasing order of effectiveness.

Brunswick County Home Health Agency CON Applications
Ratio of Net Revenue to Average Total Operating Cost per Visit: PY 2

PY 2				
Rank	**Applicant**	**Average Net Revenue per Visit**	**Average Total Operating Cost per Visit**	**Ratio of Average Net Revenue to Average Total Operating Cost per Visit**
1	UniHealth	$122	$120	1.01
2	Gentiva	$143	$137	1.04
3	HKZ	$146	$132	1.10
4	Continuum	$147	$130	1.12
5	**Maxim**	**$161**	**$139**	**1.16**
6	Advanced	$139	$117	1.18
7	NHRMC	$155	$89	1.75
		Average of Applicants Ranked 2-6	$131	1.12

As shown in the previous table, Maxim projects the third highest ratio of all seven applicants. Its ratio of 1.16 is a result of its highest average net revenue per visit and highest average total operating cost per visit.

J. Second Lowest Operating Cost as a Percentage of Average Total Cost per Visit

The percentages in the following table were calculated by dividing the average direct care cost per visit in PY 2 by the average total operating cost per visit in PY 2. Generally, the application proposing the highest percentage is the more effective alternative with regard to this comparative factor. The applications are listed in the following table in decreasing order of effectiveness.

Brunswick County Home Health Agency CON Applications
Average Total Administrative Operating Cost per Visit: PY 2

		PY 2		
Rank	Applicant	Average Total Operating Cost per Visit	Average Direct Care Operating Cost per Visit	Operating Cost as a Percentage of Average Total Cost per Visit
1	Continuum	$130	$98	75%
2	UniHealth	$120	$86	72%
3	NHRMC	$89	$64	72%
4	Advanced	$117	$79	68%
5	HKZ	$132	$89	67%
6	**Maxim**	**$139**	**$86**	**62%**
7	Gentiva	$137	$77	56%

As shown in the previous table, Maxim has the second lowest operating cost as a percentage of average total cost per visit in PY 2, which makes its CON Application the second least effective alternative with regard to that comparative factor.

For the reasons set forth above, the Maxim CON Application does not conform to CON Review Criterion (5).

G.S. 131E-183 (6)

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

As discussed in the context of CON Review Criterion (3), Maxim fails to demonstrate the need for the services proposed. Consequently, Maxim did not demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.

G.S. 131E-183 (7)

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

Salary is a significant contributing factor in recruitment and retention of home health staff.

A. Fourth Lowest RN Annual Salary

The following table compares the projected annual salary for an RN of all seven applicants.

Brunswick County Home Health Agency CON Applications
RN Annual Salary: PY 2

CON Application	Applicant	RN Annual Salary
O-10113-13	UniHealth	$76,500
O-10117-13	NHRMC	$73,329
O-10119-13	HKZ	$70,627
O-10120-13	**Maxim**	**$69,215**
O-10118-13	Advanced	$67,600
O-10122-13	Continuum	$67,172
O-10121-13	Gentiva	$50,247

As shown in the previous table, Maxim's projected RN salary is substantially lower than the other applicants.

B. Fourth Lowest Home Health Aide Annual Salary

The following table compares the projected annual salary for a home health aide of all seven applicants.

Brunswick County Home Health Agency CON Applications
HHA Annual Salary: PY 2

CON Application	Applicant	RN Annual Salary
O-10113-13	UniHealth	$35,037
O-10122-13	Continuum	$31,552
O-10119-13	HKZ	$30,810
O-10120-13	**Maxim**	**$30,320**
O-10118-13	Advanced	$30,160
O-10117-13	NHRMC	$26,237
O-10121-13	Gentiva	$22,168

As shown in the previous table, Maxim's projected home health aide salary is substantially lower than the other applicants.

C. Lowest Speech Therapist Annual Salary

The following table compares the projected annual salary for a speech therapist of the applicants that include a speech therapist in its staffing plan.

Brunswick County Home Health Agency CON Applications
ST Annual Salary: PY 2

CON Application	Applicant	ST Annual Salary
O-10117-13	NHRMC	$76,160
O-10118-13	Advanced	$75,000
O-10120-13	**Maxim**	**$73,965**
O-10121-13	Gentiva	$75,370
O-10122-13	Continuum	$88,098

As shown in the previous table, Maxim's projected speech therapist salary is substantially lower than the salary projected by Continuum.

For those reasons, Maxim does not demonstrate conformity with CON Review Criterion (7).

G.S. 131E-183 (8)

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.

No Demonstration that the Proposed Service will be Coordinated with the Existing Health Care System.

Maxim does not include documentation of outreach to an acute care hospital in Brunswick County.

Generally, hospitals make 50% of all referrals to certified home health agencies. The CON Criteria and Standards for Home Health Agencies require documentation of attempts made to establish working relationships with the sources of referrals at 10A NCAC 14C .2002 (a)(10). Continuum does not provide the required documentation for Brunswick County hospitals.

There is no demonstrated coordination by Maxim with the existing health care system in Brunswick County. For that reason, Maxim fails to demonstrate conformity to CON Review Criterion (8).

G.S. 131E-183 (18a)

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.

As discussed above, Maxim fails to demonstrate conformity with CON Review Criteria (1), (3), (4), (5), (6), (7), (8), and (13c). Consequently, Maxim fails to demonstrate that its CON Application is conforming to CON Review Criterion (18a).

V. North Carolina Criteria and Standards for Home Health Services

For the reasons set forth above, Maxim does not demonstrate conformity with North Carolina Criteria and Standards for Home Health Services.

10A NCAC 14C .2002(a)(3), (4), (5), (7), and (10)

Projections are based on flawed and unreasonable assumptions. Please see discussion in the context of CON Review Criteria (3), (5), (7), and (8).

10A NCAC 14C .2003

Projections are based on flawed and unreasonable assumptions. Please see discussion in the context of CON Review Criteria (3), (5), and (7).

10A NCAC 14C .2005(a) and (b)

Projections are based on flawed and unreasonable assumptions. Please see discussion in the context of CON Review Criterion (7).

VI. Conclusion

The Maxim CON Application has not demonstrated conformity with multiple CON Review Criteria and should be denied.

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Pursuant to G.S. 131E-183(a)(1) and the *2013 SMFP*, no more than one new Medicare-certified home health agency or office may be approved for Brunswick County in the May 2013 review. Because each applicant proposes to develop a new Medicare-certified home health agency in Brunswick County, all seven applicants cannot be approved. Therefore, after considering all of the information in each application and reviewing each application individually against all applicable statutory and regulatory review criteria, a comparative analysis of the proposals has been conducted.

Projected Access by Medicare Recipients

For each applicant in this review, the following table compares: (a) the total number of duplicated patients in Project Year 2; (b) the number of duplicated Medicare recipients in Project Year 2; and (c) duplicated Medicare recipients as a percentage of total duplicated patients. Generally, the application proposing the higher number of Medicare recipients is the more effective alternative with regard to this comparative factor. The applications are listed in the following table in decreasing order of effectiveness based on the number of Medicare patients projected to be served.

Project Year 2				
Rank	Applicant	Total Number of Duplicated Patients	Number of Duplicated Medicare Recipients	Duplicated Medicare Recipients as a Percentage of Total Duplicated Patients
1	Maxim	2,595	1,848	71.20%
2	HKZ	1,543	1,055	68.40%
3	Continuum	1,264	897	70.94%
4	Gentiva	1,059	728	68.70%
5	UniHealth	679	520	76.65%
6	Advanced	533	394	73.90%
7	NHRMC	5,990	unable to determine without percentage in VI.12.	no percentage included in VI.12.

As shown in the previous table, Maxim proposes the highest number of Medicare recipients in Project Year 2; however, as documented in HKZ's Comments in Opposition, Maxim's cannot be considered the more effective alternative with regard to projected Medicare access because it relies on overstated projections.

As shown in the previous table, HKZ proposes the second highest number of duplicated Medicare recipients in Project Year 2, which makes its application the more effective alternative with regard to that comparative factor.

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Projected Access by Medicaid Recipients

For each applicant in this review, the following table compares: (a) the total number of duplicated patients in Project Year 2; (b) the number of duplicated Medicaid recipients in Project Year 2; and (c) duplicated Medicaid recipients as a percentage of total duplicated patients. Generally, the application proposing the higher number of Medicaid recipients is the more effective alternative with regard to this comparative factor. The applications are listed in the following table in decreasing order of effectiveness based on the number of Medicaid recipients projected to be served.

Project Year 2				
Rank	Applicant	Total Number of Duplicated Patients	Number of Duplicated Medicaid Recipients	Duplicated Medicaid Recipients as a Percentage of Total Duplicated Patients
1	Maxim	2,595	452	17.40%
2	HKZ	1,543	276	17.90%
3	Gentiva	1,059	270	25.50%
4	Continuum	1,264	229	18.09%
5	UniHealth	679	120	17.73%
6	Advanced	533	83	15.60%
7	NHRMC	5,990	unable to determine without percentage in VI.12.	no percentage included in VI.12.

As shown in the previous table, Maxim proposes the highest number of Medicaid recipients in Project Year 2; however, as documented in HKZ's Comments in Opposition, Maxim's cannot be considered the more effective alternative with regard to projected Medicaid access because it relies on overstated projections.

As shown in the previous table, HKZ proposes the second highest number of duplicated Medicaid recipients in Project Year 2, which makes its application the more effective alternative with regard to that comparative factor.

Average Number of Visits per Unduplicated Patient

The majority of home health care services are covered by Medicare, which does not reimburse on a per visit basis. Rather, Medicare reimburses on a per episode basis. Thus, there is a financial disincentive to providing more visits per Medicare episode. The following table shows the average number of visits per unduplicated patient projected by each applicant in Project Year 2. Generally, the application proposing the highest number of visits per unduplicated patient is the more effective alternative with regard to this comparative factor. The applications are listed in the following table in decreasing order of effectiveness.

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Project Year 2				
Rank	Applicant	Number of Unduplicated Patients	Projected Number of Visits	Average Number of Visits per Unduplicated Patient
1	Continuum	474	11,162	23.5
2	UniHealth	508	11,576	22.8
3	Advanced	533	11,123	20.9
4	Gentiva	391	7,706	19.7
5	HKZ	582	10,935	18.8
6	Maxim	503	9,405	18.7
7	NHRMC	1,328	23,022	17.3

As shown in the previous table, Continuum proposes the highest number of visits per unduplicated patient in Project Year 2; however, as documented in HKZ's Comments in Opposition, Continuum's projections are unreasonable due to its use of unreasonably high annual growth rates. As a result, the number of visits per unduplicated patient projected by Continuum cannot be the more effective alternative with regard to that comparative factor.

As shown in the previous table, UniHealth proposes the second highest number of visits per unduplicated patient in Project Year 2; however, as documented in HKZ's Comments in Opposition, UniHealth's projections are unreasonable due to its use of unreasonably high annual growth rates. As a result, the number of visits per unduplicated patient projected by UniHealth cannot be the more effective alternative with regard to that comparative factor.

As shown in the previous table, Advanced proposes the third highest number of visits per unduplicated patient in Project Year 2; however, as documented in HKZ's Comments in Opposition, Advanced's patient visits are overstated. As a result, the unreasonably high number of visits per unduplicated patient projected by Advanced cannot be the more effective alternative with regard to that comparative factor.

As shown in the previous table, Gentiva proposes the fourth highest number of visits per unduplicated patient in Project Year 2; however, as documented in HKZ's Comments in Opposition, Gentiva's projections are unreliable due to (1) its inclusion of unduplicated patients in non-qualifying disciplines, and (2) the difference between the unduplicated patients projected when unduplicated patients by qualifying disciplines only are included. As a result, the number of visits per unduplicated patient projected by Gentiva cannot be the more effective alternative with regard to that comparative factor.

As shown in the previous table, HKZ proposes the fifth highest number of visits per unduplicated patient in Project Year 2, which, by process of elimination, makes its application the more effective alternative with regard to that comparative factor.

Average Net Patient Revenue per Visit

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Average net revenue per visit in Project Year 2 was calculated by dividing projected net revenue from Form B by the projected number of visits from Section IV., as shown in the following table. Generally, the application proposing the lowest average net revenue per visit is the more effective alternative with regard to this comparative factor. The applications are listed in the following table in decreasing order of effectiveness.

Project Year 2				
Rank	Applicant	Total Number of Visits	Net Patient Revenue	Average Net Patient Revenue per Visit
1	UniHealth	11,756	$1,430,501	$122
2	Advanced	11,123	$1,541,982	$139
3	Gentiva	7,706	$1,099,399	$143
4	HKZ	10,935	$1,595,709	$146
5	Continuum	11,162	$1,636,041	$147
6	NHRMC	23,022	$3,564,820	$155
7	Maxim	9,405	$1,518,518	$161

As shown in the previous table, UniHealth proposes the lowest average net patient revenue per visit in Project Year 2; however, as documented in HKZ's Comments in Opposition, UniHealth's projections are unreasonable due to its use of unreasonably high annual growth rates. As a result, the average net patient revenue per visit projected by UniHealth cannot be the more effective alternative with regard to that comparative factor.

As shown in the previous table, Advanced proposes the second lowest average net patient revenue per visit in Project Year 2; however, as documented in HKZ's Comments in Opposition, Advanced's patient visits are overstated. As a result, the average net patient revenue per visit projected by Advanced cannot be the more effective alternative with regard to that comparative factor.

As shown in the previous table, Gentiva projects the third lowest average net patient revenue per visit in Project Year 2; however, as documented in HKZ's Comments in Opposition, Gentiva's projections are unreliable due to (1) its inclusion of unduplicated patients in non-qualifying disciplines, and (2) the difference between the unduplicated patients projected when unduplicated patients by qualifying disciplines only are included. As a result, the average net patient revenue per visit projected by Gentiva cannot be the more effective alternative with regard to that comparative factor.

As shown in the previous table, HKZ proposes the fourth lowest average net patient revenue per visit in Project Year 2, which, by process of elimination, makes its application the more effective alternative with regard to that comparative factor.

Average Net Patient Revenue per Unduplicated Patient

Average net revenue per unduplicated patient in Project Year 2 was calculated by dividing projected net revenue from Form B by the projected number of unduplicated patients from

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Section IV., as shown in the following table. Generally, the application proposing the lowest average net revenue per unduplicated patient is the more effective alternative with regard to this comparative factor. The applications are listed in the following table in decreasing order of effectiveness.

Project Year 2				
Rank	Applicant	Number of Unduplicated Patients	Net Patient Revenue	Average Net Patient Revenue per Unduplicated Patient
1	NHRMC	1,328	$3,564,820	$2,684
2	HKZ	582	$1,595,709	$2,742
3	Gentiva	391	$1,099,399	$2,812
4	UniHealth	508	$1,430,501	$2,816
5	Advanced	533	$1,541,982	$2,893
6	Maxim	503	$1,518,518	$3,019
7	Continuum	474	$1,636,041	$3,452

As shown in the previous table, NHRMC has the lowest average net patient revenue per unduplicated patient in Project Year 2; however, as documented in HKZ Comments in Opposition, NHRMC relies on a flawed methodology resulting in overstated projections. As a result, the average net patient revenue per unduplicated patient projected by NHRMC cannot be the more effective alternative with regard to that comparative factor.

As shown in the previous table, HKZ proposes the second lowest average net patient revenue per unduplicated patient in Project Year 2, which makes its application the more effective alternative with regard to that comparative factor.

Average Total Operating Cost per Visit

The average total operating cost per visit in Project Year 2 was calculated by dividing projected operating costs from Form B by the total number of visits from Section IV., as shown in the following table. Generally, the application proposing the lowest average total operating cost per visit is the more effective alternative with regard to this comparative factor. The applications are listed in the following table in decreasing order of effectiveness.

Project Year 2				
Rank	Applicant	Total Number of Visits	Total Operating Cost	Average Total Operating Cost per Visit
1	NHRMC	23,022	$2,041,650	$89
2	Advanced	11,123	$1,306,201	$117
3	UniHealth	11,756	$1,410,200	$120
4	Continuum	11,162	$1,455,998	$130
5	HKZ	10,935	$1,445,606	$132
6	Gentiva	7,706	$1,057,821	$137
7	Maxim	9,405	$1,305,747	$139

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As shown in the previous table, NHRMC has the lowest average total operating cost per visit in Project Year 2; however, as documented in HKZ Comments in Opposition, NHRMC relies on a flawed methodology resulting in overstated projections. As a result, the average total operating cost per visit projected by NHRMC cannot be the more effective alternative with regard to that comparative factor.
As shown in the previous table, Advanced proposes the second lowest average net patient revenue per visit in Project Year 2; however, as documented in HKZ's Comments in Opposition, Advanced's patient visits are overstated. As a result, the average net patient revenue per visit projected by Advanced cannot be the more effective alternative with regard to that comparative factor.

As shown in the previous table, UniHealth proposes the third lowest average net patient revenue per visit in Project Year 2; however, as documented in HKZ's Comments in Opposition, UniHealth's projections are unreasonable due to its use of unreasonably high annual growth rates. As a result, the average net patient revenue per visit projected by UniHealth cannot be the more effective alternative with regard to that comparative factor.

As shown in the previous table, Continuum proposes the fourth lowest average total operating cost per visit in Project Year 2; however, as documented in HKZ's Comments in Opposition, Continuum's projections are unreasonable due to its use of unreasonably high annual growth rates. As a result, average total operating cost per visit projected by Continuum cannot be the more effective alternative with regard to that comparative factor.

As shown in the previous table, HKZ proposes the fifth highest number of visits per unduplicated patient in Project Year, which, by process of elimination, makes its application the more effective alternative with regard to that comparative factor.

Average Direct Care Operating Cost per Visit

The average direct care operating cost per visit in Project Year 2 was calculated by dividing projected direct care expenses from Form B by the total number of visits from Section IV., as shown in the following table. Generally, the application proposing the lowest average direct care operating cost per visit is the more effective alternative with regard to this comparative factor. The applications are listed in the following table in decreasing order of effectiveness.

Project Year 2				
Rank	Applicant	Total Number of Visits	Total Direct Care Operating Cost	Average Total Direct Care Operating Cost per Visit
1	NHRMC	23,022	$1,473,222	$64
2	Gentiva	7,706	$594,516	$77
3	Advanced	11,123	$883,641	$79
4	Maxim	9,405	$811,259	$86
5	UniHealth	11,756	$1,015,671	$86
6	HKZ	10,935	$975,508.07	$89
7	Continuum	11,162	$1,095,989	$98

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As shown in the previous table, NHRMC proposes the lowest average total direct care operating cost per visit in Project Year 2; however, as documented in HKZ Comments in Opposition, NHRMC relies on a flawed methodology resulting in overstated projections. As a result, the average total direct care operating cost per visit projected by NHRMC cannot be the more effective alternative with regard to that comparative factor.
As shown in the previous table, Gentiva proposes the second lowest average total direct care operating cost per visit in Project Year 2; however, as documented in HKZ's Comments in Opposition, Gentiva's projections are unreliable due to (1) its inclusion of unduplicated patients in non-qualifying disciplines, and (2) the difference between the unduplicated patients projected when unduplicated patients by qualifying disciplines only are included. As a result, the average total direct care operating cost per visit projected by Gentiva cannot be the more effective alternative with regard to that comparative factor.

As shown in the previous table, Advanced proposes the third lowest average total direct care operating cost per visit in Project Year 2; however, as documented in HKZ's Comments in Opposition, Advanced's patient visits are overstated. As a result, the average total direct care operating cost per visit projected by Advanced cannot be the more effective alternative with regard to that comparative factor.

As shown in the previous table, Maxim proposes the fourth lowest average total direct care operating cost per visit in Project Year 2; however, as documented in HKZ's Comments in Opposition, Maxim's cannot be considered the more effective alternative with regard to that comparative factor because Maxim relies on overstated projections.

As shown in the previous table, UniHealth proposes the fourth average total direct care operating cost per visit in Project Year 2; however, as documented in HKZ's Comments in Opposition, UniHealth's projections are unreasonable due to its use of unreasonably high annual growth rates. As a result, the average total direct care operating cost per visit projected by UniHealth cannot be the more effective alternative with regard to that comparative factor.

As shown in the previous table, HKZ proposes the six lowest average total direct care operating cost per visit in Project Year 2, which, by process of elimination, makes its application the more effective alternative with regard to that comparative factor.

Average Administrative Operating Cost per Visit

The average total operating cost per visit in Project Year 2 was calculated by dividing projected administrative expenses from Form B by the total number of visits from Section IV., as shown in the following table. Generally, the application proposing the lowest average administrative operating cost per visit is the more effective alternative with regard to this comparative factor. The applications are listed in the following table in decreasing order of effectiveness.

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Project Year 2				
Rank	Applicant	Total Number of Visits	Total Administrative Operating Cost	Average Total Administrative Operating Cost per Visit
1	NHRMC	23,022	$568,428	$25
2	Continuum	11,162	$360,009	$32
3	UniHealth	11,756	$394,629	$34
4	Advanced	11,123	$422,560	$38
5	HKZ	10,935	$470,098	$43
6	Maxim	9,405	$494,488	$53
7	Gentiva	7,706	$463,305	$60

As shown in the previous table, NHRMC has the lowest average total administrative operating cost per visit in Project Year 2; however, as documented in HKZ Comments in Opposition, NHRMC relies on a flawed methodology resulting in overstated projections. As a result, the average total administrative operating cost per visit projected by NHRMC cannot be the more effective alternative with regard to that comparative factor.

As shown in the previous table, Continuum proposes the second lowest average total administrative operating cost per visit in Project Year 2; however, as documented in HKZ's Comments in Opposition, Continuum's projections are unreasonable due to its use of unreasonably high annual growth rates. As a result, average total administrative operating cost per visit projected by Continuum cannot be the more effective alternative with regard to that comparative factor.

As shown in the previous table, UniHealth proposes the third lowest average total administrative operating cost per visit in Project Year 2; however, as documented in HKZ's Comments in Opposition, UniHealth's projections are unreasonable due to its use of unreasonably high annual growth rates. As a result, the average total administrative operating cost per visit projected by UniHealth cannot be the more effective alternative with regard to that comparative factor.

As shown in the previous table, Advanced proposes the fourth lowest average total administrative operating cost per visit in Project Year 2; however, as documented in HKZ's Comments in Opposition, Advanced's patient visits are overstated. As a result, the lowest average total administrative operating cost per visit projected by Advanced cannot be the more effective alternative with regard to that comparative factor.

As shown in the previous table, HKZ proposes the fifth lowest average total administrative operating cost per visit in Project Year 2, which, by process of elimination, makes its application the more effective alternative with regard to that comparative factor.

Ratio of Average Net Revenue per Visit to Average Total Operating Cost per Visit

The ratios in the following table were calculated by dividing the average net revenue per visit in Project Year 2 by the average total operating cost per visit in Project Year 2. Generally, the application proposing the lowest ratio is the more effective alternative with regard to this

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comparative factor. The ratio must equal one or greater in order for a proposal to be financially feasible. The applications are listed in the following table in decreasing order of effectiveness.

Project Year 2				
Rank	Applicant	Average Net Revenue per Visit	Average Total Operating Cost per Visit	Ratio of Average Net Revenue to Average Total Operating Cost per Visit
1	UniHealth	$122	$120	1.01
2	Gentiva	$143	$137	1.04
3	HKZ	$146	$132	1.10
4	Continuum	$147	$130	1.12
5	Maxim	$161	$139	1.16
6	Advanced	$139	$117	1.18
7	NHRMC*	$155	$89	1.75

*As documented in HKZ Comments in Opposition, NHRMC significantly overstates its unduplicated patients, which results in overstated duplicated patients and visits.

As shown in the previous table, UniHealth proposes the lowest net revenue to average total operating cost per visit in Project Year 2; however, as documented in HKZ's Comments in Opposition, UniHealth's projections are unreasonable due to its use of unreasonably high annual growth rates. As a result, the net revenue to average total operating cost per visit projected by UniHealth cannot be the more effective alternative with regard to that comparative factor.

As shown in the previous table, Gentiva projects the second lowest net revenue to average total operating cost per visit in Project Year 2; however, as documented in HKZ's Comments in Opposition, Gentiva's projections are unreliable due to (1) its inclusion of unduplicated patients in non-qualifying disciplines, and (2) the difference between the unduplicated patients projected when unduplicated patients by qualifying disciplines only are included. As a result, the net revenue to average total operating cost per visit projected by Gentiva cannot be the more effective alternative with regard to that comparative factor.

HKZ proposes the third lowest ratio of average net revenue to average total operating cost per visit in Project Year 2, which, by process of elimination, makes its application the more effective alternative with regard to that comparative factor.

Average Direct Care Operating Cost per Visit as a Percentage of Average Total Operating Cost per Visit

The percentages in the following table were calculated by dividing the average direct care cost per visit in Project Year 2 by the average total operating cost per visit in Project Year 2. Generally, the application proposing the highest percentage is the more effective alternative with regard to this comparative factor. The applications are listed in the following table in decreasing order of effectiveness.

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Project Year 2				
Rank	Applicant	Average Total Operating Cost per Visit	Average Direct Care Operating Cost per Visit	Operating Cost as a Percentage of Average Total Cost per Visit
1	Continuum	$130	$98	75%
2	UniHealth	$120	$86	72%
3	NHRMC	$89	$64	72%
4	Advanced	$117	$79	68%
5	HKZ	$132	$89	67%
6	Maxim	$139	$86	62%
7	Gentiva	$137	$77	56%

As shown in the previous table, Continuum projects the highest operating cost as a percentage of average total cost per visit in Project Year 2; however, as documented in HKZ's Comments in Opposition, Continuum's projections are unreasonable due to its use of unreasonably high annual growth rates. As a result, operating cost as a percentage of average total cost per visit projected by Continuum cannot be the more effective alternative with regard to that comparative factor.

As shown in the previous table, UniHealth proposes the second highest operating cost as a percentage of average total cost per visit in Project Year 2; however, as documented in HKZ's Comments in Opposition, UniHealth's projections are unreasonable due to its use of unreasonably high annual growth rates. As a result, the operating cost as a percentage of average total cost per visit projected by UniHealth cannot be the more effective alternative with regard to that comparative factor.

As shown in the previous table, NHRMC has the third highest operating cost as a percentage of average total cost per visit in Project Year 2; however, as documented in HKZ Comments in Opposition, NHRMC relies on a flawed methodology resulting in overstated projections. As a result, the operating cost as a percentage of average total cost per visit projected by NHRMC cannot be the more effective alternative with regard to that comparative factor.

As shown in the previous table, Advanced proposes the fourth highest operating cost as a percentage of average total cost per visit in Project Year 2; however, as documented in HKZ's Comments in Opposition, Advanced's patient visits are overstated. As a result, the operating cost as a percentage of average total cost per visit in Project Year 2 projected by Advanced cannot be the more effective alternative with regard to that comparative factor.

As shown in the previous table, HKZ proposes the fifth lowest average total administrative operating cost per visit in Project Year 2, which, by process of elimination, makes its application the more effective alternative with regard to that comparative factor.

May 2013 Brunswick County Home Health Comparative Review

Nursing and Home Health Aide Salaries in Project Year 2

All seven applicants propose to provide nursing and home health aide services with staff who are employees of the proposed home health agency. Only five applicants propose to provide licensed practical nursing services with staff who are employees of the proposed home health agency. The following three tables compare the proposed annual salary for registered nurses, licensed practical nurses, and home health aides in Project Year 2. Generally, the applicant that proposes the highest annual salaries is the more effective alternative with regard to those comparative factors. The applications are listed in the following tables in decreasing order of effectiveness.

Project Year 2		
Rank	Applicant	Registered Nurse
1	UniHealth	$76,500
2	NHRMC	$73,329
3	HKZ	$70,627
4	Maxim	$69,215
5	Advance	$67,600
6	Continuum	$67,172
7	Gentiva	$50,247

Project Year 2		
Rank	Applicant	Home Health Aide
1	UniHealth	$35,037
2	Continuum	$31,552
3	HKZ	$30,810
4	Maxim	$30,320
5	Advanced	$30,160
6	NHRMC	$26,237
7	Gentiva	$22,168

Project Year 2		
Rank	Applicant	Licensed Practical Nurse
1	HKZ	$48,269
2	NHRMC	$47,386
3	Advanced	$46,800
4	UniHealth	$46,155
5	Continuum	$43,497

Salaries are a significant contributing factor in recruitment and retention of staff. As shown in the previous three tables:

- UniHealth projects the highest annual salary for a registered nurse in Project Year 2.
- UniHealth projects the highest annual salary for a home health aide in Project Year 2.
- HKZ projects the highest annual salary for a licensed practical nurse in Project Year 2.

May 2013 Brunswick County Home Health Comparative Review

Thus, the application submitted by UniHealth is the more effective alternative with regard to annual salary for registered nurses, the application submitted by UniHealth is the more effective alternative with regard to annual salary for home health aides, and the application submitted by HKZ is the more effective alternative with regard to annual salary for licensed practical nurses.

May 2013 Brunswick County Home Health Comparative Review

Summary

The following is a summary of the reasons that the proposal submitted by HKZ is determined to be the more effective alternative in this review. HKZ's projection ranks first by process of elimination with regard to a comparative factor for which HKZ did not rank first when it was determined by HKZ that there non-conformity in an application with a higher ranking. HKZ proposes:

- Second highest number of Medicare recipients in Project Year 2
- Second highest number of Medicaid recipients in Project Year 2
- Fifth highest average number of visits per unduplicated patient in Project Year 2
- Fourth lowest average net patient revenue per visit in Project Year 2
- Fifth lowest average total operating cost per visit in Project Year 2
- Six lowest average total direct care operating cost per visit in Project Year 2
- Fifth lowest average total administrative operating cost per visit in Project Year 2
- Third lowest ratio of net revenue to average total operating cost per visit in Project Year 2
- Fifth highest operating cost as a percentage of average total cost per visit in Project Year 2
- Third highest annual salary for a registered nurse in Project Year 2
- Third highest annual salary for a home health aide in Project Year 2
- Highest annual salary for a licensed practical nurse in Project Year 2.

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FOR IMMEDIATE RELEASE Monday, September 12, 2011

Maxim Healthcare Services Charged with Fraud, Agrees to Pay Approximately $150 Million, Enact Reforms After False Billings Revealed as Common Practice

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

NEWARK, N.J. – Maxim Healthcare Services Inc., 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.

Today's announcement was made by Tony West, Assistant Attorney General of the Civil Division of the Department of Justice; J. Gilmore Childers, Acting U.S. Attorney for the District of New Jersey; 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, N.J., 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.

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 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.

"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 Assistant Attorney General West. "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."

"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

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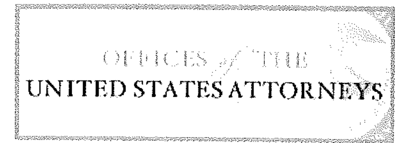
them. It is our hope that Maxim, in cleaning up its own house, will be a lighthouse influencing best practices across the industry."



"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.

Also included in the settlement is a 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.

Prosecution of Individuals

According to documents filed in these cases and statements made in Trenton, N.J., federal court:

Gregory Munzel, 35, of Charleston, S.C., was employed as a regional account manager, reporting

Gregory Munzel, 55, 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 Dec. 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 Sept. 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 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 Nov. 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 Sept. 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 Nov. 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 Sept. 26, 2011; Bouche is currently scheduled to be sentenced on Nov. 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 Sept. 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 Feb. 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 Sept. 21, 2011, and Oct. 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 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.

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. The National Association of Medicaid Fraud Control Units (NAMFCU) and the Medicaid Fraud Control Units of the New Jersey, Virginia and Massachusetts Attorney General's Offices also assisted 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 Sara McLean of the Department of Justice's Commercial Litigation Branch, Frauds Section and Assistant U.S. Attorney Alex Kriegsman of the U.S. Attorney's Office's Civil Division.

The government's involvement in this case is part of the United States' emphasis on combating health care fraud and another step for the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, which was announced by Attorney General Eric Holder and Kathleen Sebelius, Secretary of the Department of Health and Human Services in May 2009. The partnership between the two departments has focused efforts to reduce and prevent Medicare and Medicaid financial fraud through enhanced cooperation. One of the most powerful tools in that effort is the False Claims Act, which the Justice Department has used to recover more than $5.9 billion since January 2009 in cases involving fraud against federal health care programs. The Justice Department's total recoveries in False Claims Act cases since January 2009 are more than $7.5 billion.

11-1169 Civil Division

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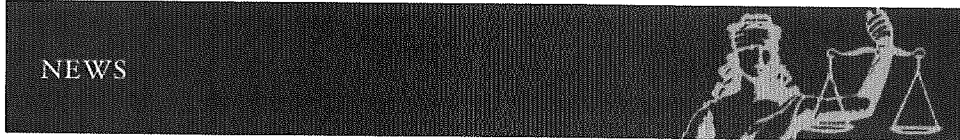

Former Maxim Healthcare Services Senior Manager Sentenced To Prison For Health Care Fraud

FOR IMMEDIATE RELEASE November 21, 2011

Eight Others, Including Senior Managers, Previously Sentenced for Felony Charges Arising out of Maxim's Activities

TRENTON, N.J. – A former senior manager and 13-year employee of Maxim Healthcare Services, Inc. ("Maxim"), was sentenced today to five months in prison and five months of home confinement with electronic monitoring for his involvement in the unlicensed operation of Maxim office that billed nearly a million dollars to government health care programs, J. Gilmore Childers, First Assistant U.S. Attorney announced.

Bryan Lee Shipman, 38, of Athens, Ga., pleaded guilty in Trenton federal court on June 17, 2010, to an Information charging him with one count of health care fraud. Shipman was charged in connection with his role as a regional account manager supervising Maxim's decision to open and operate Maxim's Gainesville, Ga., office without a license from 2008 through 2009, when he and others directed billings from that office to be submitted for reimbursement by the Medicaid program as if they were from another, licensed office. Shipman entered his guilty plea before U.S. District Judge Anne E. Thompson, who also imposed the sentence today in Trenton federal court.

On Sept. 12, 2011, Maxim – one of the nation's leading providers of home healthcare services – entered into a settlement agreement 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. Maxim was charged in a criminal Complaint with conspiracy to commit health care fraud, and entered into a Deferred Prosecution Agreement ("DPA") with the Department of Justice. The agreement allows Maxim to avoid a health care fraud conviction on the charges if it complies with the DPA's requirements. As required by the DPA, Maxim agreed to pay approximately $150 million – a criminal penalty of $20 million and approximately $130 million in civil settlements in the matter, including to settle federal False Claims Act claims.

Shipman is one of nine individuals – eight former Maxim employees, including three senior managers, and the parent of a former Maxim patient – to have pleaded guilty to and been sentenced on 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.

According to documents filed in this and related cases and statements made in court:

Shipman had been employed by Maxim for 13 years, the last eight as a regional account manager. As a regional account manager, Shipman reported directly to one of two nationwide vice presidents, who in turn reported to Maxim's president. He also managed 13 offices in 2008 with hundreds of employees and total annual sales of more than $42 million, much of which derived from government programs. In his last full year of employment, Shipman earned more than $325,000, and was among the top 25 individuals at Maxim in terms of compensation out of the more than 80,000 individuals employed by Maxim in that year.

Shipman's annual compensation – which ranked him within the top .03% of the Company – was based to a significant degree on meeting sales goals. 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." It was in response to that pressure, Shipman said, that he authorized and supervised the unlicensed operation of the Gainesville office.

At one point, when Maxim employees believed a state regulator would be visiting the office, lower-level

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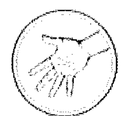
UNITED STATES ATTORNEYS' OFFICES BRIEFING ROOM

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.



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employees were directed by Shipman and others 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..

In addition to the prison term, Judge Thompson sentenced Shipman to two years of supervised release and ordered him to pay a $10,000 fine.

The other eight individuals who pleaded guilty were sentenced by Judge Thompson as follows:

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 Dec. 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 was sentenced on Sept. 29, 2011, to three months of home confinement as part of a two-year term of probation. Munzel was also ordered to pay a $1,000 fine.

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 Sept. 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, 30, 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 Nov. 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 was sentenced on Sept. 26, 2011, to six months of home confinement as part of a three-year term of probation. Sabbaghzadeh was also ordered to pay a $2,000 fine. Bouche was sentenced on Nov. 17, 2011, to a two-year term of probation and ordered to pay a $500 fine.

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 (RN), had responsibility for, among other things, ensuring that Medicaid-required supervisory visits of patients were conducted periodically – meaning that an RN 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 RNs. 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 was sentenced on Oct. 18, 2011, to four months of home confinement as part of a a three-year term of probation. Ocansey was also ordered to pay a $2,000 fine.

Mary Shelly Janvier-Pierre, 43, of Lake Worth, Fla., and Sandy Cave, 39, of West Palm Beach, Fla., pleaded guilty to health care fraud on Feb. 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 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 was sentenced on Sept. 21, 2011, to six months of home confinement as part of a three-year term of probation. Cave was sentenced on Nov. 17, 2011, to five months of home confinement as part of a three-year term of probation. Cave was also ordered to pay a $1,000 fine.

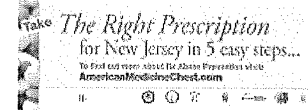
Marion Morton, 45, of North Charleston, S.C., was employed as a home health aide and personal care assistant by Maxim's Charleston, S.C., office. He pleaded guilty on May 3, 2010, to one count of making false statements relating to health care fraud matters. During his plea hearing, Morton acknowledged 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.

First Assistant U.S. Attorney Childers credited special agents and investigators from HHS/OIG, under the direction of Special Agent in Charge Thomas ODonnell; the FBI, under the direction of Special Agent in Charge Michael B. Ward; and VA OIG, under the direction of Special Agent in Charge Jeffrey Hughes for conducting the multi-year investigation.

The government is represented by Assistant U.S. Attorney Jacob T. Elberg of the U.S. Attorney's Office Health Care and Government Fraud Unit.

11-471

Civil Rights Enforcement



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En Español

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.

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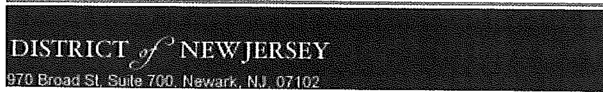

attachment 4

When Caregivers Harm
America's Unwatched Nurses

Troubled Health-Care Staffing Chain Settles With Government for $150 Million

by Charles Ornstein and Tracy Weber
ProPublica, Sept. 12, 2011, 4:03 p.m.

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One of the nation's largest health-care staffing companies has agreed to pay $150 million to settle sweeping criminal and civil fraud allegations of submitting false bills to federal and state health programs.

Maxim Healthcare Services, Inc. was accused of submitting more than $61 million in fraudulent billings to government health programs for services that were either not provided or not eligible for reimbursement, according to a press release Monday from the U.S. Department of Justice [1]. Eight former Maxim employees, as well as the parent of a former Maxim patient, have pleaded guilty to felony charges.

A different set of problems involving Maxim came up during a ProPublica investigation into the oversight of registered nurses [2] in 2009. We identified several nurses who were hired by the Maryland-based company despite having a record of problems.

While working for Maxim, registered nurse Orphia Wilson, for example, allegedly failed to call 911 [3] after a child stopped breathing while under her care. He died. After the incident, Wilson lost her Florida nursing license [4] but got a job with another Maxim office in Connecticut. There, she fell asleep, then ignored—or possibly turned off—ventilator alarms that signaled a boy in her care was not getting enough oxygen [5], state records show. That child died, as well.

Wilson wrote in a sworn statement to investigators later [6]: "I am very sorry about the deaths of the babys [sic] I cared for. Believe me I went through my share of guilt."

Wilson was sentenced to jail in 2008 for reckless endangerment and hiding her Florida discipline from Connecticut.

In another instance, Maxim hired a nurse who had previously lost his license in Minnesota for stealing drugs and faced a pending action against his California license for similar allegations, according to nursing board records and interviews.

The firm also hired a nurse whose license had been previously suspended by Virginia after she was found asleep on a sofa under a blanket when she was supposed to be taking care of a 4-month-old child with multiple health problems. After testing positive for drugs on the job with Maxim, she lost her nursing license.

Such oversights in hiring were common [2] in the temporary nurse staffing industry, we found. The articles focused on how regulators across the country did little to scrutinize troubled nurses who crossed state lines to continue working. Our earlier stories did not identify Maxim by name. We have called Maxim for comment Monday and will update this post with their response when we get it.

The main focus of the settlement, filed in U.S. District Court in New Jersey, does not involve Maxim's background checks of its nursing staff, but rather the company's billing practices. In order to conceal the fraud, the government alleged, Maxim employees falsified time sheets and covertly submitted bills for services delivered by unlicensed offices.

"Not only did Maxim fail to back up its billings with proper documentation, we found that Maxim frequently billed for services it never rendered or care it never provided," said Tony West, assistant attorney general in charge of the Justice Department's civil division, in a statement. "And, we learned, to avoid detection, Maxim's former officers and employees engaged in a variety of tactics to conceal the company's fraud."

Maxim agreed to pay a $20 million criminal fine and abide by terms of a deferred prosecution agreement. The company is also paying $70 million to the federal government and $60 million to 42 states to settle civil allegations.

Among the Maxim employees who have pleaded guilty is Gregory Munzel, who was regional account manager of Maxim's Charleston, S.C., office from 2001 to 2005. In his plea hearing in December 2009, Munzel acknowledged fabricating documentation to make it appear that

caregivers were properly credentialed when, in fact, they were not. He said he did so in response to sales pressure from his superiors to generate more revenue. He also said such falsifications were a common practice by employees in his office.

In announcing the settlement, the government went out of its way to praise Maxim for reforming its practices, including leadership changes, a stronger corporate compliance program and cooperation with prosecutors in the case.

In a statement [7], Maxim CEO Brad Bennett said, "While we regret the circumstances that led to these agreements, the resulting enhancements have clearly made Maxim a better and stronger company. Most importantly, at Maxim there is now a renewed commitment to the highest standards of conduct and consistent delivery of high quality patient care."

Update (9/13): Maxim spokeswoman Rebecca Kirkham responded via email: "Since the appointment of a new management team in 2009, Maxim has made significant investments in its infrastructure and systems -- updating and revising more than 120 policies and procedures, including its hiring and supervision practices. Today, Maxim conducts comprehensive pre-employment background checks on all employees. Our robust employee screening and hiring processes are consistent with and meet all applicable state and federal guidelines."

1. http://www.justice.gov/usao/nj/Press/files/Maxim%20News%20Release.html
2. http://www.propublica.org/series/nurses
3. http://www.propublica.org/article/nurses-disciplined-out-of-state-1227
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7. http://www.maximhealthcare.com/pressrelease.aspx?id=608

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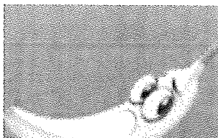

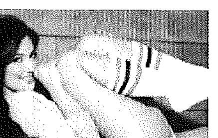

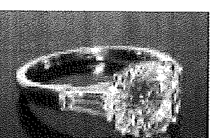

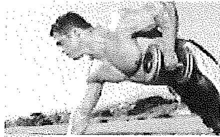

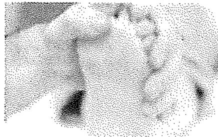

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