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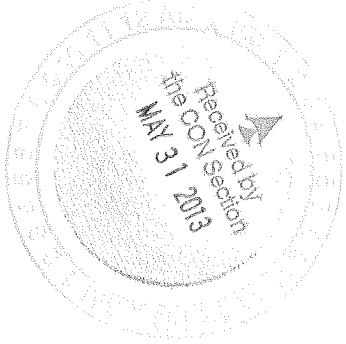


HAND DELIVERED

May 31, 2013

Mr. Greg Yakaboski, Project Analyst
Mr. Craig Smith, Section Chief
Certificate of Need Section
Division of Health Service Regulation
NC Department of Health and Human Services
809 Ruggles Drive
Raleigh, North Carolina 27603

Re: Comments on Competing Applications for a Certificate of Need for a Medicare-Certified Home Health Agency in Brunswick County, Health Service Area V; CON Project ID Numbers:

O-10117-13, NHRMC Home Care
O-10118-13, Advanced Home Care, Inc.
O-10119-13, HKZ Group, LLC
O-10120-13, Maxim Healthcare Services, Inc.
O-10121-13, Gentiva Health Services
O-10123-13, Continuum II Home Care and Hospice, Inc.

Dear Mr. Yakaboski and Mr. Smith:

On behalf of UniHealth Home Health (UniHealth), Project IDO-010113-13, thank you for the opportunity to comment on the above-referenced applications for development of a new Medicare-certified home health agency in Brunswick County.

CONTEXT

After a complete review of all the applications, it is apparent that all applicants have invested significant effort in preparing responses to the Certificate of Need applicati on questions. We recognize that the State's Certificate of Need (CON) award for the proposed home health agency will be based upon the health planning objectives outlined in G.S. 131E-175, the policies in the *2013 State Medical Facilities Plan* (*SMFP*) , the statutory criteria in G.S. 131E-183, and the special rules in 10A NCAC 14C .2000. Specifically, we request that the CON Section give careful consideration to the extent to which each application demonstrates that it will provide the most effective alternative, as reflected in:

- The need its target population has for the scope of home health services that it proposes to offer and the extent to which the applicant proposes to meet that need;
- Immediate and sustainable financial feasibility of the proposed agency;
- Availability of adequate staff to provide all proposed services;
- Ability to provide all necessary ancillary and support services; and
- Organizational structure, staff development programs and quality improvement programs that will enable the agency to sustain cost-effective delivery of quality and appropriate care, along with access to the proposed services.

We believe that UniHealth's application is competitively superior to the other competing applications in this review batch. It conforms to all statutory criteria and planning objectives. Further, its well-balanced program/cost proposal exceeds the minimum requirements and will provide the best combination of Value, Quality, and Access for the residents of Brunswick County and the surrounding area.

In this letter, we briefly discuss why UniHealth's application is competitively superior. We have also attached a more detailed analysis of each competing application using the framework of the statute's CON Review Criteria and applicable home health rules (10A NCAC 14C .2000). For each applicant, we have addressed only those criteria to which we believe the application is non-conforming.

WHY APPROVE UNIHEALTH HOME HEALTH

Competitive Overview

Each application possesses its own strengths; yet, a successful application must meet all statutory criteria and should exemplify the strongest combination of the **2013 SMFP basic principles: Value, Quality, and Access.** No one applicant will be the best in all of the competitive criteria, so it is important to consider the entirety of all applications when determining who should be approved. UniHealth's application embodies these three basic principles and will benefit ALL demonstrated unmet need in Brunswick County and the surrounding area in Year 02. UniHealth offers:

- A home health agency program that is specifically tailored to the needs of Brunswick County and the service area's residents;
- A comprehensive care management solution with the technology and management support to ensure that an individual client's care is coordinated with other care providers within the community;
- Access to home health agency services for a high percentage of underserved populations;
- High visits per unduplicated patient;
- Salaries that ensure its capacity to attract and retain high quality, well trained direct care staff; and
- Outcomes that demonstrate a commitment to quality and providing appropriate levels of care.

UniHealth's application best supports all three of the **2013 SMFP Basic Principles: Value, Quality, and Access.** It also meets the Centers for Medicare and Medicaid Services (CMS) Triple Aim of good patient experience and better health for the population at the lowest cost.

Comparison Note

Before comparing any individual applications in this batch, it is important to take note of the sizable differences in utilization. As one can see, the proposed number of unduplicated persons served differs by almost 250 percent in some cases, making comparative efforts for various financial and operating metrics especially difficult. Two applications, NHRMC and HKZ, have artificially expanded the service area to create the appearance of greater need in the area than is appropriate. Gentiva also identifies a vast service geography but proposes to serve the fewest Brunswick County residents in Year 02 (391).

Table 1 - Total Unduplicated Patients

Applicant	Year 2
Gentiva	382
Continuum	474
Maxim	503
UniHealth	508
Advanced	533
HKZ	582
NHRMC	1,328

These approaches challenge the fundamental intent of the statute to reach persons with an unmet need for the services proposed. Of specific note is Finding of Fact GS 131E-175(1) and (4) (page 3):

> *(1) That the financing of health care, particularly the reimbursement of health services rendered by health service facilities, limits the effect of free market competition and government regulation is therefore necessary to control costs, utilization and distribution of new health service facilities ....*
>
> *(4) That the proliferation of unnecessary health service facilities results in costly duplication and underuse of facilities, with the availability of excess capacity leading to unnecessary use of expensive resources and overutilization of health care services.*

Value

All Applicants

UniHealth's proposal demonstrates commitment to value. It consistently outperforms competing proposals in 14 comparative value metrics. UniHealth ranks first in four of these metrics: UniHealth proposes the lowest average net revenue per visit, the lowest ratio of net revenue per visit to average total operating cost per visit, the highest average salary for registered nurses and the highest average salary for home health aides. UniHealth also ranks in the top three of all applicants in:

- Number of duplicated Medicare patients,
- Number of duplicated Medicaid patients,
- Number of duplicated Medicare patients as a percent of total of duplicated patients,
- Number of duplicated Medicaid patients as percent of total of duplicated patients,

- Average total operating cost per visit,
- Average administrative operating cost per visit, and
- Average direct care operating cost per visit as a percent of average total operating cost per visit.

The following table demonstrates why UniHealth's proposal is more effective than other competitors. Applicants were ranked from highest to lowest in 14 value metrics, with Number 1 representing the most effective applicant. Accordingly, the lowest Total Score and the lowest Average Score represent the most consistent commitment to value.

Table 2 - .Applicant Ranking Based on Value Metrics

Comparative Value Metric	UniHealth	NHRMC	Continuum	HKZ	Advanced	Gentiva	Maxim
Number of Duplicated Medicare Patients	2	1	5	4	6	7	3
Duplicated Medicare Patients as a Percent of Total Duplicated Patients	2	1	5	7	3	6	4
Number of Duplicated Medicaid Patients	2	1	6	4	7	5	3
Duplicated Medicaid Patients as a Percent of Total Duplicated Patients	4	7	2	3	6	1	5
Average # of Visits per Unduplicated Patient	2	7	1	5	4	3	6
Average Net Revenue per Visit	1	6	5	4	2	3	7
Average Net Revenue per Unduplicated Patient	4	1	7	2	5	3	6
Average Total Operating Cost per Visit	3	1	4	5	2	6	7
Average Direct Operating Cost per Visit	5	1	7	6	3	2	4
Average Administrative Operating cost per Visit	3	1	2	5	4	7	6
Ratio of Average Net Revenue per Visit to Average Total Operating Cost per Visit	1	7	4	3	6	2	5
Average Direct Care Operating Cost per Visit as a Percent of Average Total Operating Cost per Visit	3	2	1	5	4	7	6
Registered Nurse Salary	1	2	6	3	5	7	4
Home Health Aide Salary	1	6	2	3	5	7	4
Total Score*	**34**	**44**	**57**	**59**	**62**	**66**	**70**
Average Score*	**2.43**	**3.14**	**4.07**	**4.21**	**4.43**	**4.71**	**5.00**

**Note: Lowest is most effective.*

UniHealth's Total Score and Average Score demonstrates that it is the most effective alternative when considering the 14 comparative value metrics. Not only does UniHealth possess the lowest total score and the lowest average score, it is the only applicant that consistently ranks in the top three in the value metrics and is the only applicant that never ranks either 6th or 7th in any metric.

As the leader in Total Score and Average Score (possessing the lowest in both categories), the UniHealth application provides the foundations for an agency that will reliably and steadily meet and exceed the benchmarks necessary in ALL areas to ensure broad access to the cost-effect delivery of quality care. The state may find several applications in this batch, in addition to UniHealth, conforming to required statutes and rules, but UniHealth clearly proposes the best value in its proposal to develop a new home health agency in Brunswick County while conforming to all applicable statutes, rules, and policies.

Comparison of Smaller Applicant Group

UniHealth's proposal to provide a new home health agency in Brunswick County is the most effective alternative. Two applications that score high in some of the comparative value metrics, however, merit special attention.

A competing proposal from NHRMC leads on a number of measures; however, NHRMC's proposal lacks the consistency of leadership in the comparative value metrics. Although NHRMC ranks first in seven of 14 metrics, this applicant ranks sixth or seventh in five out of the remaining seven comparative value metrics. In addition, several of NHRMC's high ranking metrics, for which NHRMC outranks the other applications (discussed in greater detail in the comments specific to NHRMC),are the direct result of this applicant's failure to include any overhead costs and/or failure to include all of the direct costs mentioned in its scope of service.

NHRMC's metrics are skewed for other reasons, as well. NHRMC ranks first in number of duplicated Medicare and Medicaid patients. However, the projected duplicated patients in Table IV.2 (5,990 in Year 02) are unreasonably high for a new agency and far exceed the identified need in the service area. NHRMC achieves this utilization by proposing to serve Columbus County, a county which both the 2013 SMFP and the NHRMC application show not only that there is no unmet need in Columbus County but, instead, excess capacity. Therefore, the duplicated Medicare and Medicaid patients proposed in this application are unreasonably high.

Some of NHRMC's financial metrics are also unjustified. NHRMC achieved the lowest administrative and operating costs among applicants in the batch by allocating no overhead or home office cost to the proposed new home health agency. This failure is inconsistent with CMS cost reporting rules (See Attachment L).Therefore, NHRMC's ranking in average administrative and total operating cost per visit must be questioned.

Finally, NHRMC achieves a low Medicare charge by weighting its values with rates for Columbus County (page 122), which, as noted earlier, has no identified need. As a result, this financial indicator, too, seems to be unwarranted.

NON-CONFORMING APPLICATIONS

Comparative value metrics aside, the NHRMC proposal is clearly non-conforming to statutory criteria: (1), (3), (3a), (5), (7) and possibly to several others.

- NHRMC proposes to serve more Brunswick County patients than the unmet need dictates and proposes to serve Columbus County which has no need and, instead, excess capacity. (Criteria (1) and (3)).
- NHRMC proposes to staff its project by relocating staff from its existing Pender County agency without demonstrating that the needs of the population of this rural low-income county will still be adequately served by the proposed relocation(please see the attached for further discussion).(Criterion (3a)).
- The application fails to consider the full cost of developing an agency. The application did not allocate the overhead cost from the parent company that is essential to sustain its operation, and it proposes insufficient direct care staff, support staff and resources needed to expand its services from Year 1 to Year 2. (Criterion (5)).
- The application does not show sufficient manpower to support both the proposed new home health agency and its existing home health agency. (Criterion (7)).
- The applicant proposes to serve a smaller percentage of Medicaid patients than the lowest of the existing home health agency providers in Brunswick County. (Criteria (13c) and (18a)).

Similarly, Gentiva's proposal is non-conforming to some statutory criteria. Gentiva's application is non-conforming to Criteria (5) and (7) and possibly non-conforming in several others. Gentiva's application:

- Fails to consider the full cost of a developing agency. The applicant includes no management contract, and no overhead for the central office is included in its budget.(Criterion (5)).
- Provides no detailed assumptions that would allow a reviewer to recreate or validate projected duplicated patients or visits in Project Year 1 or duplicated visits in Project Year 2. (Criterion (5)).
- Does not propose adequate staffing for the projected visits in nursing, physical therapy, speech therapy, and home health aide during Project Year 2, according to the methodology used in findings for recent home health CON applications in Wake County (J-8817-12) and Mecklenburg County (F-7223-05). (Criterion (7)).

A review of the competing applications without these two applicants highlights the strengths of UniHealth's proposal even further. Displayed below are rankings for the same 14 comparative value metrics without the non-conforming applications, NHRMC and Gentiva. Of the 14 comparative value metrics, UniHealth's proposal ranks:

- 1st in seven measures,
- 2nd in five measures, and
- 3rd in two measures.

Further, the other four applicants consistently rank last and/or next to last in multiple benchmarking measures while UniHealth never ranks lower than third in any metric.

Table 3 - Refined Value Metric Comparison

Comparative Value Metric	UniHealth	Continuum	HKZ	Advanced	Maxim
Number of Duplicated Medicare Patients	1	4	3	5	2
Duplicated Medicare Patients as a Percent of Total Duplicated Patients	1	4	5	2	3
Number of Duplicated Medicaid Patients	1	4	3	5	2
Duplicated Medicaid Patients as a Percentage of Total Duplicated Patients	3	1	2	5	4
Average Number of Visits per Unduplicated Patient	2	1	4	3	5
Average Net Revenue per Visit	1	4	3	2	5
Average Net Revenue per Unduplicated Patient	2	5	1	3	4
Average Total Operating Cost per Visit	2	3	4	1	5
Average Direct Operating Cost per Visit	3	5	4	1	2
Average Administrative Operating cost per Visit	2	1	4	3	5
Ratio of Average Net Revenue per Visit to Average Total Operating Cost per Visit	1	3	2	5	4
Average Direct Care Operating Cost per Visit as a Percentage of Average Total Operating Cost per Visit	2	1	4	3	5
Registered Nurse Salary	1	5	2	4	3
Home Health Aide Salary	1	2	3	5	4
Total Score*	***23***	***43***	***44***	***47***	***53***
Average Score*	***1.64***	***3.07***	***3.14***	***3.36***	***3.79***

**Note: Lowest is most effective.*

UniHealth's lowest Total Score and lowest Average Score among the applicants considered to be conforming to the Review Criteria again confirms the strength of its application. Only UniHealth demonstrates that it excels at developing a home health agency with the appropriate balance of coordinators that maintain, review and validate quality measures combined with appropriate resources for direct patient care. UniHealth's leadership in these comparative value metrics demonstrates its commitment to value. Other applicants have fewer staff, high or missing overhead costs, lack the coordination of care, and/or stretch providers thin with high productivity requirements, thereby providing lower value to the residents of Brunswick County and the surrounding area. UniHealth's application, on the other hand, shows a consistent capacity to deliver value and access and is the ideal alternative for these residents.

IMPACT OF MEDICARE SEQUESTRATION ON FINANCIALS

Although not mentioned in our discussions of other applications, it is important to note that two applications, HKZ and Continuum, do not incorporate any assumptions to reflect reductions in future Medicare reimbursement.HKZ provides no information to show how it calculated Medicare payments.

Only the UniHealth and New Hanover Regional Medical Center (NHRMC) applications *specifically* recognize and show how rates were adjusted for sequestration. This federal mandate represents a critical challenge to home health operations as the two percent 'across the board' reductions in Medicare provider payments that were implemented on April l, 2012 will affect revenues for all Medicare-certified home health agencies. Please Attachment L for a summary of how sequestration affects Medicare reimbursement. As one can see, cuts have been applied to the payment itself, not the underlying "allowed" charge in Medicare fee schedules

Table 4 - Basic Medicare Episode Rate

Applicant	Year 1	Year 2
HKZ	NA	NA
NHRMC	$2,369.49	$2,298.40
UniHealth	$2,447.00	$2,398.00
Gentiva	$2,626.00	$2,573.00
Advanced	$2,758.00	$2,672.00
Maxim	$2,714.00	$2,687.00
Continuum	**$2,698.00**	**$2,698.00**

Recent statements by members of the US Senate and House of Representatives indicate that the two percent cut will remain in place for at least the next five years. Therefore, applications that fail to adjust their Medicare reimbursement for sequestration give the appearance of much stronger financial positions than current federal statutes would project. Five of the seven applications in this batch (Gentiva, HKZ, Maxim, Advanced, and Continuum) fail to consider these reductions in Medicare reimbursement in their financial projections. Some reduce payments between the first and second years, but do not adjust from 2013 forward. UniHealth, on the other hand, demonstrates its understanding of the macroeconomics of today's health care environment by forecasting reasonable financial projections in its application that incorporate the aforementioned cuts to Medicare reimbursement. (Please see Sequestration Articles in Attachment L.)

Quality

Accreditation

UniHealth is the only applicant to budget for third-party accreditation, assuring continuous unbiased oversight of its operations. Accreditation bodies provide the structure and oversight necessary to ensure that patients always experience the safest, highest quality, and best-value health care. Three organizations accredit Medicare-certified home health agencies: Joint Commission (JC), the Accreditation Commission for Health Care (ACHC), and Community Health Accreditation Program (CHAP). UniHealth is the only applicant to demonstrate that it will pursue Joint Commission accreditation and commit the funds needed to accomplish the commitment. Advanced, Maxim and NHRMC all indicate that they will pursue accreditation, but none include funding in their operating financial proformas. In response to Section VI.1and VI.2, the Continuum, Gentiva, and HKZ applications indicate they will pursue no accreditation.

Table 5 - Response to Question VI.1 and VI.2 Regarding Accreditation

Applicant	Accreditation	Budgets Funds For Accreditation In Proforma Expenses
UniHealth	Joint Commission (JC)	Yes ($10,000)
Advanced	ACHC	Not Identified
Maxim	Accreditation Commission for Health Care (ACHC)	Not Identified
NHRMC	JC	Not Identified
Continuum	None	None
Gentiva	None	None
HKZ	None	None

Service Need

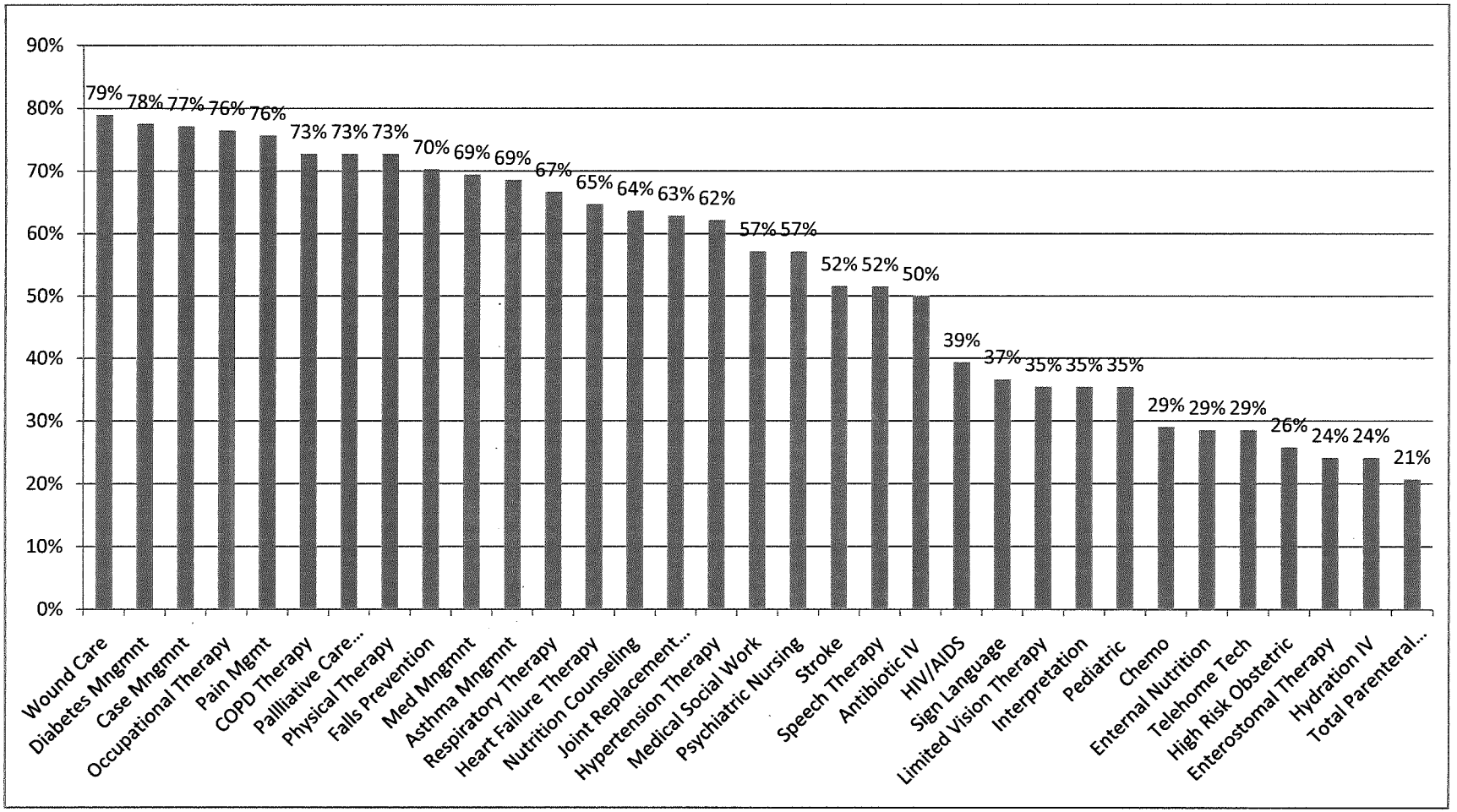
UniHealth identifies the population to be served by the proposed project as the residents of Brunswick, New Hanover and Pender Counties. Each of the applicants, including UniHealth, indicates that significant growth and aging of the population will generate need for home health services in Brunswick County. Only UniHealth went beyond this basic quantitative analysis, also examined the unmet need from a qualitative standpoint in each of the first three project years, and investigated which specific services are needed by proposed service area residents. UniHealth is also the only applicant that provides analytics on the requested services and tailored its service program specifically to address the identified unmet need. As described in greater detail in the application, UniHealth representatives spent approximately two weeks in Brunswick, New Hanover and Pender Counties surveying a broad cross-section of providers and community agencies to determine what service mix would address the areas of highest unmet need in this area. Its survey results, which included direct conversations with area providers, indicated need for a home health agency that could offer:

- Pain management and palliative care,
- Wound care management,
- Diabetes care,
- Cardiac care,
- COPD care,
- Stroke care,
- Joint replacement care,
- Chronic disease management,
- Dementia and Alzheimer's care,
- Oncology care,
- IV/infusion therapy, and
- HIV/AIDS care, among other services.

Surveys

UHS representatives devised, distributed and then collected 49 surveys from a wide cross-section of Brunswick County and surrounding area providers. The primary objective of the surveys was to get an accurate synopsis of the current home health market in the service area, to gauge which services were needed in the county and, ultimately, to address those services through a specific plan of care. Each survey posed a myriad of questions related to the current home health market in Brunswick County and the surrounding area, specifically to underserved populations in connection with service. Further, each provider was asked to score needed service types from a new home health provider in the county on a scale of 1 to 4 with 1 being a minimally needed service and 4 being a much needed service.

Figure 1 – Percentage of Survey Responses that Indicated a Service as Greatly Needed in Brunswick County (Possessed an Average Survey Score Greater than 3)



Source: UniHealth Survey

UniHealth's survey analysis also demonstrates the need for specific services that will contribute to population health. Specifically, UniHealth will:

- Accommodate people who have hearing loss,
- Provide intensive focus on transitions in care,
- Utilize information technology support,
- Employ integrated care paths, and
- Account for expanded geographic and payor access.

UniHealth's services best match the documented needs of the community. No other applicant both surveyed the local providers and the community and consistently matched the services it will provide with the results it received from the survey distribution. As such, UniHealth's application boasts a carefully tailored care plan that specifically addresses the services needed in Brunswick County and the surrounding area.

Recruitment and Retention of Staff

Providing appropriate services to match the need in the area is only one aspect of quality. Recruitment and retention by superior health care providers also directly correlates with the level of quality care an organization can offer. To ensure that it can offer a comprehensive list of services, UniHealth focuses on hiring the most experienced and well qualified staff by offering competitive salaries and benefits packages. As such, UniHealth's proposal not only provides the needed services, but also incorporates the necessary health manpower needed to provide those services.

Among the applicants in this batch, UniHealth proposes the highest average salaries for direct care staff. It also proposes the highest salaries for registered nurses and home health aides. As noted earlier, salaries are a contributing factor in not only recruitment and retention of staff, but also hiring the most experienced and well-qualified staff. Because the proposed agency will have a relatively small staff, qualifications will play a key role in the overall level of quality provided by the agency.

Staff Training

UniHealth's comprehensive service package includes a strong combination of highly trained direct care staff, strong management support and continuous education/training programs to ensure that staff can meet the community needs. UniHealth is the only applicant with a developed and systematic training program that is available to all employees and that has mandatory minimal requirements before employees can begin to deliver care. UniHealth is committed to ensuring that its employees are highly trained in current quality care techniques and offers numerous continuing education training opportunities. This continuous training is essential to maintaining pace in CMS Triple Aim. For a staff that works in homes, rather than in an institution where teaching encounters are regularly organized, consistent on-line and in-person continuing education is critical.

UHC's care plan models also ensure that its agencies are using the most up-to-date quality care techniques. This has enabled UHC agencies across the southeast be recognized in the Top 100 of all home health agency providers in the nation. Unique to other applicants in the batch, UniHealth offers a concrete, continuously improved training program that is readily available to its entire staff. The Pruitt University training program is available to all employees and provides all training required by state and federal mandates at no cost to the employee. Each UniHealth professional has all required in-service training, continuing education, and requisite training material costs paid for by UniHealth. For the proposed Brunswick UniHealth agency, in-service and continuing education will also be provided annually in person or through Pruitt University.

Table 6 -Total Compensation-Year 2

Applicant	RN	HHA
UniHealth	***$91,035***	***$41,694***
NHRMC	$90,855	$32,508
HKZ	$86,871	$37,896
Continuum	$81,950	$38,493
Maxim	$80,289	$35,171
Advanced	$80,117	$35,744
Gentiva	$67,833	$29,927

Care Management

UniHealth is also the only applicant to demonstrate that it can and will implement a comprehensive care management plan within a reasonable budget for its home health agency. UniHealth's plan includes telemonitoring, the UniGuard program, fall prevention training, Point-of Care, case management, medication management, home safety programming, health literacy/education, social networks and integrated care paths. UniHealth believes that all of these components are necessary for a comprehensive care management plan to best meet its patients' needs. Please see Section II.1.(a) and III.1.(b) of UniHealth's application for program specifics and documentation on the importance of a care management program that includes the services listed in Table 7.

Table7- Comparison of Care Management Program

Applicant	Telehealth	UniGuard Fall Prevention or similar	Case Mgmt.	Medication Mgmt.	Home Safety	Point of Care Electronic Medical Records	Health Literacy / Education	Social Networks	Care Paths
Advanced	Yes	Yes	No	Yes	Yes	No	No	No	Yes
Continuum	Yes	No	No	No	No	Yes	No	No	Yes
Gentiva	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes
HKZ	No	No	Yes	Yes	Yes	Yes	No	No	No
Maxim	No	No	No	Yes	No	No	No	Yes	No
NHRMC	No	No	Yes	Yes	No	No	No	No	No
UniHealth	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**

Access

The Basic Principals Governing the Development of the 2013 SMFP, describe access:

> *Equitable access to timely, clinically appropriate and high quality health care for all the people of North Carolina is a foundational principle for the formulation and application of the North Carolina State Medical Facilities Plan....*
>
> *The SHCC assigns highest priority to a need methodology that favors providers delivering services to a patient population representative of all payer types in need of those services in the service area.*
>
> *Access barriers of time and distance are especially critical to rural areas and small communities....*

As described in greater detail in its application, UniHealth proposes equitable access to services by payor that matches the needs of the service area population. UniHealth will have a balanced payor mix that will exceed the county average Medicaid percentage, without sacrificing service to Medicare or other beneficiaries.

CONCLUSION

It is clear that, of the projects under review, UniHealth's application best demonstrates the **2013 SMFP basic principles: Value, Quality, and Access.** While all applicants possess ability to provide care to the residents of Brunswick County, UniHealth is the only applicant that excels in all three of the aforementioned areas and is also the best alternative when considering the comparative value metrics. Further, at least two competing applications are non-conforming to the statutory CON Review Criteria and therefore offer less desirable alternatives. The application from UniHealth is competitively superior. This application:

- Provides programming for all home health services currently needed Brunswick County;
- Provides a continuously improved care management program that will make UniHealth an ideal partner for area health care providers focusing on decreasing readmissions and set a competitive benchmark for other providers;
- Increases accessibility to low income and elderly residents;
- Offers salaries that will ensure high quality, well trained direct care staff are employed;
- Demonstrates a commitment to quality and to providing appropriate levels of care, and;
- Conforms to all the statutory review criteria and special rules (10A NCAC 14C .2000);

Thank you for your time and consideration. Please do not hesitate to call me if you have any questions.

Sincerely,

Aneel Gill, MBA/MHA
Health and Financial Planning Manager
UHS-Pruitt Corporation
678-533-6699

Attachment(s)

ATTACHMENTS

UniHealth Home Health (UniHealth) Project ID # **O-10113-13**

Comments on Competing CON Proposals for a New Medicare-Certified Home Health Agency in Brunswick County

Attachment A

Application Analysis for Compliance with CON Review Criteria, and applicable home health rules 10A NCAC 14C .2000

COMPETITIVE REVIEW OF –
NHRMC HOME CARE
O-10117-13

CON REVIEW CRITERIA

OVERVIEW

NHRMC Home Care proposes to develop a new home health agency in Supply, NC, and begin delivering home health agency services on October 1, 2014. Its first year of service will be FY 2015.

This is a hospital-based agency that is a wholly owned subsidiary of Pender Memorial Hospital. The application proposes to develop the agency by shifting an existing care team from its agency in Pender County to Brunswick County.

The application is non-conforming with Criteria 1, 3, 3a, 4, 5, 6, 7, 8, 13a, 13c, 18a, and 20 for the reasons listed below.

SPECIFIC REVIEW CRITERIA

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, ambulatory surgery operating rooms, or home health offices that may be approved.***

Need Determination

On page 58 of the application, NHRMC indicates its patient origin for FY 2016, projecting 175 patients to be served from Columbus County. The applicant also proposes to serve 45 patients from Bladen County in that same year.

As displayed on page 326 of the *2013 SMFP,* in 2014, Columbus County will have no unmet need for home health services and will, instead, actually have surplus capacity to serve 58.55 *more* patients than need care. In addition, page 325 of the *2013 SMFP* displays that in 2014, Bladen County will also have no need for home health services and will also have a surplus of capacity to serve 70.92 *more* patients than need care. Moreover, Table 12B illustrates declining trends in home health use rates in Columbus County in all age groups except those under age 18, invalidating NHRMC's utilization projections in this county even further. Therefore, NHRMC's utilization projections are in direct conflict with Criterion 1 as this applicant fails to remain, "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..." as it projects to serve an astounding 220 patients in FY 2016 in counties with surplus need.

Policies

The application does not specifically address Policy GEN-3. The application refers to a discussion of Quality methods in Question II.7, non-discrimination policies in VI.3, and a table in VI.12 that indicates that 100% of duplicated patients will be Medicare payments.

Specifically, the application fails to address:

> *"plans for providing services to persons with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area."*

Furthermore, on page 264, the *2013 SMFP* indicates that the SHCC encourages home health applicants to "*provide the widest range of treatments within a given service.*" The application proposes a very narrow range of services in Section II of the application, offering not even a dietician for its proposed nutrition counseling.

This application is non-conforming to Criterion 1.

3. ***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.***

Need

On page 58, the NHRMC application presents the population to be served in FY 2016 as Bladen, Brunswick and Columbus counties but does not indicate the patient origin for FY 2015. Thus, it fails to identify the population to be served in the first project year. Page 57 of the NHRMC application shows a service area that includes Bladen, Columbus, and Brunswick Counties in North Carolina in one boundary and New Hanover County, Pender County, and Horry County, South Carolina, in another boundary. That map excludes Bald Head Island, a part of Brunswick County. Another map on page 55 of the application shows yet another set of boundaries that include Pender, Onslow and New Hanover Counties in addition to Brunswick, Columbus and Bladen Counties in NHRMC's stated "Accountable Geography." From these findings, it is apparent that the proposed population to be served by NHRMC is inconsistent.

In Section III of the NHRMC application, the applicant presents populations by age group and home health use rates by age group for Columbus, Bladen and Brunswick Counties. The application does not indicate that there is an unmet need in Columbus and Bladen Counties. Then, on page 58, in response to the request for specific documentation of the inability of existing providers to meet the identified need, the applicant cites the *2013 SMFP* identification of a need for an additional agency in Brunswick County. The application clearly ignores existing agency utilization and the *SMFP's* documentation that there is no need in either Columbus or Bladen County. In fact, the application overlooks its own documentation of no need in Bladen and Columbus County on page 412 in Exhibit 10.

On page 64, the NHRMC application shows data from the *2013 SMFP* that indicate that the sole purpose of the proposed NHRMC agency is to permit NHRMC to serve patients that it cannot presently serve with its Pender-based agency. From this, one may conclude that the applicant's need methodology is built on targeting market shares, not on need of the population to be served for the proposed services.

Finally, other than proposing generic home health agency services, the application does not demonstrate how its services will meet the needs of the population to be served.

Access

The applicant, a not-for-profit, tax exempt agency, proposes the lowest access for Medicaid patients among all applicants, 11.24 percent of visits in Year 02, according to the data on page 72. It proposes only 13.42 percent of duplicated patients will be Medicaid beneficiaries in Year 02, according to data on page 68. Because this is below the range of existing home health agencies located in Brunswick County (see UniHealth application Exhibit 56, page 929 showing a range of 15.8 to 18.05 percent), NHRMC should be non-conforming as has been the case in prior reviews; see Mecklenburg findings, December 27, 2012.

Conclusion

This application is non-conforming to Criterion 3, because it does not show need of the population to be served; nor does it demonstrate the extent to which underserved populations other than the elderly in the service area will be served.

3a. In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly to obtain needed health care.

On page 93, the application indicates:

> *Based on current plans, 2.0 FTE hires will be made in the first year of the project (office manager and receptionist/scheduler). In Year 1, agency staff will be transferred from the NHRMC Home Care Pender County agency to the NHRMC Brunswick County agency.*

Clearly, this project involves a reduction of service in the NHRMC Home Care Pender County agency. According to the *2013 SMFP,* page 326, Pender County will have a deficit of 52.95 home health agency patients served in FY 2014, if all agencies continue to serve them at their current rates of increase. Disregarding this forecast, NHRMC plans to transfer 15.4 FTEs from the NHRMC Pender agency (page 89) to the proposed agency in Brunswick County. This transfer will evidently cause a reduction of services to persons residing in Pender County. The application fails to demonstrate how the needs of the population presently served by this staff in the agency in Pender County will be met after the transfer of these services.

This application is non-conforming to Criterion 3a.

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 *2013 SMFP* indicates a need for one additional Medicare-certified home health agency in Brunswick County. Other applicants provided alternative methods of meeting the needs for the proposed project that do not involve reducing service to populations in need (Pender County) and offer the populations to be served a wider range of services. NHRMC does neither in its application.

This application is non-conforming to Criterion 4.

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.***

Operational Projections

In Exhibit 5, pages 282-3, the NHRMC application lists six positions that are required for its quality improvement program, yet the pro forma expense statement and the proposed staffing program provide no funding for these positions. The line item for ancillary support in the pro forma labeled administrative costs is also not sufficient to cover all six positions. With the budgeted amount, the average senior position would be paid only $30,900 in salary, benefits, and training in Year 02 ($185,400/6 = $30,900). This meager budget, which is already far below industry norms, would leave no allowance for the cost of billing and collections functions.

The pro forma allocations for travel on page 126 indicate that the agency has budgeted for 14 miles per patient visit. The service area maps, however, include locations that are more than 45 miles from the proposed office: Tabor City (53), Whiteville (48), Abbottsburg (62) and Chadbourn (54). The application does not explain how these communities can be reached with an allowance of only 14 miles per visit, leading one to conclude that these costs, too, have not been accounted for.

Revenue and visits also appear overstated. The forecasts of Medicare readmissions show patients readmitted in the first month of service, before a 60-day Medicare episode would have even run its course (page 63). The application does not explain how this is possible.

Financial Projections

The application includes no data processing cost, only $1,000 for a copier to serve a staff of 15.4 FTEs. The pro forma also shows no allocation of home office costs.

Start-up costs in Section IX do not show how the applicant calculated the three months of initial operating expenses.

Moreover, Section XII shows an eight-month, not a three-month, time period between acquisition of equipment and the date of Medicare certification (August 1, 2014 to April 1, 2015). The proposed new NHRMC agency will need staff to purchase equipment and to work through licensure and certification. Medicare certification will be essential for material compliance, because the application proposes that 86 percent of its admissions will be covered by Medicare (page 68). Exhibit 17, a letter from NHRMC Director, Don Thompson, commits only $50,764 to start-up and working capital for the project. The agency cannot meet licensure requirements without professional staff, and eight months of support for the office manager and receptionist listed in Table VII.2, page 89, would require $71,239, not $50,764. Clearly, start-up funds identified in Section IX are insufficient, and the applicant has committed no additional resources to cover the shortfall.

Table 1 - Cost to Support Office Manager and Receptionist for Start-up Period

	Project Year 1
Office Manager	$54,542.00
Receptionist	$31,704.00
Benefits –23.9% see page 125	$25,270.08
Annual Subtotal	$111,516.08
Prorated 8 months –(August 1,2014 to April 1, 2015)	**$71,239.20**
Start up Clinical Staff	**$++++++++**

NHRMC Home Care Pender Home Health Agency served 380 patients in 2012 (page 12). Yet, on page 58, NHRMC proposes to serve 1,108 patients in the second year of a new agency in an isolated rural area. This is close to three times the number of patients it served in 2012 in an established agency that is adjacent to an urban area. The application, however, fails to demonstrate how it would be able to serve 728 additional patients in the proposed new Brunswick County agency (1,108 – 380 = 728) with no increase in support staff (page 23).

It appears that on the NC License Renewal Application, the existing NHRMC agency has reported only direct costs and not the allocated overhead of the hospital in which it is based.[1] A full cost reporting that follows CMS rules would show much higher costs.

> *However, in the case of hospitals, which often provide services that are paid for by multiple Medicare payment systems, our measures of payments and costs for an individual sector could become distorted because of the allocation of overhead costs or complementarities of services.*
>
> *Margins for hospital-based agencies in 2011 were – 10.9 percent. The lower margins of hospital-based agencies are chiefly due to their higher costs, some of which may be due to overhead costs allocated to the HHA from its parent hospital* (MedPac report, page 33).

In any event, it would clearly be inappropriate and unfair to compare costs of this proposed agency as presented in the NHRMC application O-10117-13 to those of other applicants.

Conclusion

The application has not considered the full costs of developing a new home health agency. Hence, its financial forecasts are not based on reasonable projections of costs. The application is non-conforming with this Criterion.

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

The application indicates intent to duplicate services that NHRMC Home Care provides to Brunswick County (page 23). It also proposes to provide services in excess of services identified as needed in the *2013 SMFP* for Columbus and Bladen Counties (page 58 and Exhibit 10). Also, see discussion in Criterion 3a.

The application is non-conforming to Criterion 6.

[1]MedPac Report to the Congress: Medicare Payment Policy, March 2013 http://www.medpac.gov/documents/Mar13_entirereport.pdf, accessed May 7. 2013.

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

As discussed above, regarding Criterion (3a), the application proposes to staff the proposed project by transferring staff from an existing agency. The application does not show sufficient manpower to support both the proposed new home health agency and its existing home health agency.

Moreover, the application proposes insufficient FTEs in Year 02 in Occupational Therapy and Home Health Aides to cover the proposed visits.

Table 2 – FTEs per Visit Year 02

NHRMC	Projected Visits Project Year 2 (Section IV)	Visits per Day Project Year 2 (Section VII)	Required FTE Positions [A/B]/260	Projected FTE Positions Project Year 2	Shortfall
OT	2,042	5.50	1.43	**1.40**	**0.03**
HH Aide	1,740	5.50	1.22	**1.20**	**0.02**

The above calculations are based on 260 work days, which allows no time off. A more realistic calculation based on 240 days would put the agency even more short staffed in PT, ST, OT and Home Health Aide positions. This application proposes that all positions are employees.

The application is non-conforming to Criterion 7.

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.***

Ancillary and Support Services

On page 23, the NHRMC application states:

> *NHRMC Home Care corporate team from its Pender County agency will provide the governance, strategic leadership, control, and direction for the organization, as well as all business support services including billing, marketing, human resources, quality improvement, accounting, medical records, etc. These services are included in the "Office Support" expense line item of the pro forma financial statements in Section XIII.*

However, on page 120-1 of the application, the pro formas contain no line item for "Office Support". Further, no assumptions reference this function.

The application also makes no mention of other ancillary and support services such as laboratory, durable medical equipment, or pharmacy services. It does not show how the applicant will provide or arrange for these services for home health agency patients.

Coordination with Existing Health Care System

The application indicates that NHRMC has made no attempts to contact either of the two hospitals in Brunswick County. In fact, all of its letters of support are from providers in New Hanover County. None of the support letters specifically mention that the supporter serves patients from Brunswick County. The application demonstrates coordination with New Hanover health care system but falls short of demonstrating coordination with the Brunswick County health care system.

NHRMC describes working agreements with Brunswick providers in Section V and VI but shows no indication that it has informed these providers of NHRMC's intention to apply for this Certificate of Need.

Conclusion

The application mentions and describes ancillary and support services for administration and governance but does not budget for them. It does not explain how it will replace the care team that it removes from its existing agency. The application provides letters of support for a location in Brunswick County but fails to demonstrate connection with the health care delivery system in Brunswick County. Hence, the application fails to meet the demonstration requirements of this Criterion and is thus non-conforming.

The application is non-conforming to Criterion 8.

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

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

NHRMC served 319 patients from Brunswick County in 2011, and 380 patients in 2012 (page 12). According to NHRMC's 2013 License Renewal Application (LRA), NHRMC's proportion of service to Medicaid patients was lower than the agencies located in Brunswick County. Medicaid utilization represented only 11.4 percent of the patients served by NHRMC. See Attachment K for excerpted pages from the aforementioned LRA. The average Medicaid utilization for home health agencies located in Brunswick County, on the other hand, was 15.8 percent.

This suggests that NHRMC's existing agency fell short of meeting the needs of the medically underserved in Brunswick County and is non-conforming to this Criterion.

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

The application describes the elderly but does not describe the extent to which other underserved groups will have access to its services. It describes only policies of non-discrimination in Section VI.3. This application proposes one of the lowest levels of Medicaid access among the applicants. The application does not describe access for persons with language differences, hearing, or other impairments that require special adaptation.

The application is non-conforming to Criterion 13c.

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 the service for which competition will not have a favorable impact.***

Cost Effectiveness

The application does not include all of the costs associated with the home health agency, as noted above in the excerpt from the MedPAC report. Moreover, the applicant proposes to transfer staff from an existing and very busy agency without replacing them. The applicant fails to demonstrate how this is cost-effective.

Access

This application proposes less access for Medicaid beneficiaries than existing Brunswick County agencies, suggesting that it will shift the burden for these patients to existing agencies. The application clearly states the intent of the project is to increase market share of its existing Pender agency. It makes no mention of how it will reach underserved or un-served residents.

The application is non-conforming to Criterion 18a.

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

The application cites quality systems and policies and intent to have low staff turnover, but provides no evidence that quality care has been provided in the past.

The application is non-conforming to Criterion 20.

§ 131E-183.(B) SPECIAL HH RULES

(b) The Department is authorized to adopt rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. No such rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service.

10A NCAC 14C .2000: Criteria and Standards for Home Health Services

10A NCAC 14C .2002
INFORMATION REQUIRED OF APPLICANT

(a) An applicant shall identify:

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

Projections are unreasonable and are based on flawed assumptions. Please see discussion in Criterion (1) above.

(4) the projected number of patients to be served per service discipline for each of the first two years of operation;

Projections are unreasonable and are based on flawed assumptions. Please see discussion in Criterion (1) above.

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

10A NCAC 14C .2005
STAFFING AND STAFF TRAINING

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

As discussed in Criterion (7) above, NHRMC does not propose adequate staffing for the proposed visits in occupational therapy and home health aide. Further, NHRMC proposes to transfer staff from its Pender agency to the proposed agency.

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

As discussed in Criterion (8) above, NHRMC mentions and describes some ancillary and support services but does not budget for them.

COMPETITIVE REVIEW OF –
CONTINUUM II HOME CARE AND HOSPICE, INC.,
D/B/A CONTINUUM HOME CARE OF BRUNSWICK COUNTY,
0-10122-13

CON Review Criteria

OVERVIEW

Continuum II Home Care and Hospice, Inc. (Continuum) proposes to develop a home health agency in Supply, NC, and begin delivering home health agency services on April 1, 2014. It will be certified October 1, 2014. Thus, the project will be complete October 1, 2014 and the first project year will be FY 2015. The proposed Medicare- and Medicaid-certified home health agency would be the second location for Continuum II Home Care and Hospice in North Carolina. The other Continuum home health agency is located in Jacksonville, Onslow County, North Carolina.

This is a new freestanding home health agency that is wholly owned by Principal Long Term Care, Inc. The application proposes to develop the agency as an independent complement to a home health agency owned by the applicant in Onslow County.

The application is non-conforming with Criteria 3, 4, 5, 7, 8, 13a, 13b, 13c, and 18a for the reasons listed below.

SPECIFIC REVIEW CRITERIA

3. ***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.***

Need

The applicant identified the population to be served on page 47 as residents of Brunswick, Columbus, New Hanover and Pender Counties. On page 53, the application develops a specific quantified unmet need for home health agency services in Brunswick County through 2015, using the methodology from the 2013 State Medical Facilities Plan. The application has no such quantitative analysis for the other counties it proposes to serve. Further, patient origin pattern of existing agencies, which the application uses to justify services to the non-Brunswick counties, describes met need, not unmet need. See page 57.

This application is non-conforming to Criterion (3), because it fails to demonstrate the need that patients it proposes to serve have for the services proposed.

Access

Moreover, the application is less effective with regard to access, because it fails to demonstrate that the proposed agency will address unmet service needs that it does identify. In response to the instruction in application Section III.1.(b), to "*describe in specific terms, the unmet need that necessitated the inclusion of each of the proposed services to be offered by the home health office as set forth in the description of the scope of services in Section II.1*," the application presents results of a survey of local providers concerning home health services needed by the population to be served. A summary on page 94 indicates that pain management, nutrition counseling, and speech therapy are the most needed services in Brunswick County. In response to the need for dietary services, the applicant proposes dietary staffing in Section VII at the rate of 0.48 hours per patient in Year 01 (60 hours/year / 125 patients). However, it reduces access to only 0.14 hours (8.4 minutes) per patient in Year 02 (65 hours/year / 474 patients) (See Tables IV.1 and VII.2). The application describes no other source of this proposed service. By cutting resource availability more than three-fold for a service it documents as needed, the application fails to address the unmet need. Therefore, with a budget of 0.14 hours per patient in Year 02, it is not clear that all residents of the proposed service area will have access to nutrition counseling services.

Conclusion

Continuum's application is non-conforming to Criterion (3). The application fails to adequately demonstrate the need that its projection has for the services proposed and does not adequately demonstrate that all persons in the service area will have access to its proposed services.

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 application is non-conforming to other applicable statutory and regulatory review criteria. Therefore, the applicant did not demonstrate that the least costly or most effective alternative has been proposed. Please see discussion in Criteria (3) and (5).

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.***

Operational Projections

Continuum's operational projections are unsupported and unreliable. First, the application projects questionably fast growth between the first and second project years. The applicant projects 125 unduplicated patients during the first year and 474 unduplicated patients in the second, an increase of approximately 275 percent, projecting a rate of growth between the two years of almost twice as much as what UniHealth forecasts. Recently certified home health agencies cited by the applicant did exhibit similar growth. However, the two agencies cited are in urban Wake and Mecklenburg Counties which have tenfold more people per square mile than Brunswick, according to the US 2010 Census[1].

Brunswick:	127
Wake:	1,078
Mecklenburg:	1,755

Financial Projections

Financial pro formas over-project revenue and under-project expense.

- The applicant provides no funds to pay for interpretation services.
- Expenses for dietary staffing are reduced significantly in Year 02. Please see the discussion in Criterion (3).
- The application provides no evidence that commercial providers will pay $150 per visit. UniHealth and other applicants in this batch start with Year 01 commercial rates ranging from $31 to $105 per visit.
- Medicare revenue assumes that the Medicare episode rate will remain constant in Year 01 and Year 02. As demonstrated on page 148, Continuum fails to adjust its Medicare rate down for Medicare sequestration (2 percent annually).

[1] US Census Quick Facts Last Revised: Monday, 11-Mar-2013 14:17:15 EDT

- Moreover, the application inflates average episodes per beneficiary to drive its utilization projections. The applicant relies on an average episodic rate (1.43) that is significantly higher than the industry norms and is an outlier when compared to other applicants. On page 149, the applicant references the basis for the high rate as OCS HomeCare data from Medicare PPS 2010 Claims Data (Exhibit O). However, the rate chosen was the highest in the OCS report instead of a reasonable metric such as a calculated average. Further, the quoted 1.59 episodic rate on page 148 is for all North Carolina providers. A closer look at the OCS data actually shows lower average episode per beneficiary rates for North Carolina:
    - Annual, January 2012 through December 2012: 1.31 (Exhibit O, page 678)
    - Quarterly data further exposes the rate inflation,
        - 3rd Quarter 2012: 1.19 (Exhibit O, page 681)
        - 4th Quarter 2012: 1.20 (Exhibit O, page 676)

  The inflated rate contributes to over-projected revenue.

Conclusion

The applicant is non-conforming according to Criterion (5). The applicant's operational and financial projections are unsupported and unreliable.

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

The applicant proposes to reduce dietician service hours per day in Year 02 to only 30 percent of the Year 01 level. (0.14 hours compared to 0.48). There is no explanation for the decreased level of service. This decrease demonstrates the applicant's inability to demonstrate the necessary manpower and management personnel for the provision of services proposed.

Continuum proposes the highest average nursing visits per day among all applicants. It also proposes the second lowest nursing salaries. The lower salaries and higher job performance expectations will make it more difficult for applicant to attract highly qualified staff. Should this applicant wish to increase salaries to attract staff, other shortcomings in the financial projections, listed in Criterion 5 of this document, may give it no choice but to operate at a loss in Year 02. The high productivity reference is a national source that is weighted towards urban areas. The narrative in Section 7 of the Continuum application describes a scheduler who will make zoned staffing work. The staffing plan does not identify such a person and does not explain how in Year 01, with only one nurse, it will manage zoned staffing.

The application contains no references to availability of the staffing types it proposes in the proposed service area.

The application is under budgeted for the staff that it proposes and is non-conforming to Criterion (7).

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***

Ancillary and Support Services

The applicant states that it will provide foreign interpreter services. The applicant does not provide a copy of an executed contract or letter of intent from an interpreter service provider. The applicant, therefore, does not demonstrate an ability to make the services available. It is unclear if the applicant can provide this necessary ancillary and support service.

The applicant demonstrates that its service area includes a notable population of Hispanic/Latino residents (Section III.1.(b), page 62). The applicant states on page 66 that it will "incorporate the capability to communicate in Spanish, whether verbal or written, with these individuals" but fails to describe how this will be accomplished. Continuum does not provide foreign language interpreter services in its pro forma statement of expenses. The application does not include a plan of care to provide services to the non-English speaking patients and/or a process to recruit multi-lingual employees. The applicant fails to provide an executed copy or letter of intent from an interpreter service provider. The applicant does not demonstrate that the provider can supply the necessary ancillary and support services to a group that it specifically identifies as underserved.

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

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

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

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

The applicant does not offer sufficient programs to care for non-English speaking residents. Please see the discussion in Criterion (3). The application is non-conforming to this Criterion.

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 the service for which competition will not have a favorable impact.***

Quality

Policy GEN-3 requires that an applicant for a CON for which there is a need determination in the *SMFP* demonstrates how the project will promote safety and quality. The applicant has proposed a project with revenues of approximately $1.6 million and for its expenditures, $1.5 million in Year 02 of its budget. As part of the budget, it proposed an investment of $2,995 in a HHCAHPS survey summary (Form B, page 146) and a letter from the Alzheimer's Association offering training services (Exhibit I, page 536). There are no other budget items dedicated to quality. The applicant committed less than 0.21 percent of its budget to quality. There are no funds allocated for Alzheimer's training. Quality targets are mentioned, and the applicant provides information about quality targets but provides little or no evidence that it has succeeded in reaching and/or has a plan to reach those targets.

In Year 01, only one Registered Nurse to serve an entire county that covers 1,050 square miles. With plans for 5.3 visits per RN per day, either the agency will limit its service geography or staff will be stretched very thin to reach people in need of services. The latter is more likely. Furthermore, with the second lowest RN salaries among the applicants, the applicant will not have the resources to attract the best qualified staff, which in turn affects patient experience and patient care. Salaries are also a contributing factor in recruitment and retention of staff. Agencies with high turnover lose significant investments in staff development and staff training.

10A NCAC 14C .2000: Criteria and Standards for Home Health Services

§ 131E-183.(B) SPECIAL HH RULES

(b) The Department is authorized to adopt rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. No such rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service.

10A NCAC 14C .2002
INFORMATION REQUIRED OF APPLICANT

(a) An applicant shall identify:

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

Projections are unreasonable and are based on flawed assumptions. Please see discussion in Criterion (5) above.

(4) the projected number of patients to be served per service discipline for each of the first two years of operation;

Projections are unreasonable and are based on flawed assumptions. Please see discussion in Criterion (5) above.

(5) the projected number of visits by service discipline for each of the first two years of operation;

Continuum's proposed average nursing visits per day are unreasonable and based on flawed assumptions. Please see discussion in Criterion (7) above.

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

10A NCAC 14C .2005
STAFFING AND STAFF TRAINING

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

As discussed in Criterion (3) and (7) above, Continuum reduces dietician service hours per day from Year 01 to Year 02. There is no explanation for the decreased level of service. Further, Continuum under budgeted for the staff and productivity levels it proposes. Please see discussion in Criterion (7).

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

Continuum does not provide a letter of interest, executed contractual arrangement, or budgeted expenses for an interpreter service provider. Please see discussion in Criterion (8) above.

COMPETITIVE REVIEW OF –
TAR HEEL HEALTH SERVICES, LLC, D/B/A GENTIVA HEALTH SERVICES (GENTIVA), 0-10121-13

CON Review Criteria

OVERVIEW

Tar Heel Health Services, LLC, d/b/a Gentiva Health Services (Gentiva) proposes to develop a home health agency in Supply, NC and begin delivering home health agency services on October 1, 2014. Gentiva has 273 home health offices in 41 states, including 32 existing agencies in North Carolina. Gentiva proposes to serve 236 unduplicated patients in Project Year 1 and 391 in Project Year 2.

Per the North Carolina statute § 131E-183, the application is non-conforming with Criterion (a), specifically 3, 4, 5, 7, 8, 13c, 18a, as well as Criterion (b), the Special Rules, for the reasons listed below.

SPECIFIC REVIEW CRITERIA

3. ***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.***

Need

On page 60, Gentiva proposes to serve patients from Brunswick, New Hanover and Pender Counties, serving 188 Brunswick County clients in 2014 and 313 in 2015. Gentiva states that it will:

> *Meet the need for home health care in an efficient manner and ensure that every patient in need of such care will receive the services they require. (page 65)*

On page 59, this application indicates that the unmet need in Brunswick County, after existing agencies have grown at their historical pace, is 471 patients in 2014 and 652 in 2015. Gentiva does not propose to meet the need of "every patient in need." In fact, Gentiva proposes to leave more of Brunswick County's unmet need for home health agency services un-served than it proposes to serve. Please see the table below.

Table 1 - Residual Unmet Brunswick County Need afterGentiva

	2014	2015
Brunswick County Need, page 59	471	652
Gentiva Projected Brunswick Patients, page 60	188	313
(Unmet Need Un-Served)	(283)	(339)

Gentiva proposes to serve the fewest number of Brunswick County residents of any applicant in this batch and leaves Brunswick County need un-served, while simultaneously extending its operational capacity into other counties.

This applicant is non-conforming to this criterion, because the criterion specifically states that the applicant shall demonstrate that "all residents of the area…are likely to have access to the services proposed." The application demonstrates that 52 percent of Brunswick County residents in need in the second year will remain un-served.

Medicare is the primary payor for persons over 65. Gentiva, however, proposes the second lowest percent Medicare among the applicants. Page 38 specifically notes Brunswick County's rank as third oldest in the state but Gentiva proposes to serve fewer persons over 65 in Brunswick County than other applicants. Its low patient count and low Medicare utilization means that only 215 Brunswick persons over 65 will be served in the second year (313 projected patients* 68.7% projected Medicare utilization = 215 Brunswick patients over 65).

In contrast, Gentiva proposes that a very high proportion of its patients will be Medicaid beneficiaries (25.5 percent). However, this application provides no analysis of Medicaid need in Brunswick, New Hanover, or Pender County to demonstrate such a high proportion of service to this group. Most Medicaid beneficiaries are under 65 and have low home health agency use rates. Gentiva justified this projection based on its experience in Pender County in 2012. However, even there, in a different demographic age profile, its Medicaid utilization was 21.9 percent (page 51). The application contains no discussion to justify a new home health agency offering a larger proportion of Medicaid services than existing agencies that are located in Brunswick County. Please see further discussion in Criterion (13c).

Access

On page 41, Section III.1.(b), Gentiva states it will provide translator services and employ Language Line Solutions. However, the Pro Forma Form B of this application does not indicate funds for interpretation services. Additionally, the applicant provides no contract or correspondence with any organization that can provide interpreter services. The applicant states on the same page that LanguageLine Solutions is utilized in its existing agencies. However, based on the LanguageLine Solutions website, over-the-phone interpreting and personal interpreting are billed by the minute.[1] Gentiva does not budget any central office overhead.

Conclusion

This application is non-conforming to Criterion (3) because it neither identifies the need of the population to be served for the services it proposes, nor provide the resources for access to all of the services it proposes to offer.

[1] http://www.languageline.com/solutions/interpretation/

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.***

- Gentiva proposes the second highest average total operating cost per visit and highest average administrative operating cost per visit in Project Year 2 in the applicant pool. Thus, Gentiva should not be considered as a low cost provider. Please see the tables below.

Table 3 - Average Total Operating Cost per Visit – Project Year 2

Applicant	Average Total Operating Cost per Visit, Project Year 2
Maxim	$138.84
Gentiva	$137.14
HKZ	$132.20
Continuum	$130.44
UniHealth	$121.82
Advanced	$117.43
NHRMC	$88.68

Table 4 - Average Administrative Operating Cost per Visit – Project Year 2

Applicant	Average Administrative Operating Cost per Visit, Project Year 2
Gentiva	$59.99
Maxim	$52.58
HKZ	$42.99
Advanced	$37.99
UniHealth	$34.09
Continuum	$32.25
NHRMC	$24.69

- Among the applicants, Gentiva proposes the lowest ratio of direct care to total operating cost per visit in Project Year 2. However, the actual ratio of direct to total costs may be even lower, because this applicant has not included central office overhead in its administrative cost allocations. Further, it should be noted that Gentiva's low direct costs are a function, in large part, of its proposed low RN salaries. At $50,247 in Project Year 2, Gentiva's nurse salaries are approximately $17,000 lower than the next closest applicant's salaries. With such low salaries, this applicant will have difficulty recruiting the talent that is needed to provide effective care.

Table 5 - Average Direct Care Operating Cost per Visits as a Percent of Average Total Operating Cost per Visit – Project Year 2

Applicant	Project Year 2
Continuum*	75.27%
NHRMC	72.16%
UniHealth	72.02%
Advanced	67.65%
HKZ	67.48%
Maxim	62.13%
Gentiva	56.26%

**See cover letter for discussion of Continuum*

Table 6 - Average Direct Operating Cost per Visit – Project Year 2

Applicant	Project Year 2
Continuum*	$98.19
HKZ	$89.21
UniHealth	$87.73
Maxim	$86.26
Advanced	$79.44
Gentiva	$77.15
NHRMC	$63.99

**See cover letter for discussion of Continuum*

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.***

Operational Projections

This application under-projects operating cost.

- Gentiva's application includes no management contract and no budget for central office overhead with its parent company, Tar Heel Health Care Services, LLC. On page 101, Section X.7(b), Gentiva states that it, "does not allocate central office overhead expense or any management fees to its individual agency offices. Given the magnitude of Gentiva's operations and annual visit volume, the proposed new agency office is not expected to result in any new incremental overhead or management costs at the corporate level that would need to be allocated."

- CMS cost report rules require central office overhead allocation (See Attachment B). Hence, it would be inappropriate to compare this applicant to others without an overhead allocation.

- Gentiva's failure to include central office costs presents an incomplete picture of the cost to offer this project is unreasonable, and is contradicted by several statements throughout the document that indicate that corporate resources will be used in, "strategic planning, financial forecasting, facility planning and site selection, human resources, purchasing, and marketing," (page 16, Section II.1 (a)). On page 24, Gentiva states that its, "vast corporate resources and experience will allow it to efficiently and thoroughly implement the start-up of a new agency, including site preparation and move-in, recruitment, training, and service implementation." Also on page 24, Gentiva states that the new agency,

  > *"will benefit from its corporate infrastructure...including start up services, clinical consultation, recruitment and staff support, accounting and billing services, information technology, strategic planning, continuous quality improvement and outcomes measurement, human resources, and corporate compliance. Thus, hefty overhead and administrative costs associated with these functions can be significantly reduced and dollars that would otherwise be budgeted for these expenses can be redirected to direct patient care services."*

- The application fails to acknowledge the accounting fact that resources diverted from other agencies to share with the proposed new agency will have cost. Those costs will be associated with the new agency.

- In further verification of the cost allocation, Gentiva states the proposed agency will have access to an internal Recruitment Team that consists of over 40 recruiters (page 83), national specialists to support local clinical leaders in researching difficult cases and provide training (page 85), and a regional triage nurse (page 85). These corporate resources are clearly a cost to the parent company, one that is likely to be allocated to the proposed agency. Gentiva's application does not sufficiently explain the extent of the proposed agency's financial responsibility for the use of corporate resources or how these costs are to be covered by a new office. Thus, Gentiva's expenses are underestimated.

- Gentiva provides no detailed assumptions that would allow a reviewer to recreate or validate projected duplicated patients or visits in Project Year 1 or duplicated visits in Project Year 2 in Table IV.2. Gentiva states on page 66, that it first projected Medicare episodes of care at an average of 1.3 episodes per patient. The figures for unduplicated patients in Project Year 2 from Table IV.1 were then multiplied by 1.3 to determine the number of duplicated patients in Project Year 2 for Table IV.2. However, it is not clear how any other results in Table IV.2 were determined. Gentiva does not provide patients or visits by payor type. Gentiva states that projected patients and visits are based on the applicant's operating experience and the utilization of existing Brunswick County home health agencies. Page 66 also states that Gentiva, "spread out" projected duplicated patients by discipline. No further assumptions, calculations, or supporting evidence is given. Gentiva fails to meet the test of, "reasonable projections" listed in the statutory language of Criterion (5). This application also fails to meet the regulatory requirement in 10A NCAC 14C .2002(a) to document these assumptions and the specific methodology used to make such projections.

- The applicant's utilization projections stated in Tables IV.1 and IV.2 are unreliable. Table 7 below illustrates the issues.
    - Gentiva projects 490 and 813 unduplicated patients in Table IV.1 for Project Year 1 and 2, respectively. However, Section III.1.(b), (pages 56-60), and the patient origin in Section III.4 (page 64), show a total of 236 and 391 patients in Project Year 1 and 2, respectively.
    - Duplicated speech therapy patients in Table IV.2 decrease from 19 to 12 from Project Year 1 to 2. Gentiva provides no assumptions or further information to show why the decrease is reasonable.
    - The increase in occupational therapy, medical social work, and home health aide patients from Project Year 1 to 2 is inconsistent with the change in nursing patients for the same period. Gentiva provides no assumptions or further information to support its projections.

Table 7 - Gentiva Table IV.2 Analysis –
Projected Duplicated Patients by Service Discipline

	Nurse	PT	ST	OT	MSW	HHA
Project Year 1	236	217	19	25	2	16
Project Year 2	391	359	12	189	54	54
% Change	66%	65%	-37%	656%	2600%	238%

Source: Table IV.2

Financial Projections

The applicant's projections for utilization are unsupported and unreliable for all of the stated reasons under Operational Projections for Criterion (5), above. Consequently, costs and revenues that are based on the applicant's utilization projections are unreliable.

- On pages 20-21, Gentiva states it will utilize Telemonitor Assessment Screening and Telehealth Solutions but includes no budget for equipment or maintenance associated with the service. Though Gentiva budgeted $35,000 in movable equipment and $35,000 in furniture in Section VIII, page 91, it is not clear whether telehealth equipment is covered by this budget. Gentiva does not provide a detailed movable equipment or furniture list. Furthermore, maintenance costs are not included in the operating expenses.

- On page 96-97, Section X.1, Gentiva lists $443,815 and $474,805 in total indirect costs for Project Year 1 and 2, respectively. However, Form B on page 108, lists $445,315 and $462,305 in total indirect costs for Project Year 1 and 2, respectively. This discrepancy calls into question the validity and accuracy of the applicant's indirect costs.

- Page 99, Section X.7.(b), states that patient receivables on the applicant's projected balance sheet, found on page 106, were calculated based on 65 days in Year 1 and 57 days in Year 2. In the proforma, Gentiva provides no assumptions or further information to explain why using 65 days one year, and 57 days the next is reasonable.

- It is impossible to verify the reasonableness of the applicant's revenue projections for the following reasons:
    - Gentiva provides no per visit reimbursement for commercial patients.
    - On page 100, Section X.7.(b), Gentiva's projections do not allow for any outlier Medicare episodes. Gentiva is the only applicant that does not provide this information, and the absence of such allowance suggests that this applicant will avoid the difficult chronic disease patient.

- On page 101, Section X.7.(b), Gentiva states that travel expenses are based on the assumption of $4 per visit, which is based on $0.41 per mile paid and approximately 9.75 miles per visit. This low travel allocation per visit, along with the relatively lean staff, will make it difficult for this applicant to cover a county that encompasses 1,050 square miles.

- Gentiva underestimated costs associated with its proposed site. Exhibit H includes a realtor letter for the applicant's primary, secondary, and tertiary sites in Supply, NC. The letter states that lease rates range from $15.00-$18.00 per square foot and that there is a common area maintenance fee of $3.00 per square foot. If rent is set at $15 per square foot, Gentiva budgeted enough for the primary site only if rent and utilities are combined. However, if the applicant's primary site is not available upon approval, Gentiva will be forced to utilize its secondary or tertiary site. The rent and utilities for either project year, as represented in Form B, will not be enough to cover the rent of the secondary and tertiary sites at $15 per square foot. If rent is set at $18 per square foot, the amount budgeted for rent and utilities in either project year is not enough to cover costs associated with the site. Please see the tables below.

**Table 8 - Gentiva Site Cost Calculation –
Rent at $15 per Square Foot**

Site	Site Address	Square Feet	Rent, $15 per SF, Exhibit H	Common Area Maintenance, $3 per SF, Exhibit H	Total Cost at $15 per SF
Primary	6 Doctors Circle, Suite 1, Supply, NC 28462	2,725	$40,875	$8,175	**$49,050**
Secondary	18 Doctors Circle, Suites 2&3, Supply, NC 28462	5,067	$76,005	$15,201	**$91,206**
Tertiary	10 Doctors Circle, Suites 1&2, Supply, NC 28462	6,050	$90,750	$18,150	**$108,900**

Source: Exhibit H, Realtor Letter

**Table 9 - Gentiva Site Cost Calculation –
Rent at $18 per Square Foot**

Site	Site Address	Square Feet	Rent, $18 per SF, Exhibit H	Common Area Maintenance, $3 per SF, Exhibit H	Total Cost at $18 per SF
Primary	6 Doctors Circle, Suite 1, Supply, NC 28462	2,725	$49,050	$8,175	**$57,225**
Secondary	18 Doctors Circle, Suites 2&3, Supply, NC 28462	5,067	$91,206	$15,201	**$106,407**
Tertiary	10 Doctors Circle, Suites 1&2, Supply, NC 28462	6,050	$108,900	$18,150	**$127,050**

Source: Exhibit H, Realtor Letter

Table 10 - Gentiva Budgeted Site Expenses, Form B

Form B	Project Year 1	Project Year 2
Rent Expense	$46,116	$47,499
Utilities	$4,088	$4,210
Total	**$50,204**	**$51,709**

- Gentiva clearly underestimates space cost of all three sites. In the worst case, cost of the tertiary site would cause the project to lose money in Project Year 2. The applicant has not provided a source of income for such continued losses, and the project would not be financially feasible based on reasonable projections of costs and charges.

Table 11 - Gentiva Unbudgeted Site Cost Calculation

	Tertiary Site
Gentiva Rent/Lease Expense, Form B	$47,499.00
Gentiva Needs	$127,050.00
Unbudgeted Expense	$ (79,551.00)
Net Income	$ 42,578.00
Year 02 Net Income After Rent Adjustment	$ (36,973.00)

Conclusion

In conclusion, Gentiva has not considered the full costs of developing a new home health agency. It has not budgeted sufficient resources to support a viable new home health agency in Brunswick County. Thus, on multiple counts, this application is non-conforming to Criterion (5).

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

- Gentiva does not propose adequate staffing for the projected visits in nursing, physical therapy, speech therapy, and home health aide during Project Year 2. According to the methodology used in findings for recent home health CON applications in Wake County (J-8817-12) and Mecklenburg County (F-7223-05), inaccurate, inadequate staffing results in a finding of non-conformity. Dividing projected visits by the visits per day projected for each discipline results in the total work days required to complete visits. The resulting quotient is divided by 260 work days per year (2,080 work hours per year per FTE position / 8 hours per day = 260 work days per year). This results in the required number of FTE positions. The number of required FTE positions is then compared to the number of projected FTE positions in Section VII. Because Gentiva did not provide home health aide visits per FTE per day, UniHealth assumed 4.6 HHA visits per day given that Gentiva projected 4.6 visits per day for all other disciplines. This calculation for each discipline is illustrated in the following table.

Table 12 - Gentiva Required FTE Positions Calculation

Discipline	Projected Visits Project Year 2 (Table IV.2) (A)	Visits per Day Project Year 2 (Table VII.2) (B)	Required FTE Positions [A/B]/260	Projected FTE Positions Project Year 2 (Table VII.2)	Shortfall
Nursing	3,066	4.60	**2.56**	**2.49**	**-0.07**
Physical Therapist	3,076	4.60	**2.57**	**2.49**	**-0.08**
Speech Therapist	619	4.60	**0.52**	**0.40**	**-0.12**
Occupational Therapist	490	4.60	0.41	0.50	
Certified Nursing Assistant	397	4.60	**0.33**	**0.32**	**-0.01**
Medical Social Worker	58	4.60	0.05	0.05	

Note: In Table VII.2, Gentiva rounded FTEs to the nearest tenths place. Projected positions in column 4 above have been calculated using TableVII.2's column 1 and column 2 (part time personnel total hours per year). Even if required FTE positions are rounded to the nearest tenths place, Gentiva has under-budgeted FTEs in nursing, PT, and ST.

This applicant has under-budgeted for four positions. Moreover, this calculation makes no allowance for time off; 260 days a year is 52 weeks times 5 days. Such budgeting would be unrealistic and unachievable. The proposed low salary structure only adds to the infeasible nature of this budget.

- In Table VII.2, page 89, Gentiva proposes an average salary of $58,870 for a nurse supervisor in Project Year 2. The salary is unreasonably low, especially in comparison to proposed Project Year 2 nurse supervisor, OASIS Coordinator, and equivalent positions' salaries proposed by the other applicants. According to Exhibit S, page 384, this Gentiva nurse supervisor will handle the time-consuming task of care plan development and review of OASIS paperwork. This will make it difficult for Gentiva to compete in the recruitment and retention of qualified, trained staff. Please see the table below.

Table 13 - Nurse Supervisor FTE Salaries – Project Year 2

Applicant, Position	Average Salary for a FTE
UniHealth, Nurse Supervisor	$78,540
Maxim, Clinical Team Leader	$76,261
Continuum, Nurse Supervisor	$73,526
Continuum, Director of Professional Services	$73,526
Advanced, Nurse Supervisor	$70,000
Continuum, OASIS Coordinator	$67,172
Maxim, OASIS Coordinator	$62,294
Gentiva, Nurse Supervisor	$58,870
HKZ (No equivalent position)	N/A
NHRMC (No equivalent position)	N/A

Source: Tables VII.2

- Gentiva proposes the lowest Project Year 2 registered nurse and home health aide salaries among the applicants. This will make it difficult for Gentiva to compete in the recruitment and retention of qualified, trained staff. Please see the Tables 14 and 15 below.

Table 14 - Registered Nurse FTE Salaries – Project Year 2

Applicant	RN Salary for a FTE
UniHealth	$76,500
NHRMC	$73,329
HKZ	$70,627
Maxim	$69,215
Advanced	$67,600
Continuum	$67,172
Gentiva	$50,247

Source: Tables VII.2

Table 15 - Home Health Aide FTE Salaries – Project Year 2

Applicant	HHA Salary for a FTE
UniHealth	$35,037
Continuum	$31,552
HKZ	$30,810
Maxim	$30,320
Advanced	$30,160
NHRMC	$26,237
Gentiva	$22,168

Source: Tables VII.2

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***

Ancillary and Support Services

Gentiva does not demonstrate that it will make available or otherwise make arrangements for the provision of the necessary ancillary and support services, because the applicant does not provide copies of letters of interest, preliminary agreements, or executed contractual arrangements from a physician that is willing to serve on the agency's required advisory committee. An advisory committee is a requirement of Medicare Conditions of Participation (42 CFR 484.16).[2]

The applicant's Exhibit I includes letters of intent from local providers of infusion services, durable medical equipment, and routine medical supplies. However, the applicant fails to budget funds for these services and on page 16, the application indicates that at least infusion therapy will be part of the home health services. Gentiva also budgets no central office overhead.

Coordination with Existing Health Care System

In Exhibit L, Gentiva provides letters of support from South Carolina hospitals. This does not demonstrate coordination with the Brunswick County health care system. Moreover, the South Carolina letters do not state that Gentiva will *serve* North or South Carolina patients of their agencies, nor does Gentiva's application (see page 215).

Conclusion

This applicant has not budgeted for, or arranged for adequate resources for the proposed agency. Thus, it is non-conforming to Criterion (8).

[2] http://www.gpo.gov/fdsys/pkg/CFR-1999-title42-vol3/pdf/CFR-1999-title42-vol3-part484.pdf

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

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

Although the applicant proposes to serve Medicare and Medicaid beneficiaries and to provide service to uninsured persons, it proposes to serve a smaller proportion of Medicare than the service area age would merit, and more Medicaid than it justifies.

- Gentiva's proposed proportion of Medicare beneficiaries is below the county average. As stated on page 81, Section VI.12, the applicant projects that 68.7 percent of duplicated patients will be covered by Medicare. As noted in the UniHealth application Exhibit 56, page 929, on average, 71.2 percent of patients provided by existing Brunswick County agencies were to Medicare beneficiaries in FY 2012. Moreover, Gentiva proposes the second lowest access to Medicare in the applicant pool. Please see the table below. This proposal will not adequately serve a county with the third highest proportion of persons over 65 in the state.

Table 16 - Applicant Medicare Comparison – Project Year 2

Applicant	Duplicated Medicare Patients as % of Total Duplicated Patients
NHRMC*	85.57%
UniHealth	76.65%
Advanced	73.9%
Brunswick County Average, FY 2012	**71.2%**
Maxim	71.2%
Continuum	70.94%
Gentiva	**68.7%**
HKZ	68.4%

Source: Projected Payor Mix, Section VI.12

** In Section VI.12, page 87, NHRMC lists 100% of its duplicated patients will be Medicare patients. UniHealth calculated 85.57 percent Medicare patients based on Medicare admissions as a percent of total admissions on NHRMC application page 6, (1,275 / 1,490 = 85.57%).*

- Gentiva projects that 25.5 percent of duplicated patients will be Medicaid beneficiaries in Section VI.12, page 81. This is unreasonably high. Please see the table below. On page 74, Gentiva states its agency in Pender County in 2012, "*served 90 Medicaid patients out of a total of 411 patients served or 21.9 percent.*" The Gentiva home health agency referenced is not in Pender County but in Pink Hill, Lenoir County (HC1565). According to its License Renewal Application, this agency served 90 Medicaid patients out of 411 total patients in FY 2012. However, this fact does not provide enough support for Gentiva's proposed Medicaid percentage. In fact, on average, approximately 15.5 percent of Gentiva's eastern North Carolina home health agencies' clients were Medicaid beneficiaries. Please see Attachment I. Gentiva failed to provide any detailed utilization assumptions or a basis for its payor mix. As such, it is impossible to verify projected payor mix.

Table 17 - Applicant Medicaid Comparison – Project Year 2

Applicant	Duplicated Medicaid Patients as a % of Total Duplicated Patients
Gentiva	**25.5%**
Continuum	18.09%
HKZ	17.9%
UniHealth	17.73%
Median	**17.73%**
Maxim	17.4%
Brunswick County Average, FY 2012	**18.05%**
Advanced	15.6%
NHRMC	13.42%

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 the service for which competition will not have a favorable impact.***

Competition

With below average staffing and inadequate resources, this application will not provide beneficial aspects of competition in the area.

Cost Effectiveness

High ratios of indirect to direct costs indicate that Gentiva's front line worker will be less resourced than other applicants propose. Because home health is labor-intensive, the lack of planned resources makes this applicant's proposal not the most cost effective alternative in comparison to others, and the proposed agency will do little to enhance local competition.

Quality

In Section VI.2, Gentiva does not propose accreditation by a third party. Accrediting bodies provide the structure and oversight necessary to ensure that patients always experience the safest, highest quality health care for the best value. As such, Gentiva proposes a less effective alternative. Gentiva's proposed agency would not have a positive impact on the level of quality in the service area, thus do little to enhance local competition.

Gentiva proposes a higher proportion of skilled visits compared to existing home health agencies in Brunswick County on page 50, Section III.1.(b). Gentiva projects to provide more physical therapy, occupational therapy, speech therapy, and social work visits per patient, suggesting that its focus will be short-term rehabilitation, rather than care for chronic disease patients. The application fails to show the benefits or the need for this orientation. As demonstrated in the UniHealth application, the patient demographic in Brunswick County necessitates a focus on long-term, at home care.

Access

As discussed, Gentiva proposes the lowest access for Medicare patients.

§ 131E-183.(b) SPECIAL HH RULES

(b) The Department is authorized to adopt rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. No such rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service.

10A NCAC 14C .2000: Criteria and Standards for Home Health Services

10A NCAC 14C .2002
INFORMATION REQUIRED OF APPLICANT

(a) An applicant shall identify:

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

Gentiva does not provide detailed assumptions for its utilization. The projections are unsupported. Please see discussion in Criterion (5) above.

(4) the projected number of patients to be served per service discipline for each of the first two years of operation;

Gentiva does not provide detailed assumptions for its utilization. The projections are unsupported. Please see discussion in Criterion (5) above.

(5) the projected number of visits by service discipline for each of the first two years of operation;

Gentiva does not provide detailed assumptions for its utilization. The projections are unsupported. Please see discussion in Criterion (5) above.

(6) within each service discipline, the average number of patient visits per day that are anticipated to be performed by each staff person;

Gentiva failed to provide the average number of home health aide patient visits per day in Tables VII.1 and VII.2. Please see further discussion in Criterion (7) above.

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

Gentiva does not provide specific methodology and assumptions by which patient utilization is projected. Gentiva also does not provide detailed assumptions by which costs are projected. Please see Criterion (5) for further discussion.

10A NCAC 14C .2005
STAFFING AND STAFF TRAINING

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

As discussed in Criterion (7) above, Gentiva does not propose adequate staffing for the proposed visits in nursing, physical therapy, speech therapy and home health aide.

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

Gentiva provides no contract or correspondence with any organization that can provide interpreter services. Please see discussion in Criterion (3) above. The applicant does not provide copies of letters of interest, preliminary agreements, or executed contractual arrangements from a physician that is willing to serve on the agency's required advisory committee. Gentiva also states that it will offer infusion services, durable medical equipment, and medical supplies but failed to budget for these services. Please see discussion in Criterion (8) above. Gentiva proposed to offer infusion therapy (page 18). According to 10 NCAC 13 J.1108, a home health agency that offers infusion therapy "shall provide on-call infusion nursing services on 24-hour basis 7-days a week." The applicant provides only 1.6 RNs in Year 01 and does not describe how it has budgeted for the 24/7 on-call standard.

COMPETITIVE REVIEW OF –
ADVANCED HOME CARE, INC., D/B/A ADVANCED HOME CARE (ADVANCED), 0-10118-13

CON REVIEW CRITERIA

OVERVIEW

Advanced Home Care, Inc. (Advanced) proposes to develop a home health agency in Leland, NC, and begin delivering home health agency services on March 1, 2014. Advanced is a not-for-profit company that is owned by thirteen hospitals and health systems. Advanced also operates over 30 branch locations in Georgia, North Carolina, South Carolina, Tennessee, and Virginia. Advanced proposes to serve 316 unduplicated patients in Project Year 1 and 533 in Project Year 2.

Per the North Carolina statute § 131E-183, the application is non-conforming with Criteria (a), specifically 3, 5, 7, 8, 12, 14, and 20as well as (b), for the reasons listed below.

SPECIFIC REVIEW CRITERIA

3. 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.

Need

- Advanced does not adequately demonstrate a need for each of the proposed services described in Section II.1.(b).Section III.1.(a) instructs applicants to, "*describe, in specific terms, the unmet need that necessitated the inclusion of each of the proposed services to be offered by the home health office as set forth in the description of the scope of services in Section II.1.*"
    - Advanced proposes a home health agency that will offer all covered home health agency services, and on application pages 19 to 20 and 23 to 25, Advanced describes several "Disease Solution Programs." However, the application makes no attempt to correlate needs of the population to be served with these services to be offered.
    - The application does not indicate that the diseases to be treated are present among the population that the application proposes to serve.

- On page 48, Section III.1.(b), Advanced argues that decreasing historical and, therefore, projected home health utilization rates from 2011 to 2014 in the applicant's proposed service area indicate a need for additional home health services. This is inappropriate and incomplete. An applicant must also project patients served by existing providers and subtract the total from anticipated patients that will utilize home health services, something Advanced's application fails to address. This is important, because assumptions about existing providers affect the number of patients in need in future years.
- Advanced proposes to serve fewer Brunswick County patients than the deficit of 324.94 Medicare-certified home health agency patients projected by the *2013 SMFP*. On page 54, Advanced projects to serve only 303 patients from Brunswick in Year 02.
- More importantly, on page 45, Advanced cites the projected deficit of patients from the *2013 SMFP* in 2014 to indicate a need for additional home health services. However, Advanced fails to project a need beyond 2014. Advanced provides no independent calculation of need to support the number of patients it proposes to serve in Year 02.

Access

- The applicant's proposed access to Medicaid beneficiaries is below the county average. As stated on page 80, Section VI.12, Advanced projects 15.6 percent of duplicated patients and 12.9 percent of visits will be covered by Medicaid. As noted in UniHealth's application Exhibit 56, page 929, on average, in FY 2012, 15.8 percent of patients and 18.1 percent of visits provided by existing Brunswick County agencies were provided to Medicaid beneficiaries. Moreover, Advanced proposes the second lowest access Medicaid beneficiaries among the applicants. Please see the table below.

Table 1 - Applicant Medicaid Comparison – Project Year 2

Applicant	Duplicated Medicaid Patients as % of Total Duplicated Patients	Projected Visits as % of Total Projected Visits
Gentiva	25.5%	20.2%
Continuum	18.09%	21.77%
HKZ	17.9%	14.8%
UniHealth	17.73%	18.32%
Maxim	17.4%	17.8%
Brunswick County Average, FY 2012	**15.8%**	**18.1%**
Advanced	**15.6%**	**12.9%**
NHRMC	13.42%*	11.24%**

Source: Projected Payor Mix, Section VI.12

** In Section VI.12, page 87, NHRMC does not list any duplicated Medicaid patients in its payor mix. However, UniHealth calculated 13.42 percent Medicaid patients based on the Medicaid admissions as a percent of total admissions on NHRMC application page 68. (200 / 1,490 = 13.42%)*

*** In Section VI.12, page 87, NHRMC does not list any Medicaid visits in its payor mix. UniHealth calculated 11.24 percent Medicaid visits based on Medicaid visits as a percent of total visits on NHRMC application page 72. (2,588 / 23,031 = 11.24%)*

- On page 26, Section II.1.(b), Advanced states it contracts with a company that specializes in providing foreign language interpreter services. However, the application does not indicate funds for interpretation services. Additionally, the application provides no recruitment plan for bi-lingual staff and no contract or correspondence with any organization that can aide in interpreter services.
- Advanced provides a very limited answer to Question VI.3, page 76, which asks for a description of the availability of services to groups with limited financial access. The application indicates only that it will not discriminate on the basis of ability to pay, gender, age, disability or racial, ethnic or religious background.

Conclusion

In conclusion, the applicant did not adequately demonstrate the need that its projected patient population has for the services proposed and does not adequately demonstrate that all persons will have access to its proposed services. Thus, the application is non-conforming to Criterion (3).

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.*

Availability of Funding

- On page 102, Section X.7, the applicant's Form A, Balance Sheet, is a consolidated balance sheet that reflects the assets and liabilities of the overall operations of Advanced Home Care, Inc., including *non-home health agency operations* as well as operations outside North Carolina. The applicant failed to follow directions to provide a balance sheet for the entire proposed home health agency. Thus, the application provides an incomplete picture of the proposed agency.The missing balance sheet for the proposed agency makes it impossible to follow a funds flow for this proposed agency.

- More importantly, it is impossible to determine if cash and cash equivalents projected for Project Year 1 and 2 will be available for capital costs or initial operating expenses of the proposed agency. The applicant provided a balance sheet for its whole operations without providing any detailed assumptions about the operations of its other 30 agencies and how they will achieve the projected amounts. Absent of those details, it is impossible to determine the validity of the balance sheet. Because the application indicates a lack of awareness of cash flows in this new agency, a reader must at least suspect similar lack of awareness in operating vulnerabilities in other aspects of its agencies.
- In Section IX, the applicant shows a clear lack of awareness of the lag between start of operations and Medicare/Medicaid Certification. Page 97 notes that the initial operating period will be zero (0) months. The application proposes a new agency in Section I.7, page 11. A new agency will have a new provider number. A new provider number will involve a delay between initial license and receipt of a Medicare provider number. See Attachment J.

Operational Projections

- Advanced provides no methodology or detailed assumptions that would allow a reviewer to recreate or validate any of the projected duplicated patients or visits in Table IV.2. The applicant simply states on page 68 that projections are based on the applicant's operating experience and on local market demographics. A number of factors go into generating accurate and reliable visit projections, such as: readmission rate by payor type, visits by payor type, and visits by payor type by service discipline. Advanced provides none of these factors. UniHealth understands that applicants have several options for generating visit estimates. However, Advanced states only that a "conversion" factor was applied to determine episodes or visits per patient. It fails to provide that conversion factor or a basis for that conversation factor. Additionally, Advanced gives no basis for the distribution of duplicated patients and visits by discipline in Table IV.2. It fails to meet the test of "reasonable projections" listed in the statutory language of Criterion (5). It also fails to meet the regulatory requirement in 10A NCAC 14C .2002(a) to document these specific assumptions.
- In Section XII, page 109, Advanced does not project a date for North Carolina licensure of the proposed agency. Because Medicare and Medicaid certification is contingent on licensure, the date of certification of the proposed agency is also unreliable.

Financial Projections

- The applicant's projections for utilization are unsupported and unreliable. Please see discussion under Operational Projections for Criterion (5) above. Consequently, costs and revenues that are based on the applicant's utilization projections are unreliable.
- Advanced provides confusing statements regarding Form B. On page 102, Section X.7, the applicant states that,

  > *"a statement of revenue and expenses is not available for home health agency operations only. As the proposed Brunswick County-based home health agency will be separately licensed upon approval and start-up, the information provided in Form B reflects the projected revenues and expenses for that entity."*

- It is impossible to assess the reasonableness of the applicant's revenue for the following reasons:
  - It is impossible to validate the applicant's Medicare revenue projections, because Advanced failed to provide detailed utilization assumptions for payor mix. As such, it is impossible to verify projected Medicare patients or gross revenue.
  - Advanced provides no per visit reimbursement assumptions for Medicaid, commercial, self pay, indigent, charity or managed care patients. On page 103, the applicant simply states that visits, charge, payor mix, and deductions are based on the applicant's operating experience but gives no further assumptions, calculations or supporting evidence. Thus, the application fails the test of reasonable projections in Criterion (5). It also fails to meet the regulatory requirement in 10A NCAC 14C .2002(a), to document these assumptions and specific methodology used to make such projections.
  - As discussed under Operational Projections above, the applicant provided no detailed utilization assumptions by payor such as: readmission rate by payor type, visits by payor type, or visits by payor type by service discipline. As such, it is impossible to validate the applicant's gross or net revenue.

- The applicant's start-up and initial operating expenses are unreasonable for the following reasons:
    - On page 97, Advanced projects the initial operating period will be zero (0) months. This is unreasonable for several reasons. First, the initial operating period is the period of time from admission of the first patient until for the agency total revenues equal total expenses. The applicant shows a net loss of $68,358 in Project Year 1 of its pro formas on page 113. Second, Advanced failed to allow for the period between the date the proposed new agency is licensed and Medicare and Medicaid certification. In Section XII, page 109, Advanced schedules no date for licensure of the proposed agency before being Medicare and Medicaid certified. Nor does the schedule in Section XII allow for a comparable time and expense delay. After licensure, it will take at least a month to obtain DHSR Certification Section recommendation approval. An agency cannot even get on the Section's review schedule until it has served 10 patients.[1]Additionally, once the Certification Section recommends approval, it is another one to three months for a Medicare number to be issued. Please see Attachment J. Advanced clearly indicates by these lapses alone that it does not understand the process of opening a new home health agency and has not made allowances for sufficient resources to support the required "reasonable projections" of costs and charges required by this Criterion.
    - Advanced projects only $3,000 for inventory for start-up expenses. The applicant has a fundamentally flawed definition of the initial operating period as discussed above. For example, the start-up costs include no staffing to meet the required initial 10 visits.[2]Thus, the applicant's start-up expenses are unreliable and do not account for costs associated with start-up.
    - Advanced shows no source of working capital to cover the net loss of $68,358 in Project Year 1.
- The applicant's direct expenses are underestimated and unreliable for the following reasons:
    - The applicant under budgets for all staffing expenses. Staff salaries are not inflated for Project Year 2. The applicant provides no assumption to support why this is reasonable. Please also see Criterion (7).
    - Advanced states its Occupational Therapists will provide custom orthotic fabrication on page 21and a "pain toolbox" that includes kinesiotape, ultrasound, and e-stimulation on page 28, but fails to budget any supply costs for occupational therapy.
    - Advanced states its Physical Therapists will provide therapeutic taping and electrotherapy on page 21 as well as a "pain toolbox" on page 28, but fails to budget any supply costs for physical therapy.

[1] http://www.ncdhhs.gov/dhsr/ahc/flohh.htm
[2] Ibid

- Advanced states it will provide vital stim therapy on page 22, but fails to budget supply costs for speech therapy. Vital stim therapy equipment can cost up to $1,595 per kit, not counting the cost to continually replace electrodes. Please see Attachments D and E.
- The applicant fails to budget any supply costs for medical social work. Though Advanced budgeted $5,000 in movable equipment and $5,000 in furniture in Section VIII, it is not clear if supply costs for occupational therapy, physical therapy, speech therapy, or medical social work are covered by this budget.

- Advanced underestimated capital costs for the following reasons:
  - Advanced budgeted only $5,000 for movable equipment. This is unreasonable. This budget appears too sparse to permit the employment of 14 FTE field staff (Table VII.2, page 85), with the requisite purchase of a minimal number of computers and office supplies. Advanced has not provided a detailed movable equipment budget.
  - Advanced budgeted only $5,000 for furniture. This is unreasonable. The furniture allowance is too small to permit all field staff to be seated in the office at the same time, as well as outfit a conference room. Advanced has not provided a detailed furniture list to demonstrate that its assumption is reasonable and supported.
  - Advanced fails to provide any detailed assumptions underlying its capital costs beyond stating that the capital costs are based on the applicant's operating experience.
- On page 26, Section II.2, Advanced states it will offer home medical equipment. Although the applicant operates a home medical equipment company in Wilmington, New Hanover County, the applicant includes no budget, contract, or letter of intent for this service.
- The application details a telehealth program on page 25. Because Advanced has not provided a detailed budget of overhead expenses or of capital costs, it is not clear if the applicant has budgeted for telehealth equipment or its maintenance.
- On page 26, Section II.1.(b), the applicant lists a need for language assistance but includes no budget to support it.
- Advanced indicates that it will be accredited, but does not include funds to pay for costs associated with accreditation through the Accreditation Commission for Home Care, Inc. (ACHC). The applicant is likely to argue that the cost is covered in its management agreement. However, the applicant has not provided a management contract or detailed budget of overhead expenses. Moreover, the agency cannot apply for deemed status until licensed. According to page 109, Section XII, Advanced has not accounted for licensure of the proposed agency.
- Advanced suggests on page 101, Section X.3, that patients will have additional supply costs. Advanced provides no indication of the amount on page 101 or in the pro formas. This makes a comparison of the applicant's true cost to patients impossible.

- The applicant underestimated costs associated with the site. Exhibit 18 lists a letter of intent for the applicant's primary site in Leland, NC. On page 354, the letter of intent lists taxes and costs associated with the site that are not budgeted in the applicant's pro formas. Please see the table below.

Table 2 - Advanced Site Cost Calculation, Site 1 - Leland, NC

Item	Cost	Project Year 1 Cost	Project Year 2 Cost
Minimum rent	Months 1 - 12: $2,675 per month; Months 13 - 24: $2,755.25 per month	$32,100	$33,063
Common area payment	$470.80 per month	$5,650	$5,650
Tax payment	$144.45 per month	$1,733	$1,733
Insurance payment	$75.97 per month	$912	$912
Security deposit	$6,894.72; $3,366.22 credited to first month rent	$3,529	
Total (a)		**$43,923**	**$41,358**
Pro forma Form B, Rent (b)		$30,000	$30,000
Pro forma Form B, Utilities (c)		$6,000	$6,000
Amount not budgeted:(a) – (b+c)		**$7,923**	**$5,358**

Source: Exhibit 18, Letter of intent

Exhibit 19 lists a letter of intent for the applicant's secondary site in Supply, NC. The rent is listed as $2,000 per month for the first three years. However, there are also taxes and costs associated with the secondary site. The applicant did not budget for costs that come in addition to rent.

- Advanced fails to budget funds for a physician to sit on its required advisory committee. Please see discussion in Criterion (8).

- Advanced states that it will utilize wound images and Wound Advisor software on page 20, but fails to show that costs associated with the software have been accounted for in capital cost estimates, the pro formas or a management agreement. The applicant might argue in response that the management company has purchased the software and any agency operated by Advanced can utilize the software. However, based on a conversation with McKesson, there are fees associated with additional services needed for a new agency. Please see Attachment F. Advanced may also argue that page 102 states, "central office overhead includes shared expenses for human resources, education, authorizations, verifications, OASIS/coding review, evidence based practices, billing, strategic planning, purchasing, and facilities management." However, it is not clear if the aforementioned services fall into any of these categories. Moreover, Advanced claims the central office will provide many support functions, including a Disease Management and Practice Team (page 28), documentation analysts (page 32), a clinical recruiter (page 87), a merger specialist (page 88), a regional triage nurse who will coordinate and document the needs of patients and referral sources (page 89), and a regional customer support center (page 90). These positions are in addition to the consultant services discussed in Criterion (8). Without a detailed budget, management contract or additional assumptions, it is impossible to verify that the central office overhead will be sufficient to cover these and any other unaccounted expenses.

Conclusion

In conclusion, this application has not considered the full costs of developing a new home health agency. Thus, the applicant's operational and financial projections are unreliable and unsupported. As such, the application is non-conforming to Criterion (5).

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

The applicant does not show evidence of the availability of resources including health manpower and management personnel for the following reasons:

- The application under-budgets for nursing staff expenses in Project Year 2. Multiplying Nurse Supervisor, RN, LPN and HHA FTEs provided in Column 3 of Table VII.2, by the salaries also in Table VII.2, the applicant under budgets costs in Form B, page 111, by approximately $81,651. Please see the table below.

Table 3– Advanced Nursing Salary Calculation – Project Year 2

	FTEs per Column 3 of Table VII.2	Salaries per Column 5 of Table VII.2	Cost
Nurse Supervisor	1.50	$ 70,000	$ 105,000
RN	3.80	$ 67,600	$ 256,880
LPN	1.00	$ 46,800	$ 46,800
Home Health Aide	0.80	$ 30,160	$ 24,128
Total Calculated Cost			***$ 432,808***
Total Staff Cost in Form B			*$ 351,157*
Amount Under Budgeted			**$ 81,651**

- Advanced under-budgets for physical therapy staff expenses in Project Year 2 by approximately $1,383. Please see the table below.

Table 4– Advanced Physical Therapy Salary Calculation – Project Year 2

	FTEs per Column 3 of Table VII.2	Salaries per Column 5 of Table VII.2	Cost
Physical Therapist	2.90	$ 75,000	$ 217,500
Total Staff Cost in Form B			***$ 216,117***
Amount Under Budgeted			**$ 1,383**

- It under-budgets for occupational therapy staff expenses in Project Year 2 by approximately $15,251. Please see the table below.

Table 5– Advanced Occupational Therapy Salary Calculation – Project Year 2

	FTEs per Column 3 of Table VII.2	Salaries per Column 5 of Table VII.2	Cost
Occupational Therapist	1.00	$ 75,000	$ 75,000
Total Staff Cost in Form B			*$ 59,749*
Amount Under Budgeted			**$ 15,251**

- Advanced over-budgets for speech therapy staff expenses in Project Year 2 by $2,321 and for medical social work staff expenses by $4,327. The $6,648 over-budgeted in staffing for speech therapy and medical social work is not enough to cover the $98,285 under-budgeted in nursing, physical therapy, and occupational therapy. Please see the tables below.

Table 6– Advanced Speech Therapy Salary Calculation – Project Year 2

	FTEs per Column 3 of Table VII.2	Salaries per Column 5 of Table VII.2	Cost
Speech Therapist	0.25	$ 75,000	$ 18,750
Total Staff Cost in Form B			*$ 21,071*
Amount Over Budgeted			**$ 2,321**

Table 7 – Advanced Medical Social Work Salary Calculation – Project Year 2

	FTEs per Column 3 of Table VII.2	Salaries per Column 5 of Table VII.2	Cost
Medical Social Worker	0.25	$ 45,000	$ 11,250
Total Staff Cost in Form B			*$ 15,577*
Amount Over Budgeted			**$ 4,327**

Table 8– Advanced Net Salary Calculation – Project Year 2

	Amount Over or (Under) Budgeted
Nursing	($ 81,651)
PT	($ 1,383)
OT	($ 15,251)
ST	$ 2,321
MSW	$ 4,327
Net Amount Under Budgeted	**($ 91,637)**

- On page 113 of the pro formas, Advanced budgets $70,000 and $107,000 in Project Year 1 and 2, respectively, under Indirect Expenses for a "Patient Care Manager" position that is not listed in Tables VII.1 or VII.2. However, a job description is included in Exhibit 14. In addition, it is UniHealth's management experience that a position similar to the Patient Care Manager is necessary to handle the paperwork, quality audits, and compliance issues to operate an agency with over 500 unduplicated patients. UHS-Pruitt operates 15 Medicare-certified home health offices. While the $107,000 for a Patient Care Manager may be enough to cover the shortfalls in staffing expenses discussed above, if the reviewer assumes that this Patient Care Manager is a necessary position, then the amount is not enough to cover the $91,637 under-budgeted in staff salaries.

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

Ancillary and Support Services

Advanced does not demonstrate that it will make available or otherwise make arrangements for the provision of the necessary ancillary and support services, because the applicant does not provide copies of letters of interest, preliminary agreements, or executed contractual arrangements from a physician that is willing to serve on the agency's required advisory committee. An advisory committee is a requirement of Medicare Conditions of Participation (42 CFR 484.16).[3]

[3] http://www.gpo.gov/fdsys/pkg/CFR-1999-title42-vol3/pdf/CFR-1999-title42-vol3-part484.pdf

In Section II.1(b), page 34, the application states that it will provide consultant services including consultant respiratory therapy (also on page 23), infusion services (also on page 20), registered dietician consultations (also on page 20), pharmacist consultations (also on page 20), and wound care and incontinence care nurses (also on page 20). Though Advanced has budgeted central office overhead, the applicant does not provide a copy of contracts or letters of intent for any of these services. As such, Advanced does not demonstrate that it will make available or otherwise make arrangements for the provision of the necessary ancillary and support service. According to page 102, "central office overhead includes shared expenses for human resources, education, authorizations, verifications, OASIS/coding review, evidence based practices, billing, strategic planning, purchasing, and facilities management." However, Advanced provides no detailed budget of the central office overhead. Thus, it not clear if the allotted central office overhead will be sufficient to cover foreign language interpretation, OT, PT, ST, and MSW supply costs, telehealth, accreditation, additional site costs, a physician advisor, wound imaging software, and several corporate support roles in addition to the clinical consultant services mentioned in the application.

Coordination with Existing Health Care System

The applicant does not demonstrate that the proposed service will be coordinated with the existing health care system. Advanced's application failed to document a single letter of support, demonstrating a willingness of area healthcare providers to refer to its proposed home health agency. On page 71, Section V.2, the applicant states it already has referrals via its existing home medical equipment (HME) company in Wilmington, New Hanover County. However, these referrals are referrals to their HME company and do not demonstrate a willingness to refer patients to its proposed agency.

Conclusion

This applicant is non-conforming to this criterion. It has not budgeted adequate resources for the proposed agency.

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

In Section VIII, page 92, Advanced budgets $5,000 for a "build out contingency," but does not provide any details on what these construction costs will entail. Thus, it is impossible to determine if the cost, design, and means of construction proposed represent the most reasonable alternative.

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

On page 70, the applicant lists only its *existing* agreements with health professional training programs. However, none of these *existing* training programs are located in Brunswick, New Hanover or Pender Counties, the applicant's proposed service area. Advanced attempted to develop a relationship with only one area health professional training program, UNC-Wilmington, in Exhibit 13.However, the applicant did not demonstrate efforts to seek out relationships with any *Brunswick County* training programs. UniHealth identified at least six area health professional training programs that could be potential candidates for a training agreement. Clearly, the applicant spent no time trying to develop relationships with area health professional training programs and was trying to do the bare minimum to be deemed conforming to Criterion (14). An applicant who reached out to only one school has insufficiently demonstrated that the proposed agency will accommodate the clinical needs of health professional training programs in the area and should be found non-conforming to Criterion (14).

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

Advanced details the methods that will be used to maintain quality care in Section II.7.(a), pages 31-33. However, Advanced does not cite specific evidence that quality care has been provided in the past.

§ 131E-183.(B)SPECIAL HH RULES

(b) ***The Department is authorized to adopt rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. No such rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service. (TW question for NL to decide)***

10A NCAC 14C .2000: Criteria and Standards for Home Health Services

10A NCAC 14C .2002
INFORMATION REQUIRED OF APPLICANT

(a) ***An applicant shall identify:***

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

Advanced does not providedetailed assumptions for its utilization. The projections are unsupported. Please see discussion in Criterion (5) above.

(4) ***the projected number of patients to be served per service discipline for each of the first two years of operation;***

Advanced does not provide detailed assumptions for its utilization. The projections are unsupported. Please see discussion in Criterion (5) above.

(5) ***the projected number of visits by service discipline for each of the first two years of operation;***

Advanced does not provide detailed assumptions for its utilization. The projections are unsupported. Please see discussion in Criterion (5) above.

(7) ***theprojected average annual cost per visit for each service discipline;***

Advanced did not budget supply costs for physical therapy, occupational therapy, speech therapy, or medical social work. Thus, the applicant's projected average annual costs per visit for each service discipline are flawed. Please see further discussion in Criterion (5).

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

Advanced failed to documentany potential referrals from area healthcare providers, specific to the proposed home health agency. Please see discussion in Criterion (8) above.

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

Advanced does not provide specific methodology and assumptions by which patient utilization is projected. Advanced also does not provide detailed assumptions by which costs are projected. Please see Criterion (5) for further discussion.

The applicant failed to provide the specific methodology to support its utilization calculations for rules (3), (4), (5), and (7), thus is non-conforming to this criterion.

10A NCAC 14C .2005
STAFFING AND STAFF TRAINING

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

The applicant does not provide copies of letters of interest, preliminary agreements, or executed contractual arrangements from a physician that is willing to serve on the agency's required advisory committee. Please see discussion in Criterion (8) above.

COMPETITIVE REVIEW OF –
HKZ GROUP, INC. D/B/A HEALTHKEEPERZ OF BRUNSWICK (HKZ), O-10119-13

CON Review Criteria

OVERVIEW

HKZ Group, Inc, d/b/a HealthKeeperz Brunswick (HKZ) proposes to develop a new home health agency in Sunset Beach or Shallotte, NC, and will begin delivering home health agency services on October 1, 2014. Its first year of service will be FY 2015.

This is a freestanding agency that is a wholly owned subsidiary of HKZ Group, LLC. The application proposes to develop the agency and provide management services by agreement with HealthKeeperz, Inc.

The application is non-conforming with Criteria 1, 3, 3a, 4, 5, 6, 7, and 8 for the reasons listed below.

SPECIFIC REVIEW CRITERIA

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, ambulatory surgery operating rooms, or home health offices that may be approved.***

Need Determinations

In developing its need determination, HKZ departs from the methodology in the 2013 State Medical Facilities Plan (SMFP) and applies a statewide average use rate to Brunswick County (page 43). This enables it to forecast significantly more patients in need than would be forecast with the methodology in the *2013 SMFP*. The application fails to recognize the requirement that the *SMFP* provides a "determinative limitation."

The application references its 2013 petition to the State Health Coordinating Council (SHCC) as justification for changing the methodology. The petition did cite the low use rate in Brunswick County. However, in approving that petition, the SHCC did not adjust the Brunswick County use rate. It chose instead to round the need calculated by the SMFP methodology to the nearest whole number.

Because the application ignores the "determinative limitation," it is non-conforming to this Criterion.

3. ***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.***

<u>*Need and Population to be Served*</u>

On page 39, the application identifies the population to be served as "*residents in Brunswick and New Hanover counties. In addition, HealthKeeperz of Brunswick will serve any residents of any contiguous county ...and living within a 60-minute drive time of HealthKeeperz of Brunswick's agency.*"

The application is inconsistent. Starting on page 27, it bases need on: the adjusted need determination for Brunswick Countyin the *2013 SMFP*, the SMFP's calculated New Hanover County deficit of 186.04patients in 2014, projected population growth in Brunswick and New Hanover, and the generalized value of home care. However, the application then compares use rates for persons over 65 among North Carolina counties, noting that Brunswick rates are lower than the state average and lower than other counties selected by HKZ as comparable (page 40). Only seven of the 11 selected have populations over 65 that are close to Brunswick. One, New Hanover, is served by the same agencies that serve Brunswick.

On page 43, using a statewide use rate for persons 65 to 74, the application claims an unmet need of 536.53 patients in Brunswick County in 2014. If it were reasonable to apply a higher use rate to Brunswick County, the SHCC would have done so in development of the SMFP. It did not. The application states that a lower use rate is an indicator of unmet need, but provides no evidence other than the age of the population to demonstrate the higher need in any of the counties it proposes to serve.[1] Age of the population is one of the factors already considered in the *2013 SMFP* methodology. Thus the high percent of persons over 65 in Brunswick County is covered by the *2013 SMFP* methodology.

The application contains forecasts for Brunswick and New Hanover County, but it does not forecast the quantitative need by the remainder of this applicant's proposed service area: "*the population of other counties within 60 miles of the proposed agency.*" Hence, the application does not project need for the services proposed in its proposed service area.

The application identifies generic reasons why persons over 65 may need home health services, but does not address the needs of other age groups for the service. In fact, it focuses its need analysis only on persons over 65 (page 27).

[1]In fact, one of the comparison counties is Cumberland County, whose use rate for persons over 65 is lower than Brunswick. HealthKeeperz is the primary home health provider in Cumberland County and Cumberland is served by more agencies than Brunswick.

The application forecasts utilization in Exhibit 8. Calculations of need in the project years, in application Table 5 are inconsistent. They use, not the Region O use rates or the *2013 SMFP* methodology. Calculations mix methodologies and apply the North Carolina state average use rates to project 2014 need. The HKZ methodology forecasts forward from 2014 at the historic rate of increase in Brunswick County home health patients (Tables 2 and 7). The HKZ methodology then assumes a 13 percent market share of the deficits in Brunswick County and 25 patients a year for New Hanover County. The rationale for the 13 percent is not clear. On page 56, the application notes that the *2013 SMFP* forecast of unmet need for home health agency patients is 13 percent of the *2013 SMFP* forecast of Brunswick County home health patients. The logic falls apart because the HKZ methodology does not follow the *2013 SMFP* methodology and the application provides no other assumptions.

The service area is also inconsistent. The application lists patients to be served in only Brunswick and New Hanover Counties. However, the maps on pages 19 and 20 show other counties: Columbus, Pender, Sampson, and Bladen Counties, as well as South Carolina. With maps showing one service area and tables showing another, the application is internally inconsistent and has demonstrated neither the need of the population to be served nor access of that population to the proposed services.

Other examples of inconsistency between service and need are apparent. In Section II, page 12, the application indicates that HKZ will provide physical therapy for Industrial Injuries but shows no need for such a service.

The application describes a HealthSync Pharmacy program that reviews pharmaceuticals monthly. However, this is not a service of HKZ. Rather it is a service of HealthKeeperz, Inc. (page 9). Moreover, the free delivery is only available to patients who have eight or more medications (page 13).

Access

The application proposes to offer incontinence nursing to Medicaid patients but does not describe or quantify a need for this service by the population to be served. It cites only emails from the NCAHHC seeking interested providers "in the state" (page 77). Medicaid is the payor of last resort for persons over 65, and the Office of the Inspector General has expressed concern about duplicate billings for supplies for Medicaid patients who are covered by Medicare.[2] North Carolina was cited as a state with Medicaid payments, particularly for incontinence, that would have been eligible for Medicare coverage. The OIG has recommended further investigation of this practice. Specifically:

> Home health providers in North Carolina can insert condition codes on claims to override the need for a Medicare denial when Medicaid criteria are met (e.g., beneficiary is receiving incontinence supplies but no therapeutic or assistive services). Providers must have documentation supporting the override available upon request. This may explain how the claims in North Carolina that correctly indicated the beneficiaries' eligibility for Medicare were paid; however, we did not request data on what claims providers overrode (page 11)[3].

(Please see the full report in Attachment M.)

On page 45, the application reiterates commitment to providing care to Medicaid incontinence patients, but the application has demonstrated no need for such services. On page 46, the application indicates that the incontinence service will be done in conjunction with the HealthKeeperz HME but does not describe how that program relates to HKZ or which company will provide what.

The application describes no services for medically underserved groups with special needs like non-English language interpretation, care paths for chronic diseases like diabetes or wound care, although it lists care for diabetes as a benefit of home health agency care (pages36, 83, and 110).

On page 82, the application describes HKZ commitment and intent to serve American Indians and African Americans. The application provides no data on American Indians in the service area. A US Census Fact Finder query for Brunswick County turns up no Native Americans or American Indians in Brunswick County. The application provides no data on African Americans in the proposed service area.

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[2] Office of the Inspector General. Duplicate Medicare and Medicaid Home Health Payments: Supplies and ServicessOEI-07-06-00640, May 2008, https://oig.hhs.gov/oei/reports/oei-07-06-00640.pdf, viewed May 9, 2013.

[3] Ibid

Conclusion

The application is unclear about the population to be served, their need for services or the services it proposes to offer through the proposed new home health agency, and is thus non-conforming to Criterion (3).

3a. ***In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly to obtain needed health care.***

On page 94, the application indicates that the proposed application may utilize contract staff or "existing staff from HealthKeeperz, Inc's Cumberland, Robeson and/or Scotland agency(ies) until additional local staff can be hired."

The application does not demonstrate how this reduction of an existing service in an existing home health agency will adequately meet the needs of the population presently served if staff is relocated.

Hence, the application is non-conforming with this Criterion (3a).

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.***

This application documents efforts to connect with the health care delivery system in Brunswick County and letters of endorsement from providers in other counties that are served by other HKZ home health agencies. However, the application does not propose or document an array of services that match the needs of residents of Brunswick County or any part of its proposed service area and the application falls short on several statutory criteria. Only one CON is available and other applicants, particularly UniHealth, offer alternative services that are matched to the needs of the population it proposes to serve.

Hence, this application is non-conforming to Criterion (4).

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.***

Operational Projections

The application appears to present a robust service program. However, close examination shows that a significant part of the program will be referred to other providers.

The program description in Section II, page 12 includes a HealthSync Pharmacy management program, but this appears to be available only to patients who obtain their pharmaceuticals through HealthKeeperz pharmacy. The pro forma assumptions show no provisions for the HealthSync medication management program (pages 129 and 130). Neither the staffing chart in Section VII nor the pro forma Expense Statement in Section XIII list HealthSync Pharmacists.

The application describes respiratory care services, but a careful reading indicates that these will be provided not by HKZ of Brunswick but by HealthKeeperz, Inc. (page 13). The application does not describe how these will be coordinated.

Other referral services to be provided by HealthKeeperz include, home medical equipment, and hospice (page 13).

Although proposing to increase the number of patients by 366 from Year 01 to Year 02 (page 64), HKZ does not increase the management fee. In fact, HKZ indicates that it can add all proposed 1,598 new patients with no increase in central office staff (page 18). Mathematically, this means that management services provided to existing HKZ home health agencies will be reduced proportionately.

Financial Projections

Although the application discusses services to Veterans in Section III and VI, the pro formas show no revenue associated with VA in the cash flow on page 136 or the statement of revenue and expense on page 116.

Conclusion

Financial and operational projections are inconsistent with proposed services, and the application is non-conforming to this criterion.

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

This application shows intent to serve counties for which it does not demonstrate need and it proposes to serve more patients than the SMFP methodology calculates, without providing a clear justification for changing the methodology. Thus, to meet its proposed volumes the applicant will duplicate existing resources. The applicant does not demonstrate that such duplication is necessary.

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

The application indicates on page 95 that it will rely on CoreMedical Group in Salem, New Hampshire, to provide staffing for nursing, therapists, and medical social workers. A letter of interest is in Exhibit 12, but the letter does not indicate that CoreMedical has such staff, nor does it provide a means to verify the proposed costs of staffing that is used in the HKZ pro formas.

The same page 95 indicates intent to develop a relationship with Home Choice Partner and HealthCare Staffing, but no letters of interest are included in the application. Moreover, the proposal to obtain a nutritionist from HealthCare Staffing (page 95) is inconsistent with the claim on page 146 that nutritional support will be provided through the management contract in Exhibit 2.

For these reasons, the application appears non-conforming with Criterion (7).

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***

Ancillary and Support Services

The applicant proposes no increase in management support for this agency and projects no fees for the recruiting agency it proposes to employ to staff the proposed agency's positions.

Conclusion

The applicant has provided insufficient information to support its claims to provide ancillary and support services and is non-conforming to Criterion (8).

§ 131E-183.(B) SPECIAL HH RULES

(b) ***The Department is authorized to adopt rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. No such rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service.***

10A NCAC 14C .2000: CRITERIA AND STANDARDS FOR HOME HEALTH SERVICES

10A NCAC 14C .2002
INFORMATION REQUIRED OF APPLICANT

(a) ***An applicant shall identify:***

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

The service area proposed by HKZ is inconsistent. Maps and tables in HKZ's application show inconsistent service areas. Please see discussion in Criterion (3) above.

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

HKZ is inconsistent in the number of projected patients to be served. Further, projections are based on flawed assumptions. Please see discussion in Criterion (3) above.

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

10A NCAC 14C .2005
STAFFING AND STAFF TRAINING

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

HKZ proposes it may utilize existing staff from its Cumberland, Robeson and/or Scotland agencies. Please see discussion in Criterion (3a) above.

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

As discussed in Criterion (7), HKZ proposes to utilize CoreMedical Group but letters of support do not indicate that CoreMedical has the means to provide its services. The application also states an intent to develop a relationship with Home Choice Partner and HealthCare Staffing but no letters of interest are included in the application.

COMPETITIVE REVIEW OF –
MAXIM HEALTHCARE SERVICES, INC. (MAXIM),
0-10120-13

CON REVIEW CRITERIA

OVERVIEW

Maxim Healthcare Services, Inc. (Maxim) proposes to develop a home health agency in Shallotte, NC, and begin delivering home health agency services on January 1, 2014. It will be certified July 1, 2014. Its first year of service will be July 1, 2014 through June 30, 2015. The application does not distinguish between Medicare and Medicaid certification dates.

This is a new freestanding home health agency that is wholly owned by Maxim Healthcare Services, Inc. The application proposes to develop the agency as an independent complement to a home care agency owned by the applicant in New Hanover County. Maxim Healthcare Services, Inc is owned by Stephen Biscotti, Oak Investment Trust, and Oak Investment Trust II.

The application is non-conforming with Criteria 3, 5, 7, 8, 13b,13c, 13d,18a, and 20 for the reasons listed below.

SPECIFIC REVIEW CRITERIA

3. 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.

Need

The applicant proposes to serve only Brunswick County, and fails to demonstrate the need of the population to be served for the services proposed:

- Section II.1 and Section III.1 (a) instructs applicants to "describe in specific terms, the unmet need that **necessitated the inclusion of each of the proposed services** to be offered..." The applicant lists a variety of services it intends to provide to the Brunswick community (Section II, pages 11 – 21). The applicant fails to discuss why its proposedblend of services is needed.The applicant did not provide an independent need discussion for each of the proposed offered services.

- The applicant failed to fully complete an independent assessmentof services needed and did not in specific terms describe the unmet need that necessitated inclusion of each of services to be offered. The applicant used 2013 and 2016 NCOSBM population data to develop a compound annual population growth rate (CAGR) of 1.8 percent (Section III, page 49). The applicant then applied that CAGR to the *2013 SMFP*projection of 3,927 patients to project home health need for 2014 – 2016 (Section III, page 56). The applicant incorrectly applied the 1.8 percent CAGR broadly across allage cohorts. This is incorrect for home health, for which use rates change almost 80-fold among age groups.[1]The applicant failed to correctly project need based on age cohort. Yet, the applicant proposed age-specific services (Section II.1, pages 11-12). It clearly failed to project need for these services.

Access

The applicant does not adequately demonstrate the extent which all residents of the area, in particular, racial and ethnic minorities, women, handicapped persons, and other underserved groups are likely to have access to the services proposed.

The applicantnotes that not all service area residents will speak English. It does not include a plan of care for non-English speaking residents. The applicant fails to demonstrate how it will address adequately address language needs. The application did not include a plan of action and/or funding for interpreter services, nor did the applicant demonstrate how it plans to target bilingual staff.

Conclusion

The applicant did not demonstrate the need of the population for the services proposed, therefore, is non-conforming to Criterion (3).

[1]2013 SMFP p 26.

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.***

Availability of Funding

It is unclear if the applicant can fully fund the project. The Pro Forma Balance Sheet Form A on the unnumbered page 139 appears to be for the entire company. The order of magnitude tracks the audited financials in Exhibit 16. However, Form A has no assumptions to support its forecasts. Form A includes no liability for payments that are required as part of the civil settlement (Maxim SA) and deferred prosecution agreement (Maxim DPA). See Attachments G and H for the settlement and prosecution agreement. Exhibit 16 Audited Financials appear to predate the settlement and agreement.

The applicant fails to demonstrate that it can fund both the proposed the new agency and non-conforming to Criterion (5).

Financial Projections

The applicant's Form B under-projectscost of operations.

- Staffing costs are insufficient and incorrect. A shortfall in the amount of nursing staff needed alters salaries and benefits projections. Please see further discussion in Criterion (7). As a result, it understates the costs needed to provide the services. The applicant's statement of revenues and expenses is therefore incorrect. Net income will decrease and expenses will increase.

- The applicant's financial projections did not include costs for interpreter services. The applicant states in Section II, page 15, that it would provide language interpreter services. Costs for interpreter services are not included in the pro .

- The applicant's financial projections did not include the costs for a qualified mental health staff. The list of services included (Section II, page 15-16) requires a mental health nurse. Costs for a mental health and/or behavioral health practitioners were not included in the pro forma. Please see further discussion in Criterion (7).The application claims these will be provided by medical social workers but provides only 0.10 FTE's for this position in both years (pages 109-110).

The applicant entered a Corporate Integrity Agreement with the United States Department of Health and Human Services in 2011 (see attached Deferred Prosecution Agreement-DPA). Under the terms of the agreement, the applicant agreed to pay a $20 million criminal penalty and approximately $130 million in civil penalties (DPA, page 2) to settle claims that Maxim submitted fraudulent and false claims to state Medicaid services (Maxim Settlement Agreement – SA, page 3). Payments are scheduled out for several years, including the proposed project years. The total payment schedule can be found in Maxim SA, Exhibit B, pages 29-32. Payments are excluded from the pro forma balance sheets. With the payments included, Maxim Form A Pro Forma Balance Sheets would show insufficient cash to support the proposed project. Payment amounts through 2018 are $1,267,750 per year. After that, they increase. The initial payment was $55 million and the application does not indicate if this has been accounted for in the financials provided. Moreover, the settlement required that certain activities that generated cash for the company, including activities in North Carolina, would cease.

The applicant fails to fully document the availability of accumulated reserves or owner's equity. Section VIII.5 requires the owner to demonstrate the availability of the funds in accumulated reserves. In the carefully worded letter in Exhibit 15, the CFO does not fully verify that the reserves are there for the life of project. Availability of the funds is further suspect, because Form A does not show the regular payments of the fraud settlement Maxim SA, Exhibit B, pages 29-32).

The applicant is therefore non-conforming to Criterion (5).

Conclusion

The application is non-conforming to Criterion (5). The applicant understaffed its proposed agency. The operational projections did not include all costs, the Balance Sheet is unsupported and the source of cash for the project is not verified.

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

- The applicant's RNs are expected to conduct 5,348 visits during year 2 of the operation, averaging 5.00 visits per day and working 260 days per year (Section VII, page 111). To provide 5,348 visits, 4.11 nursing FTE's would be needed (5,348 divided by 260 and then divided by 5). The applicant projects to have 4.10 RNs in the secondprojected year of operation (Section VII, page 110). The applicant has failed to adequately project the amount of nursing staff needed. As a result, current staffing and benefits costs are understated. The applicant's operational projections are therefore unsupported and unreliable. The applicant fails to adequately staff the proposed agency with the correct number of nursing FTE's.

- The applicant fails to include an Advanced Practice Psychiatric/Mental Health Nurse or reasonable medical social worker staffing to provide the level of mental health and behavioral health services expected to be offeredon page 15 (Section II). A true psychiatric behavioral health program proposed requires an Advanced Practice Nurse and/or mental health nurse practitioner. The budget fails to include mental health nurse staffing. A staff of 0.10 MSW spread over 502 patients is minimum to provide required MSW services.

With the shortage of staffing resources to provide proposed services, the applicant is non-conforming to Criterion (7).

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

Ancillary and Support Services

The applicant states that it will provide foreign language interpreter services. The applicant fails to provide an executed copy or letter of intent from an interpreter service provider. The applicant does not demonstrate that the provider can provided the necessary ancillary and support services.

Coordination with Existing Health Care System

The application fails to discuss how it will coordinate its current services with existing providers. Section V.2 requires that the applicant document referrals from physicians that will support the proposal and/or have a willingness to refer patients to the agency for services. The applicant cites letters of support from providers (Section V, page 101) but no letters of support or referral letters are included in either exhibit. Exhibit 19 includes letters of support from providers outside of Brunswick County (New Hanover, Onslow, and Bladen counties). No letters of support are included from the service area,Brunswick County. There are letters of support from nine organizations (not referral letters). Of the letters of support only one organization (Brunswick County Schools) is located within the Brunswick service area. Two of the organizations (UNCW and Brunswick Community College) are not referral resources or letters of support, but instead letters supporting training opportunities for students. Exhibit 20 lists potential referral resources, but no letters are included. The applicant failed to provide referral letters from providers within its service area. The applicant fails to demonstrate support from other providers within the community, and fails to demonstrate how it will work with other providers to better coordinate care. The applicant also does not discuss how it will work with existing providers to coordinate care.

Conclusion

The applicant does not demonstrate that the proposed services will be coordinated within the existing health care system and fails to provide for all of its proposed ancillary services. This application is non-conforming to Criterion (8).

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

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

The applicant entered a Corporate Integrity Agreement with the United States Department of Health and Human Services in 2011 (see attached Deferred Prosecution Agreement-DPA). Under the terms of the agreement, the applicant agreed to pay a $20 million criminal penalty and approximately $130 million in civil penalties (DPA, pg 2) to settle claims that Maxim submitted fraudulent and false claims to state Medicaid services (Maxim Settlement Agreement – SA, page 3). The state of North Carolina is one of the states listed (Maxim SA, Exhibit A). The total payment schedule can be found in Maxim SA, Exhibit B, pages 29-32. The DPA also required the applicant to undertake several compliance and remedial actions: subject to monitoring by an independent agent, develop a compliance training program, launch a compliance hotline and reporting system, and continuously educate staff on compliance measures.

The applicant failed to mention this major issue or to provide information to demonstrate that it is meeting the requirements of the settlement.

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

The application is non-conforming to Criterion (13). As discussed in Criterion (3), the applicant did not offer sufficient programs for non-English speaking residents

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 the service for which competition will not have a favorable impact.***

The applicant's proposal may increase competition in Brunswick County, but it is uncertain it will have a positive impact on cost effectiveness, quality, and access to the services proposed for the following reasons:

- The applicant provides no plan or funds for care on non-English speaking patients. Please see discussion in Criterion (3).
- The applicant does not demonstrate the need for each of the proposed services described. Please see the discussion in Criterion (3).
- The applicant's projected costs are unreliable because of unreliable operations and financial projections. The applicant did not adequately staff for the projected need. Please see the discussion in Criterion (7).
- The applicant did not adequately demonstrate the availability of sufficient funds for capital and operating needs. Please see the discussion in Criterion (5).
- The applicant's high costs relative to other applicant make it a less effective choice for Brunswick County.

Total Operating Cost per Visit

Applicant	Year 2 Cost
Maxim	$138.84
Gentiva	$137.14
HKZ	$132.20
Continuum	$130.44
UniHealth	$121.82
Advanced	$117.43
NHRMC	$88.68

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

The applicant entered a Corporate Integrity Agreement with the United States Department of Health and Human Services in 2011 (Attachment A, Deferred Prosecution Agreement-DPA). Under the terms of the agreement, the applicant agreed to pay a $20 million criminal penalty and approximately $130 million in civil penalties (DPA, pg 2) to settle claims that Maxim submitted fraudulent and false claims to state Medicaid services (Maxim Settlement Agreement – SA, page 3). The total payment schedule can be found in Maxim SA, Exhibit B, pages 29-32. North Carolina is one of the states listed (Maxim SA, Exhibit A). Charges in the document include billing Medicaid from unlicensed offices. The DPA also required the applicant to undertake several compliance and remedial actions including: allow monitoring by an independent agent, develop a compliance training program, launch a compliance hotline and reporting system, and educate staff on annually compliance measures.

The applicant has failed to discuss this public issue that affects its North Carolina home health agency services; thus, is non-conforming to Criterion (20).

§ 131E-183.(b) SPECIAL HH RULES

(b) ***The Department is authorized to adopt rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. No such rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service.***

10A NCAC 14C .2000: Criteria and Standards for Home Health Services

10A NCAC 14C .2002
INFORMATION REQUIRED OF APPLICANT

(a) *An applicant shall identify:*

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

Projections are unreasonable and are based on flawed assumptions. Please see discussion in Criterion (5) above.

(4) *the projected number of patients to be served per service discipline for each of the first two years of operation;*

Projections are unreasonable and are based on flawed assumptions. Please see discussion in Criterion (5) above.

(5) *the projected number of visits by service discipline for each of the first two years of operation;*

Maxim's proposed average nursing visits per day are unreasonable and based on flawed assumptions. Please see discussion in Criterion (7) above.

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

10A NCAC 14C .2005
STAFFING AND STAFF TRAINING

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

As discussed in Criterion (3) and (7) above, Maxim reduces dietician service hours per day from Year 01 to Year 02. There is no explanation for the decreased level of service. Further, Maxim under budgeted for the staff and productivity levels it proposes. Please see discussion in Criterion (7).

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

Maxim does not provide a letter of interest, executed contractual arrangement, or budgeted expenses for an interpreter service provider. Please see discussion in Criterion (8) above.

Attachment B

CMS Central Office Overhead Form

10-Jan FORM CMS 1728-94 3290 (Cont.)

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period b(FORM APPROVED as overpayments (42 USC 1395g). OMB NO. 0938-0022

HOME HEALTH AGENCY COST REPORT PROVIDER NO.: PERIOD:
CERTIFICATION AND SETTLEMENT SUMMARY From: _____ WORKSHEET S
_____ To: _____

Intermediary Use Only:

[ ] Audited Date Received _____[ ] Initial [ ] Re-opened
[ ] Desk Re Intermediary No. _____[ ] Final

PART I - CERTIFICATION

Check [ ] Electronically filed cost report Date: _____
applicable box [ ] Manually submitted cost report Time: _____

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR DIRECTOR OF THE AGENCY

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Home Health Agency Cost Report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____(Provider name(s) and number(s)) for the cost report beginning _____and ending _____, and that to the best of my knowledge and belief, it is a true, correct and complete report prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
Officer or Director

_____
Title

_____
Date

PART II - SETTLEMENT SUMMARY

	TITLE XVIII	
	PART A	PART B
	1	2

Attachment C

Continuum Jacksonville, Medicare Compare

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Attachment D

Vital Stim Order Form

Empi

VitalStim® Therapy
FAX ORDER FORM

For your convenience, this form may be copied and re-used.

Fax to: 1-800-896-1798
Call in your order: 1-800-506-1130

Today's Date:_____

Ship to: If different than Bill to information

Customer Account Number

Customer Name

Attention

Department

Address

City State Zip

Phone

Fax

PO # Your Name

VitalStim Certification # and Name
(Must complete to process order)

Bill to:

Customer Account Name

Address

City State Zip

Phone

Fax

Accounts Payable Contact

METHOD OF PAYMENT

☐ Invoice

☐ Credit Card Accnt. # ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐ Visa ☐ MasterCard ☐ Discover ☐ Amex Card

Name (Please Print) Exp. Date

Signature Date

Credit Card Billing Address

City State Zip

Product selection

Quantity	Product number	Product description	Price each	Total
_____	5950	**VitalStim Experia kit**	$13,880	_____
_____	5900	**VitalStim portable kit, adult** Includes device, case, leads, battery, 12 pack electrodes	$1595	_____
_____	5905	**VitalStim portable kit, youth** Includes device, case, leads, battery, 12 pack electrodes	$1595	_____
_____	59000	**VitalStim adult electrodes, 12 pack**	$209	_____
_____	59042	**VitalStim adult electrodes, 30 pack**	$450	_____
_____	59043	**VitalStim adult electrodes, 50 pack**	$675	_____
_____	59044	**VitalStim adult electrodes, 100 pack**	$1300	_____
_____	59005	**VitalStim youth electrodes, 12 pack**	$209	_____
_____	59006	**VitalStim lead wires, set**	$40	_____

Thank you for choosing Empi, Inc. a DJO Global Company!

SALES TAX APPLIES WHERE REQUIRED BY LAW. IF YOU ARE TAX EXEMPT, PLEASE FAX YOUR TAX EXEMPTION CERTIFICATE ALONG WITH YOUR ORDER.

Attachment E

Vital Stim Conversation Log

PDA

C O N V E R S A T I O N L O G

DATE:	5/10/13	**TIME:** 10:45 am	**PDA Job #:**66-6021-13
CLIENT	UHS-Pruitt	**PROJECT:**Brunswick HH CON	
SUBJECT:	VitalStim Therapy Costs		**INITIATED BY:**Connie Tran
WITH:	Sarah, Ordering	**COMPANY:**VitalStim Therapy	
Phone X	**In Person**	**PHONE #:**800-506-1130	

NOTES

- According to the order form, the Experia kit is a large kit used at hospitals.
- A home health agency would likely use the VitalStim portable kit, adult.
    - The kit is all inclusive and is portable and can be used over and over.
    - The only items that must be continually replaced are the electrodes.
    - Sarah was not aware of how many electrodes are used in one visit.
- The items listed on the order form are all the items available through VitalStim.

Attachment F

McKesson Wound Advisor Conversation Log

PDA

C O N V E R S A T I O N L O G

DATE:	5/15/13	**TIME:** 2:15 pm	**PDA Job #:**66-6021-13
CLIENT	UHS-Pruitt	**PROJECT:**Brunswick HH CON	
SUBJECT:	McKesson Homecare Wound Advisor		**INITIATED BY:**Connie Tran
WITH:	Morgan Wright, Lead Generation Specialist	**COMPANY:**McKesson	
Phone X	**In Person**	**PHONE #:**1-800-800-5403 ext. 4336	

AGENDA

- McKesson Homecare Wound Advisor product information on website: http://www.mckesson.com/en_us/McKesson.com/For%2BHealthcare%2BProviders/Home%2BCare/Clinical%2BManagement/McKesson%2BHomecare%2BWound%2BAdvisor.html
- Can you tell me about your Homecare Wound Advisor product?
- What hardware is needed?
- What is the cost?
- If I start with one agency and I add a second agency, what costs will be incurred (eg, new software licenses, extra equipment)?

NOTES

- McKesson typically works with mid- to large agencies that have 18-20 clinicians in the field.
- There is no hardware needed. The Wound Advisor software is based on individual licenses. Usually, individual licenses must be purchased for each clinician.
- Add-ons can also be purchased based on the parent company's current software package. The price is dependent on the parent company's current package. However, there is a cost associated with any additional services that may be needed.

Attachment G

Maxim Settlement Agreement

SETTLEMENT AGREEMENT

I. PARTIES

This Settlement Agreement ("Agreement") is entered into among the United States of America, acting through the United States Department of Justice and on behalf of the Office of Inspector General ("HHS-OIG") of the Department of Health and Human Services ("HHS") and the United States Department of Veterans Affairs (the "VA") (collectively the "United States"); Maxim Healthcare Services, Inc., on behalf of itself and its current and former parent corporations, each of its direct and indirect subsidiaries and divisions, and brother or sister entities underneath any of the foregoing, and the predecessors, successors and assigns of any of them (collectively "Maxim") and Richard West ("Relator"), (collectively the "Parties") through their authorized representatives.

II. PREAMBLE

As a preamble to this Agreement, the Parties agree to the following:

A. Maxim Healthcare Services, Inc. is a Maryland corporation headquartered in Maryland that provides home health and nursing staffing services in the United States.

B. Maxim Healthcare Services, Inc. represents that it is contemplating a reorganization of its corporate structure, pursuant to which (i) a newly formed holding company will become the ultimate parent company of all Maxim legal entities, and (ii) Maxim and some or all of its existing subsidiaries will transfer some or all of their respective operations, assets, and liabilities to the various newly formed second and lower tier subsidiaries of such holding company.

C. Richard West is an individual resident of New Jersey. On October 8, 2004, West filed a qui tam action in the United States District Court for the District of New Jersey captioned United States ex rel. West v. Maxim Healthcare Services, Inc., No. 04-496 (D. N.J.) ("the Civil Action").

D. Contemporaneously herewith, Maxim is entering into separate settlement agreements ("Medicaid State Settlement Agreements") with the states listed in Exhibit A hereto (the "Medicaid Participating States") that will be receiving settlement funds from Maxim pursuant to Paragraph 1(c) below for the Covered Conduct described in Paragraph G below.

E. Maxim has entered into a separate Deferred Prosecution Agreement ("DPA") with the United States.

F. The United States and the Medicaid Participating States contend that Maxim Healthcare Services, Inc. caused to be submitted improper claims for payment to the Medicaid Program ("Medicaid"), 42 U.S.C. §§ 1396-1396w-5, and the VA.

G. The United States contends that it and the Medicaid Participating States have certain civil claims against Maxim, under the False Claims Act, 31 U.S.C. §§ 3729 et seq., and common law doctrines, as specified in Paragraph 4, below, for the following conduct by Maxim Healthcare Services, Inc. (hereinafter the "Covered Conduct"):

(i) during the period from October 1, 1998 to May 31, 2009, submitting or causing to be submitted false claims to state Medicaid programs and the United States Department of Veterans Affairs (the "VA"), for services not rendered;

(ii) during the period from October 1, 1998 to May 31, 2009, submitting or causing to be submitted false claims to state Medicaid programs and the VA, for services not reimbursable by

state Medicaid programs or the VA because Maxim lacked adequate documentation to support the services purported to have been performed; and

(iii) for the following offices, during the following periods, submitting or causing to be submitted false or fraudulent claims to state Medicaid programs for services not reimbursable by state Medicaid programs because the offices were unlicensed:

a. Trenton, New Jersey (January 2003 to February 2004)

b. Egg Harbor, New Jersey (July 2003 to February 2004)

c. Gainesville, Georgia (October 2007 to February 2008)

d. Brunswick, Georgia (December 2007 to February 2008)

e. Cartersville (Northwest), Georgia (December 2007 to February 2008)

f. East Houston, Texas (November 2005 to November 2006)

g. East Tampa, Florida (April 2008 to November 2008)

h. Orlando South, Florida (May 2008 to October 2008)

i. The Villages, Florida (July 2008 to October 2008)

j. Treasure Coast, Florida (June 2008 to October 2008)

k. New London, Connecticut (January 2009 to June 2009)

l. Stamford, Connecticut (June 2007 to June 2009)

m. Middletown, Connecticut (March 2009 to June 2009)

H. The United States contends also that it has certain administrative claims, as specified in Paragraph 5, below, against Maxim for engaging in the Covered Conduct.

I. The United States and the Relator have reached an agreement with respect to the Relator's claim of entitlement under 31 U.S.C. § 3730(d) to a share of the proceeds of this Agreement.

J. The Relator and Maxim have reached an agreement with respect to the Relator's claim of entitlement under 31 U.S.C. § 3730(d) to attorney's fees and costs.

K. This Agreement is neither an admission of liability by Maxim nor a concession by the United States that its claims are not well-founded.

L. To avoid the delay, uncertainty, inconvenience, and expense of protracted litigation of the above claims, the Parties mutually desire to reach a full and final settlement pursuant to the Terms and Conditions below.

III. TERMS AND CONDITIONS

NOW THEREFORE, in consideration of the mutual promises, covenants, and obligations set forth below, and for good and valuable consideration as stated herein, the Parties agree as follows:

1. Maxim agrees to pay to the United States and the Medicaid Participating States, collectively, the sum of $121,511,694.08, plus any interest that may have accrued between June 24, 2010 and the Effective Date of this Agreement at a rate of 1.25% per annum ("Settlement Amount"). On the Effective Date of this Agreement, as defined in Paragraph 30 herein, this sum shall constitute a debt due and immediately owing to the United States and the Medicaid Participating States. Maxim shall discharge its debt to the United States and the Medicaid Participating States under the following terms and conditions:

a. Maxim shall pay to the United States the principal sum of $65,554,484.45 plus interest accrued thereon between June 24, 2010 and the Effective Date of this Agreement, at the rate of 1.25 % per annum (the "Federal Settlement Amount"), in accordance with the payment schedule attached hereto as Exhibit B ("Payment Schedule"). Within 10 days after the Effective Date of this Agreement, Maxim shall pay to the United States the initial fixed payment in the amount of $26,942,476.46, plus any interest that may have accrued on the Federal Settlement Amount between June 24, 2010 and the Effective Date of this Agreement ("Initial Payment"), and shall thereafter make principal payments with interest at the rate of 1.25% per annum according to the Payment Schedule.

b. All payments set forth in this Paragraph 1(a) shall be made to the United States by electronic funds transfer pursuant to written instructions provided by the Office of the United States Attorney for the District of New Jersey. The entire principal balance of the Federal Settlement Amount or any portion thereof, plus any interest accrued on the principal as of the date of any prepayment, may be prepaid without penalty.

c. Maxim shall pay to the Medicaid Participating States the principal sum of $55,957,209.63, plus interest accrued thereon between June 24, 2010 and the Effective Date of this Agreement, at the rate of 1.25 % per annum ("Medicaid State Settlement Amount"), in accordance with the Payment Schedule. Within 10 days after the Effective Date of this Agreement, Maxim shall set aside into an interest bearing money market or bank account held in the name of Maxim, but segregated from other Maxim accounts, $23,057,523.54, plus any interest that may have accrued on the Medicaid State Settlement Amount between June 24, 2010 and the Effective Date of this Agreement, as agreed upon between Maxim and the

National Association of Medicaid Fraud Control Units Settlement Team ("NAMFCU Team"), and upon receipt of written payment instructions from the NAMFCU Team, shall pay the Medicaid State Settlement Amount (or portion thereof) as directed by each settling Medicaid Participating State. Maxim shall thereafter make fixed pro rata payments according to the schedule in Exhibit B and as directed by each settling Medicaid Participating State. The entire principal balance of the Medicaid State Settlement Amount or any portion thereof, plus any interest accrued on the principal as of the date of any prepayment, may be prepaid without penalty.

d. Maxim shall pay attorneys' fees to the Relator's attorneys in the amount of $128,046.68 (one hundred twenty eight thousand forty six dollars and sixty eight cents) consisting of $113,846.68 (one hundred thirteen thousand eight hundred forty six dollars and sixty eight cents) to Robin Page West and $14,200.00 (fourteen thousand two hundred dollars) to Herbert Posner. Maxim shall make payment of this amount by electronic funds transfer pursuant to written instructions from Relator's counsel, Robin Page West, on the same date as the Initial Payment referred to in Paragraph 1(a) above.

e. In the event of either (i) a Change in Ownership of Maxim or (ii) a sale of all or substantially all of the assets of Maxim before Maxim has made all payments due under this Settlement Agreement, all remaining payments due in the Payment Schedule shall be immediately due and payable. Specifically, Maxim shall pay the entire principal owed on the Settlement Amount, plus any interest that may have accrued on the remaining principal. Notwithstanding the foregoing, the United States acknowledges that the contemplated reorganization of the corporate structure of Maxim Healthcare Services, Inc. set forth above in

Paragraph B shall not trigger an acceleration event under this Paragraph 1(e) as long as the ownership of the ultimate parent company of the Maxim legal entities described in Paragraph B.i above remains the same as the ownership of Maxim Healthcare Services, Inc. as of January 1, 2011, as set forth in the April 28, 2011 letter from Laura Laemmle-Weidenfeld to Joyce R. Branda. For purposes of this Paragraph 1(e), "Change in Ownership" otherwise means the occurrence of any transaction or series of transactions involving the sale, transfer or exchange of equity ownership interests that changes by more than two percent the ownership or beneficial ownership of Maxim from the ownership or beneficial ownership of Maxim Healthcare Services, Inc. on January 1, 2011, as set forth in the April 28, 2011 letter; provided, however, that no transfer of ownership or beneficial ownership permitted by Paragraph 1(f)(ii) because of resignation or termination of employment shall constitute a Change of Ownership or trigger an acceleration event under this Paragraph 1(e).

f. In no event will Maxim pay, or cause to be paid by any affiliate or other entity, to Maxim's stockholders any: dividends, distributions, salary, rent, interest, loans, remuneration, compensation, or any payments of any kind until Maxim has paid in full to the United States and the Medicaid Participating States the Settlement Amount, plus any interest owing on the Settlement Amount based on the Payment Schedule as of the time the Settlement Amount is paid in full.

i. Nothing in this Paragraph 1(f) shall prevent Maxim from making tax distributions to its stockholders for actual income tax liability on Maxim's earnings, including making periodic estimated payments related to their projected tax liability as required by federal or state law, as long as Maxim is treated as a pass-through or disregarded entity for

federal and/or state income tax purposes. However, until such time as Maxim pays in full the Settlement Amount, plus any interest owing on the Settlement Amount based on the Payment Schedule as of the time the Settlement Amount is paid in full, Maxim shall submit to the United States a copy of its complete federal tax returns as filed, including all schedules and attachments within fifteen days after filing with the Internal Revenue Service.

ii. Nothing in this Paragraph 1(f) shall prevent Maxim from repurchasing shares of common stock from, or making payments with respect to incentive compensation arrangements to, a Maxim stockholder to the extent required under the terms of the specific incentive stock option agreements and incentive compensation arrangements provided to the United States by letter from Laura Laemmle-Weidenfeld to Joyce R. Branda of April 28, 2011.

iii. Nothing in this Paragraph 1(f) shall prevent Maxim or its agents from paying reasonable remuneration to any Maxim stockholder for the fair market value of services rendered to Maxim or its agents, provided that any such remuneration must be reported to the United States together with a description of the services rendered and an explanation for why such remuneration constitutes fair market value, on each anniversary of the Effective Date of this Agreement until such time as Maxim pays in full the Settlement Amount.

iv. Any reports or submissions to the United States required by this Paragraph 1(f) shall be sent to Joyce R. Branda, Director, Commercial Litigation Branch, Civil Division, United States Department of Justice, P.O. Box 261, Ben Franklin Station, Washington DC, 20044 and marked "Pursuant to Maxim-United States settlement, DJ 46-48-2086."

2. In the event that Maxim fails to remit the amount due to the United States in accordance with the Payment Schedule, within five (5) days after the date indicated in the Payment Schedule, Maxim shall be in Default of its payment obligations (hereinafter "Default"). In the event of Default, the United States will provide written notice of the Default ("Notice of Default"), and Maxim shall have an opportunity to cure such Default within thirty (30) days from the date of receipt of the Notice of Default ("Cure Period"). Notice of Default will be delivered to Laura Laemmle-Weidenfeld, Patton Boggs LLP, 2550 M Street, NW, Washington, DC 20037, and concurrently to Toni-Jean Lisa, General Counsel, Maxim Healthcare Services, Inc., 7227 Lee DeForest Drive, Columbia, MD 21046, or to such other representative as Maxim shall designate in advance in writing. If Maxim fails to cure the Default within the Cure Period (hereinafter "Failure to Cure Default"), the remaining unpaid balance of the Federal Settlement Amount, less any payments already made, shall become immediately due and payable, and interest shall accrue at the Medicare interest rate (per 42 C.F.R. part 405.378) as of the date of Default until payment in full of the Federal Settlement Amount plus any interest owing as of the date of payment pursuant to the Payment Schedule. Furthermore, in the event of a Failure to Cure Default, the United States may at its option: 1) rescind its releases; 2) offset the remaining unpaid balance from any amounts due and owing to Maxim by any department, agency, or agent of the United States, including any state Medicaid program, at the time of the Default; and/or 3) reinstitute an action or actions against Maxim in this Court. Maxim agrees not to contest any offset imposed and not to contest any collection action undertaken by the United States or any state Medicaid program pursuant to this Paragraph, either administratively or in any state or federal court. Maxim shall pay the United

States all reasonable costs of collection and enforcement under this Paragraph, including attorney's fees and expenses (collection costs). In the event the United States reinstitutes this action under this Paragraph, Maxim expressly agrees not to plead, argue, or otherwise raise any defenses under the theories of statute of limitations, laches, estoppel, or similar theories, to any such civil or administrative claims, actions, or proceedings, which: (a) are brought by the United States within one hundred-twenty (120) calendar days of receipt of Notice of Default, and (b) relate to the Covered Conduct, except to the extent such defenses were available on October 8, 2004.

3. In the event of Failure to Cure Default, HHS-OIG may, at its sole discretion, exclude Maxim from participating in all Federal health care programs until Maxim pays the Federal Settlement Amount, any interest owing as of the date of payment pursuant to the Payment Schedule, and collection costs as set forth in Paragraphs 1 and 2 above in the case of Failure to Cure Default (hereinafter "Exclusion for Default "). Exclusion for Default shall have national effect and shall also apply to all other federal procurement and non-procurement programs. Federal health care programs shall not pay anyone for items or services, including administrative and management services, furnished, ordered, or prescribed by Maxim in any capacity while Maxim is excluded. This payment prohibition applies to Maxim and all other individuals and entities (including, for example, anyone who employs or contracts with Maxim, and any hospital or other provider where Maxim provide services). Exclusion for Default applies regardless of who submits the claim or other request for payment. Maxim shall not submit or cause to be submitted to any Federal health care program any claim or request for payment for items or services, including administrative and management services, furnished,

ordered, or prescribed by Maxim during the Exclusion for Default. Violation of the conditions of the Exclusion for Default may result in criminal prosecution, the imposition of civil monetary penalties and assessments, and an additional period of Exclusion for Default. Maxim further agrees to hold the Federal health care programs, and all federal beneficiaries and/or sponsors, harmless from any financial responsibility for items or services furnished, ordered, or prescribed to such beneficiaries or sponsors after the effective date of the Exclusion for Default. HHS-OIG shall provide written notice of any such exclusion to Maxim. Maxim waives any further notice of the Exclusion for Default under 42 U.S.C. § 1320a-7(b)(7), and agrees not to contest such Exclusion for Default either administratively or in any state or federal court. Reinstatement to program participation is not automatic. If at the end of the period of Exclusion for Default Maxim wishes to apply for reinstatement, Maxim must submit a written request for reinstatement to OIG-HHS in accordance with the provisions of 42 C.F.R. §§ 1001.3001-.3005. Maxim will not be reinstated unless and until the HHS-OIG approves such request for reinstatement.

4. Subject to the exceptions specified in Paragraph 6, below, conditioned upon Maxim's full payment of the Settlement Amount, and subject to Paragraph 21, below (concerning bankruptcy proceedings commenced within 91 days of the Effective Date of this Agreement or any payment made under this Agreement), the United States (on behalf of itself, its officers, agents, agencies, and departments) agrees to release Maxim together with its affiliates and the predecessors, successors and assigns of any of them from any civil or administrative monetary claim the United States has or may have for the Covered Conduct under the False Claims Act, 31 U.S.C. §§ 3729-3733; the Civil Monetary Penalties Law, 42

U.S.C. § 1320a-7a; the Program Fraud Civil Remedies Act, 31 U.S.C. §§ 3801-3812; or the common law theories of payment by mistake, unjust enrichment, disgorgement, recoupment and fraud. No individuals are released by this Agreement.

5. In consideration of the obligations of Maxim set forth in this Agreement and in the Corporate Integrity Agreement ("CIA") entered into between HHS-OIG and Maxim, and conditioned upon Maxim's full payment of the Settlement Amount, and subject to Paragraph 21, below (concerning bankruptcy proceedings commenced within 91 days of the Effective Date of this Agreement or any payment made under this Agreement), the HHS-OIG agrees to release and refrain from instituting, directing, or maintaining any administrative claim or action seeking exclusion from Medicare, Medicaid, and other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) against Maxim under 42 U.S.C. § 1320a-7a (Civil Monetary Penalties Law) or 42 U.S.C. § 1320a-7(b)(7) (permissive exclusion for fraud, kickbacks, and other prohibited activities) for the Covered Conduct, except as reserved in Paragraph 6, below, and as reserved in this Paragraph. The HHS-OIG expressly reserves all rights to comply with any statutory obligations to exclude Maxim from Medicare, Medicaid, or other Federal health care programs under 42 U.S.C. § 1320a-7(a) (mandatory exclusion) based upon the Covered Conduct. Nothing in this Paragraph precludes the HHS-OIG from taking action against entities or persons, or for conduct and practices, for which claims have been reserved in Paragraph 6, below.

6. Notwithstanding any term of this Agreement, specifically reserved and excluded from the scope and terms of this Agreement as to any entity or person (including Maxim and Relator) are the following:

a. Any claims for the conduct alleged in UNDER SEAL v. UNDER SEAL, No. 10-362 (D. UT);

b. Any civil, criminal, or administrative liability arising under Title 26, U.S. Code (Internal Revenue Code);

c. Any criminal liability;

d. Except as explicitly stated in this Agreement, any administrative liability, including mandatory exclusion from Federal health care programs;

e. Any liability to the United States (or its agencies) for any conduct other than the Covered Conduct;

f. Any liability based upon such obligations as are created by this Agreement;

g. Any liability for personal injury or property damage or for other consequential damages arising from the Covered Conduct;

h. Any liability of individuals, including officers, directors, and employees; and

i. Any liability for express or implied warranty claims or other claims for defective or deficient products or services, including quality of goods and services.

7. Maxim waives and shall not assert any defenses Maxim may have to any criminal prosecution or administrative action relating to the Covered Conduct, which defenses may be based in whole or in part on a contention that, under the Double Jeopardy Clause in the Fifth Amendment of the Constitution, or under the Excessive Fines Clause in the Eighth Amendment of the Constitution, this Agreement bars a remedy sought in such criminal

prosecution or administrative action. Nothing in this Paragraph or any other provision of this Agreement constitutes an agreement by the United States concerning the characterization of the Settlement Amount for purposes of the Internal Revenue laws, Title 26 of the United States Code.

8. Maxim, together with its affiliates and the predecessors, successors and assigns of any of them, fully and finally releases the United States, its agencies, employees, servants, and agents from any claims (including attorney's fees, costs, and expenses of every kind and however denominated) that Maxim or its affiliates, and the successors and assigns of any of them, has asserted, could have asserted, or may assert in the future against the United States, its agencies, employees, servants, and agents, related to the Covered Conduct or the Civil Action and the United States' investigation and prosecution thereof.

9. Relator and his heirs, successors, attorneys, agents and assigns agree not to object to this Agreement and agree and confirm that settlement of this Civil Action and the Payment Schedule are fair, adequate and reasonable under all the circumstances, agree not to challenge this Agreement pursuant to 31 U.S.C. § 3730(c)(2)(B), and expressly waive the opportunity for a hearing on any objection to this Agreement pursuant to 31 U.S.C. § 3730(c)(2)(B).

10. Contingent upon the United States receiving the Federal Settlement Amount and any interest due and owing on that Federal Settlement Amount from Maxim, and as soon as feasible after receipt of each payment from Maxim, the United States agrees to pay the Relator, pursuant to the Payment Schedule, $10,085,561.49, plus any interest paid by

Maxim on that amount, as the Relator's share of the proceeds pursuant to 31 U.S.C. § 3730(d) (the "Relator Share").

11. Conditioned upon his receipt of the Relator Share, the Relator, individually, and for his heirs, successors, agents and assigns, fully and finally releases, waives, and forever discharges the United States, its agencies (including but not limited to, the HHS-OIG), employees, servants, and agents from any claims arising from or relating to 31 U.S.C. § 3730; from any claims arising from the filing of the Civil Action; and from any other claims for a share of the Federal Settlement Amount; and in full settlement of any claims Relator may have under this Agreement. This Agreement does not resolve or in any manner affect any claims the United States has or may have against the Relator arising under Title 26, U.S. Code (Internal Revenue Code), or any claims arising under this Agreement.

12.a. In consideration of the obligations of Maxim in this Agreement, Relator, for himself and for his heirs, successors, attorneys, agents, and assigns, fully and finally releases Maxim and its attorneys and agents, and each of them, from any liability, claims, demands, actions, or causes of action whatsoever existing as of the Effective Date of this Agreement, whether known or unknown, fixed or contingent, in law or in equity, in contract or tort, of any kind or character, for damages, statutory penalties, equitable relief or otherwise, including attorneys' fees, costs, and expenses of every kind and however denominated, that Relator would have standing to bring against them, or any of them.

b. In consideration of the obligations of Relator in this Agreement, Maxim agrees to release Relator, his heirs, successors, attorneys, agents, and assigns, and each of them, from any liability, claims, demands, actions, or causes of action whatsoever existing as of the

Effective Date of this Agreement, whether known or unknown, fixed or contingent, in law or in equity, in contract or tort, of any kind or character, for damages, statutory penalties, equitable relief or otherwise, including attorneys' fees, costs, and expenses of every kind and however denominated, that Maxim would have standing to bring against them, or any of them.

13. Maxim has provided sworn financial disclosure statements (Financial Statements) to the United States and the United States has relied on the accuracy and completeness of those Financial Statements in reaching this Agreement. Maxim warrants that the Financial Statements are complete, accurate, and current. If the United States learns of asset(s) in which Maxim had an interest at the time of this Agreement that were not disclosed in the Financial Statements, or if the United States learns of any misrepresentation by Maxim on, or in connection with, the Financial Statements, and if such nondisclosure or misrepresentation changes the estimated net worth set forth in the Financial Statements by $2,500,000 or more, the United States may at its option: (a) rescind this Agreement and reinstate suit based on the Covered Conduct or (b) let the Agreement stand and collect the full Federal Settlement Amount and any interest due and owing as of the date of payment plus one hundred percent (100%) of the value of the net worth of Maxim previously undisclosed. The United States agrees to provide written notice to Maxim, and to provide 20 days for Maxim to respond to the United States, before undertaking a collection action pursuant to this Paragraph. Maxim agrees not to contest any collection action undertaken by the United States pursuant to this provision, and immediately to pay the United States all reasonable costs incurred in such an action, including attorney's fees and expenses.

14. In the event that the United States, pursuant to Paragraph 13 (concerning disclosure of assets), above, opts to rescind this Agreement, Maxim agrees not to plead, argue, or otherwise raise any defenses under the theories of statute of limitations, laches, estoppel, or similar theories, to any civil or administrative claims that (a) are filed by the United States within 120 calendar days of written notification to Maxim that this Agreement has been rescinded, and (b) relate to the Covered Conduct, except to the extent these defenses were available on October 8, 2004.

15. After this Agreement is executed and the Initial Payment is paid by Maxim to the United States and the Relator's attorney fees are paid to Relator's counsel in accordance with Paragraph 1 of this Agreement, the United States will file a Notice of Intervention and the Parties will file a stipulation in the Civil Action requesting that, pursuant to and consistent with the terms of this Agreement, the Civil Action be dismissed with prejudice to the Relator as to all claims, with prejudice to the United States as to the Covered Conduct, and without prejudice to the United States as to any other claims asserted.

16. The Settlement Amount shall not be decreased as a result of the denial of claims for payment now being withheld from payment by any Medicare carrier or intermediary or any state payer, related to the Covered Conduct; and, if applicable, Maxim agrees not to resubmit to any Medicare carrier or intermediary or any state payer any previously denied claims related to the Covered Conduct, and agrees not to appeal any such denials of claims.

17. Maxim agrees to the following:

a. Unallowable Costs Defined: That all costs (as defined in the Federal Acquisition Regulation, 48 C.F.R. § 31.205-47; and in Titles XVIII and XIX of the Social Security Act, 42 U.S.C. §§ 1395-1395kkk-1 and 1396-1396w-5; and the regulations and official program directives promulgated thereunder) incurred by or on behalf of Maxim, its current and former parent corporations; its direct and indirect subsidiaries; its brother or sister corporations; its divisions; its current or former owners, officers, directors, employees, shareholders, and agents in connection with the following shall be "Unallowable Costs" on government contracts and under the Medicare Program, Medicaid Program, TRICARE Program, and Federal Employees Health Benefits Program (FEHBP):

(1) the matters covered by this Agreement, the Medicaid State Settlement Agreement, the DPA, and any related plea agreements;

(2) the United States' audit(s) and civil and any criminal investigation(s) of the matters covered by this Agreement;

(3) Maxim's investigation, defense, and corrective actions undertaken in response to the United States' audit(s) and civil and any criminal investigation(s) in connection with the matters covered by this Agreement (including attorney's fees);

(4) the negotiation and performance of this Agreement, the Medicaid State Settlement Agreement, the DPA, and any related plea agreements;

(5) the payment Maxim makes to the United States or any State pursuant to this Agreement, the Medicaid State Settlement Agreement or the DPA and any payments that Maxim may make to the Relator, including any costs and attorneys fees; and

(6) the negotiation of, and obligations undertaken pursuant to the CIA to:

(i) retain an independent review organization to perform annual reviews as described in Section III of the CIA; and

(ii) prepare and submit reports to the HHS-OIG.

However, nothing in this Paragraph 17(a)(6) that may apply to the obligations undertaken pursuant to the CIA affects the status of costs that are not allowable based on any other authority applicable to Maxim. (All costs described or set forth in this Paragraph 17(a) are hereafter "Unallowable Costs.")

b. Future Treatment of Unallowable Costs: These Unallowable Costs shall be separately determined and accounted for by Maxim, and Maxim shall not charge such Unallowable Costs directly or indirectly to any contracts with the United States or any State Medicaid program, or seek payment for such Unallowable Costs through any cost report, cost statement, information statement, or payment request submitted by Maxim or any of its subsidiaries or affiliates to the Medicare, Medicaid, TRICARE, or FEHBP Programs.

c. Treatment of Unallowable Costs Previously Submitted for Payment: Maxim further agrees that within 90 days of the Effective Date of this Agreement it shall identify to applicable Medicare and TRICARE fiscal intermediaries, carriers, and/or contractors, and Medicaid and FEHBP fiscal agents, any Unallowable Costs (as defined in this Paragraph) included in payments previously sought from the United States, or any State Medicaid program, including, but not limited to, payments sought in any cost reports, cost statements, information reports, or payment requests already submitted by Maxim or any of its

subsidiaries or affiliates, and shall request, and agree, that such cost reports, cost statements, information reports, or payment requests, even if already settled, be adjusted to account for the effect of the inclusion of the Unallowable Costs. Maxim agrees that the United States, at a minimum, shall be entitled to recoup from Maxim any overpayment plus applicable interest and penalties as a result of the inclusion of such Unallowable Costs on previously-submitted cost reports, information reports, cost statements, or requests for payment.

Any payments due after the adjustments have been made shall be paid to the United States pursuant to the direction of the Department of Justice and/or the affected agencies. The United States reserves its rights to disagree with any calculations submitted by Maxim or any of its subsidiaries or affiliates on the effect of inclusion of unallowable costs (as defined in this Paragraph) on Maxim or any of its subsidiaries or affiliates' cost reports, cost statements, or information reports.

d. Nothing in this Agreement shall constitute a waiver of the rights of the United States to examine or reexamine the Unallowable Costs described in this Paragraph.

18. This Agreement is intended to be for the benefit of the Parties only. The Parties do not release any claims against any other person or entity, except to the extent provided for in Paragraphs 4, 8, 11, 12, and 19.

19. Maxim waives and shall not seek payment for any of the health care billings covered by this Agreement from any health care beneficiaries or their parents, sponsors, legally responsible individuals, or third party payors based upon the claims defined as Covered Conduct.

20. Maxim warrants that it has reviewed its financial situation and that it currently is solvent within the meaning of 11 U.S.C. §§ 547(b)(3) and 548(a)(1)(B)(ii)(I), and expects to remain solvent following its payment to the United States of the Federal Settlement Amount. Further, the Parties warrant that, in evaluating whether to execute this Agreement, they (a) have intended that the mutual promises, covenants, and obligations set forth constitute a contemporaneous exchange for new value given to Maxim, within the meaning of 11 U.S.C. § 547(c)(1); and (b) conclude that these mutual promises, covenants, and obligations do, in fact, constitute such a contemporaneous exchange. Further, the Parties warrant that the mutual promises, covenants, and obligations set forth herein are intended to and do, in fact, represent a reasonably equivalent exchange of value that is not intended to hinder, delay, or defraud any entity to which Maxim was or became indebted, on or after the date of this Agreement, all within the meaning of 11 U.S.C. § 548(a)(1).

21. If within 91 days of the Effective Date of this Agreement or of any payment made under this Agreement, Maxim commences, or a third party commences, any case, proceeding, or other action under any law relating to bankruptcy, insolvency, reorganization, or relief of debtors (a) seeking to have any order for relief of Maxim's debts, or seeking to adjudicate Maxim as bankrupt or insolvent; or (b) seeking appointment of a receiver, trustee, custodian, or other similar official for Maxim or for all or any substantial part of Maxim's assets, Maxim agrees as follows:

a. Maxim's obligations under this Agreement may not be avoided pursuant to 11 U.S.C. § 547, and Maxim shall not argue or otherwise take the position in any such case, proceeding, or action that: (i) Maxim's obligations under this Agreement may be

avoided under 11 U.S.C. § 547; (ii) Maxim was insolvent at the time this Agreement was entered into, or became insolvent as a result of the payment made to the United States; or (iii) the mutual promises, covenants, and obligations set forth in this Agreement do not constitute a contemporaneous exchange for new value given to Maxim.

b. If Maxim's obligations under this Agreement are avoided for any reason, including, but not limited to, through the exercise of a trustee's avoidance powers under the Bankruptcy Code, the United States, at its sole option, may rescind the releases in this Agreement and bring any civil and/or administrative claim, action, or proceeding against Maxim for the claims that would otherwise be covered by the releases provided in Paragraphs 4-5, above. Maxim agrees that (i) any such claims, actions, or proceedings brought by the United States (including any proceedings to exclude Maxim from participation in Medicare, Medicaid, or other Federal health care programs) are not subject to an "automatic stay" pursuant to 11 U.S.C. § 362(a) as a result of the action, case, or proceedings described in the first clause of this Paragraph, and Maxim shall not argue or otherwise contend that the United States' claims, actions, or proceedings are subject to an automatic stay; (ii) Maxim shall not plead, argue, or otherwise raise any defenses under the theories of statute of limitations, laches, estoppel, or similar theories, to any such civil or administrative claims, actions, or proceeding that are brought by the United States within 120 calendar days of written notification to Maxim that the releases have been rescinded pursuant to this Paragraph, except to the extent such defenses were available on October 8, 2004; and (iii) the United States has a valid claim against Maxim in the amount of $182,267,541.12 and penalties, and the United States may pursue its

claim in the case, action, or proceeding referenced in the first clause of this Paragraph, as well as in any other case, action, or proceeding.

c. Maxim acknowledges that its agreements in this Paragraph are provided in exchange for valuable consideration provided in this Agreement.

22. Except as expressly provided to the contrary in this Agreement, each Party to this Agreement shall bear its own legal and other costs incurred in connection with this matter, including the preparation and performance of this Agreement.

23. Maxim and Relator represent that this Agreement is freely and voluntarily entered into without any degree of duress or compulsion whatsoever.

24. This Agreement is governed by the laws of the United States. The Parties agree that the exclusive jurisdiction and venue for any dispute arising between and among the Parties under this Agreement is the United States District Court for the District of New Jersey, except that disputes arising under the CIA and DPA shall be resolved exclusively under the dispute resolution provisions in those agreements.

25. This Agreement constitutes the complete agreement between the Parties. This Agreement may not be amended except by written consent of all of the Parties.

26. The individuals signing this Agreement on behalf of Maxim represent and warrant that they are authorized by Maxim to execute this Agreement. The individual signing this Agreement on behalf of the Relator warrants that she is authorized by Relator to execute this Agreement. The United States signatories represent that they are signing this Agreement in their official capacities and that they are authorized to execute this Agreement.

27. For purposes of construction, this Agreement shall be deemed to have

been drafted by all Parties to this Agreement and shall not, therefore, be construed against any Party for that reason in any subsequent dispute.

28. This Agreement may be executed in counterparts, each of which constitutes an original and all of which constitute one and the same Agreement.

29. This Agreement is binding on Maxim's successors, transferees, heirs, and assigns, each of which shall be jointly and severally liable.

30. This Agreement is effective on the later of (1) the date of signature of the last signatory to the Agreement; or (2) the date the Court approves of the DPA ("Effective Date of this Agreement"). Facsimiles of signatures shall constitute acceptable, binding signatures for purposes of this Agreement.

31. Maxim and Relator hereby consent to the United States' disclosure of this Agreement, and information about this Agreement, to the public.

THE UNITED STATES OF AMERICA

Tony West
Assistant Attorney General
Civil Division
United States Department of Justice

J. Gilmore Childers
Attorney for the United States, Acting
Under Authority Conferred by 28 U.S.C.
515
District of New Jersey

DATED: 9/12/11

BY: _____
SARA McLEAN
Assistant Director
Commercial Litigation Branch
Civil Division
United States Department of Justice

DATED: 9/9/11

BY: _____
ALEX KRIEGSMAN
Assistant United States Attorney

DATED: _____

BY: _____
GREGORY E. DEMSKE
Assistant Inspector General for
Legal Affairs
Office of Counsel to the
Inspector General
Office of Inspector General
United States Department of
Health and Human Services

THE UNITED STATES OF AMERICA

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ALEX KRIEGSMAN
Assistant United States Attorney

DATED: 9/9/11 BY: _____
GREGORY E. DEMSKE
Assistant Inspector General for
Legal Affairs
Office of Counsel to the
Inspector General
Office of Inspector General
United States Department of
Health and Human Services

MAXIM

DATED: 9/6/11 BY: _____
W. BRADLEY BENNETT
Chief Executive Officer, Maxim Healthcare Services

DATED: 9/6/11 BY: _____
TONI-JEAN LISA, ESQ.
General Counsel for Maxim Healthcare Services, Inc.
Counsel for Maxim

DATED: _____ BY: _____
LAURA LAEMMLE-WEIDENFELD, ESQ.
Counsel for Maxim

MAXIM

DATED:_____ BY: _____
W. BRADLEY BENNETT
Chief Executive Officer, Maxim Healthcare Services

DATED:_____ BY: _____
TONI-JEAN LISA, ESQ.
General Counsel for Maxim Healthcare Services, Inc.
Counsel for Maxim

DATED: 7/6/2011 BY: _____
LAURA LAEMMLE-WEIDENFELD, ESQ.
Counsel for Maxim

RICHARD WEST - Relator

DATED: 9-8-2011 BY: Richard West
RICHARD WEST

DATED: 9-8-11 BY: Robin Pacewest
ROBIN WEST, ESQ.
Counsel for Richard West

Exhibit A

1. Alabama
2. Alaska
3. Arizona
4. California
5. Colorado
6. Delaware
7. Florida
8. Georgia
9. Idaho
10. Illinois
11. Indiana
12. Iowa
13. Kansas
14. Louisiana
15. Maine
16. Maryland
17. Massachusetts
18. Michigan
19. Minnesota
20. Missouri
21. Nebraska
22. Nevada
23. New Hampshire
24. New Jersey
25. New Mexico
26. New York
27. North Carolina
28. Ohio
29. Oklahoma
30. Oregon
31. Pennsylvania
32. Rhode Island
33. South Carolina
34. Tennessee
35. Texas
36. Utah
37. Virginia
38. Washington
39. West Virginia
40. Wisconsin
41. Wyoming

EXHIBIT B - TOTAL MAXIM PAYMENT SCHEDULE

Quarter	Payment	1.25% Interest	Principal	Balance
				121,511,694.08
9/22/2011*	51,893,418.52	1,893,418.52	50,000,000.00	71,511,694.08
12/22/2011	291,750.00	223,474.04	68,275.96	71,443,418.12
3/22/2012	291,750.00	223,260.68	68,489.32	71,374,928.81
6/22/2012	291,750.00	223,046.65	68,703.35	71,306,225.46
9/24/2012	291,750.00	222,831.95	68,918.05	71,237,307.41
12/24/2012	291,750.00	222,616.59	69,133.41	71,168,174.00
3/22/2013	291,750.00	222,400.54	69,349.46	71,098,824.54
6/24/2013	291,750.00	222,183.83	69,566.17	71,029,258.37
9/23/2013	291,750.00	221,966.43	69,783.57	70,959,474.80
12/23/2013	291,750.00	221,748.36	70,001.64	70,889,473.16
3/24/2014	291,750.00	221,529.60	70,220.40	70,819,252.76
6/23/2014	291,750.00	221,310.16	70,439.84	70,748,812.93
9/22/2014	291,750.00	221,090.04	70,659.96	70,678,152.97
12/22/2014	291,750.00	220,869.23	70,880.77	70,607,272.20
3/23/2015	291,750.00	220,647.73	71,102.27	70,536,169.92
6/22/2015	291,750.00	220,425.53	71,324.47	70,464,845.45
9/22/2015	291,750.00	220,202.64	71,547.36	70,393,298.10
12/22/2015	291,750.00	219,979.06	71,770.94	70,321,527.15
3/22/2016	291,750.00	219,754.77	71,995.23	70,249,531.92
6/22/2016	291,750.00	219,529.79	72,220.21	70,177,311.71
9/22/2016	291,750.00	219,304.10	72,445.90	70,104,865.81
12/22/2016	291,750.00	219,077.71	72,672.29	70,032,193.52
3/22/2017	291,750.00	218,850.60	72,899.40	69,959,294.12
6/22/2017	291,750.00	218,622.79	73,127.21	69,886,166.92
9/22/2017	291,750.00	218,394.27	73,355.73	69,812,811.19
12/22/2017	8,250,000.00	218,165.03	8,031,834.97	61,780,976.22
3/22/2018	8,250,000.00	193,065.55	8,056,934.45	53,724,041.77
6/22/2018	8,250,000.00	167,887.63	8,082,112.37	45,641,929.40
9/24/2018	8,250,000.00	142,631.03	8,107,368.97	37,534,560.43
12/24/2018	10,000,000.00	117,295.50	9,882,704.50	27,651,855.93
3/22/2019	10,000,000.00	86,412.05	9,913,587.95	17,738,267.98
6/24/2019	10,000,000.00	55,432.09	9,944,567.91	7,793,700.07
9/23/2019	7,818,055.38	24,355.31	7,793,700.07	-
Total	129,713,473.90	8,201,779.82	121,511,694.08	

* Includes interest accruing on the entire settlement balance from June 24, 2010 through September 22, 2011.

EXHIBIT B - FEDERAL PAYMENT SCHEDULE

Quarter	Payment	1.25% Interest	Principal	Balance
				65,554,484.45
9/22/2011*	27,963,959.01	1,021,482.55	26,942,476.46	38,612,007.99
12/22/2011	157,125.47	120,662.52	36,462.95	38,575,545.04
3/22/2012	157,125.47	120,548.58	36,576.89	38,538,968.15
6/22/2012	157,125.47	120,434.28	36,691.19	38,502,276.96
9/24/2012	157,125.47	120,319.62	36,805.85	38,465,471.10
12/24/2012	157,125.47	120,204.60	36,920.87	38,428,550.23
3/22/2013	157,125.47	120,089.22	37,036.25	38,391,513.98
6/24/2013	157,125.47	119,973.48	37,151.99	38,354,361.99
9/23/2013	157,125.47	119,857.38	37,268.09	38,317,093.90
12/23/2013	157,125.47	119,740.92	37,384.55	38,279,709.35
3/24/2014	157,125.47	119,624.09	37,501.38	38,242,207.97
6/23/2014	157,125.47	119,506.90	37,618.57	38,204,589.40
9/22/2014	157,125.47	119,389.34	37,736.13	38,166,853.28
12/22/2014	157,125.47	119,271.42	37,854.05	38,128,999.22
3/23/2015	157,125.47	119,153.12	37,972.35	38,091,026.87
6/22/2015	157,125.47	119,034.46	38,091.01	38,052,935.86
9/22/2015	157,125.47	118,915.42	38,210.05	38,014,725.82
12/22/2015	157,125.47	118,796.02	38,329.45	37,976,396.37
3/22/2016	157,125.47	118,676.24	38,449.23	37,937,947.13
6/22/2016	157,125.47	118,556.08	38,569.39	37,899,377.75
9/22/2016	157,125.47	118,435.56	38,689.91	37,860,687.83
12/22/2016	157,125.47	118,314.65	38,810.82	37,821,877.01
3/22/2017	157,125.47	118,193.37	38,932.10	37,782,944.91
6/22/2017	157,125.47	118,071.70	39,053.77	37,743,891.14
9/22/2017	157,125.47	117,949.66	39,175.81	37,704,715.33
12/22/2017	4,443,136.82	117,827.24	4,325,309.58	33,379,405.75
3/22/2018	4,443,136.82	104,310.64	4,338,826.18	29,040,579.57
6/22/2018	4,443,136.82	90,751.81	4,352,385.01	24,688,194.56
9/24/2018	4,443,136.82	77,150.61	4,365,986.21	20,322,208.35
12/24/2018	5,385,620.39	63,506.90	5,322,113.49	15,000,094.86
3/22/2019	5,385,620.39	46,875.30	5,338,745.09	9,661,349.77
6/24/2019	5,385,620.39	30,191.72	5,355,428.67	4,305,921.10
9/23/2019	4,319,377.10	13,456.00	4,305,921.10	(0.00)
Total	69,983,755.84	4,429,271.39	65,554,484.45	

* Includes interest accruing on the entire settlement balance from June 24, 2010 through September 22, 2011.

EXHIBIT B - STATE PAYMENT SCHEDULE

Quarter	Payment	1.25% Interest	Principal	Balance
				55,957,209.63
9/22/2011*	23,929,459.51	871,935.97	23,057,523.54	32,899,686.09
12/22/2011	134,624.53	102,811.52	31,813.01	32,867,873.08
3/22/2012	134,624.53	102,712.10	31,912.43	32,835,960.65
6/22/2012	134,624.53	102,612.38	32,012.15	32,803,948.50
9/24/2012	134,624.53	102,512.34	32,112.19	32,771,836.31
12/24/2012	134,624.53	102,411.99	32,212.54	32,739,623.77
3/22/2013	134,624.53	102,311.32	32,313.21	32,707,310.56
6/24/2013	134,624.53	102,210.35	32,414.18	32,674,896.38
9/23/2013	134,624.53	102,109.05	32,515.48	32,642,380.90
12/23/2013	134,624.53	102,007.44	32,617.09	32,609,763.81
3/24/2014	134,624.53	101,905.51	32,719.02	32,577,044.79
6/23/2014	134,624.53	101,803.26	32,821.27	32,544,223.53
9/22/2014	134,624.53	101,700.70	32,923.83	32,511,299.69
12/22/2014	134,624.53	101,597.81	33,026.72	32,478,272.98
3/23/2015	134,624.53	101,494.60	33,129.93	32,445,143.05
6/22/2015	134,624.53	101,391.07	33,233.46	32,411,909.59
9/22/2015	134,624.53	101,287.22	33,337.31	32,378,572.28
12/22/2015	134,624.53	101,183.04	33,441.49	32,345,130.79
3/22/2016	134,624.53	101,078.53	33,546.00	32,311,584.79
6/22/2016	134,624.53	100,973.70	33,650.83	32,277,933.96
9/22/2016	134,624.53	100,868.54	33,755.99	32,244,177.98
12/22/2016	134,624.53	100,763.06	33,861.47	32,210,316.50
3/22/2017	134,624.53	100,657.24	33,967.29	32,176,349.21
6/22/2017	134,624.53	100,551.09	34,073.44	32,142,275.77
9/22/2017	134,624.53	100,444.61	34,179.92	32,108,095.85
12/22/2017	3,806,863.18	100,337.80	3,706,525.38	28,401,570.47
3/22/2018	3,806,863.18	88,754.91	3,718,108.27	24,683,462.20
6/22/2018	3,806,863.18	77,135.82	3,729,727.36	20,953,734.84
9/24/2018	3,806,863.18	65,480.42	3,741,382.76	17,212,352.08
12/24/2018	4,614,379.61	53,788.60	4,560,591.01	12,651,761.07
3/22/2019	4,614,379.61	39,536.75	4,574,842.86	8,076,918.22
6/24/2019	4,614,379.61	25,240.37	4,589,139.24	3,487,778.98
9/23/2019	3,498,678.28	10,899.31	3,487,778.98	-
Total	59,729,718.07	3,772,508.44	55,957,209.63	

* Includes interest accruing on the entire settlement balance from June 24, 2010 through September 22, 2011.

EXHIBIT B - UNITED STATES - RELATOR PAYMENT SCHEDULE

Quarter	Payment	1.25% Interest	Principal	Balance
				10,085,561.49
up front	4,308,496.31	157,155.15	4,151,341.16	5,934,220.33
1	25,140.08	18,544.44	6,595.64	5,927,624.69
2	25,140.08	18,523.83	6,616.25	5,921,008.44
3	25,140.08	18,503.15	6,636.93	5,914,371.51
4	25,140.08	18,482.41	6,657.67	5,907,713.84
5	25,140.08	18,461.61	6,678.47	5,901,035.36
6	25,140.08	18,440.74	6,699.34	5,894,336.02
7	25,140.08	18,419.80	6,720.28	5,887,615.74
8	25,140.08	18,398.80	6,741.28	5,880,874.46
9	25,140.08	18,377.73	6,762.35	5,874,112.11
10	25,140.08	18,356.60	6,783.48	5,867,328.63
11	25,140.08	18,335.40	6,804.68	5,860,523.95
12	25,140.08	18,314.14	6,825.94	5,853,698.01
13	25,140.08	18,292.81	6,847.27	5,846,850.74
14	25,140.08	18,271.41	6,868.67	5,839,982.07
15	25,140.08	18,249.94	6,890.14	5,833,091.93
16	25,140.08	18,228.41	6,911.67	5,826,180.26
17	25,140.08	18,206.81	6,933.27	5,819,247.00
18	25,140.08	18,185.15	6,954.93	5,812,292.06
19	25,140.08	18,163.41	6,976.67	5,805,315.39
20	25,140.08	18,141.61	6,998.47	5,798,316.93
21	25,140.08	18,119.74	7,020.34	5,791,296.59
22	25,140.08	18,097.80	7,042.28	5,784,254.31
23	25,140.08	18,075.79	7,064.29	5,777,190.02
24	25,140.08	18,053.72	7,086.36	5,770,103.66
25	710,901.89	18,031.57	692,870.32	5,077,233.35
26	710,901.89	15,866.35	695,035.54	4,382,197.81
27	710,901.89	13,694.37	697,207.52	3,684,990.29
28	710,901.89	11,515.59	699,386.30	2,985,603.99
29	861,699.26	9,330.01	852,369.25	2,133,234.74
30	861,699.26	6,666.36	855,032.90	1,278,201.84
31	861,699.26	3,994.38	857,704.88	420,496.96
32	248,154.80	1,314.05	246,840.75	-
Total	10,588,718.37	676,813.10	9,911,905.27	

* Includes interest accruing on the entire settlement balance from June 24, 2010 through September 22, 2011.

Attachment H

Maxim Deferred Prosecution Agreement

Deferred Prosecution Agreement

1. Maxim Healthcare Services, Inc., and its subsidiaries (the "Company"), by its undersigned attorneys, pursuant to authority granted by its Board of Directors, and the United States Attorney's Office for the District of New Jersey (the "Office"), enter into this Deferred Prosecution Agreement (the "DPA" or this "Agreement"). Except as specifically provided below, the DPA shall be in effect for a period of twenty-four (24) months from the date on which it is fully executed (the "Effective Date").

2. The Office has informed the Company that it will file, on or shortly after the Effective Date of this DPA, a criminal complaint in the United States District Court for the District of New Jersey charging the Company with conspiracy to commit violations of the Health Care Fraud Statute, contrary to Title 18, United States Code, Section 1347, in violation of Title 18, United States Code, Section 1349, during the years 2003 through 2009 (the "Criminal Complaint"). This Office acknowledges that neither this DPA nor the Criminal Complaint alleges the Company's conduct adversely affected patient health or patient care.

3. The Company and the Office agree that, upon filing of the Criminal Complaint in accordance with the preceding paragraph, this DPA shall be publicly filed in the United States District Court for the District of New Jersey, and the Company agrees to post the DPA prominently on the Company website for the duration of the DPA.

4. The Company accepts and acknowledges responsibility for the facts set forth in the Statement of Facts attached as Appendix A (the "Statement of Facts") and incorporated by reference herein by entering into this Agreement and by, among other things, (a) the extensive remedial actions that it has taken to date, (b) its continuing commitment to full cooperation with the Office and other governmental agencies, and (c) the other undertakings it has made as set forth in this Agreement.

5. The Company agrees that in the event that future criminal proceedings are brought by the Office in accordance with paragraphs 29 and 30 of this Agreement, the Company will not contest nor contradict the facts as set forth in the Statement of Facts, and the Statement of Facts shall be admitted against the Company in any such proceedings as an admission, without objection. Neither this Agreement nor the Statement of Facts is a final adjudication of the matters addressed in such documents. Nothing in this Agreement shall be construed as an acknowledgment by the Company that the Agreement, including the Statement of Facts, is admissible or may be used in any proceeding other than in a proceeding brought by the Office.

6. The Company agrees that it shall not, through its present or future attorneys, Board of Directors, agents, officers or employees, make any public statement contradicting any fact contained in the Statement of Facts. Any such contradictory public statement by the Company, its present or future attorneys, Board of Directors, agents, officers or employees, shall if not repudiated upon notification by the Office as described below in this paragraph, constitute a breach of this Agreement as governed by paragraphs 29 and 30 of this Agreement, and the Company will thereafter be subject to prosecution pursuant to the terms of this Agreement. The decision of whether any public statement by any such person contradicting a fact contained in the

Statement of Facts will be imputed to the Company for the purpose of determining whether the Company has breached this Agreement shall be at the sole discretion of the Office. The Office shall notify the Company of a public statement by any such person that in whole or in part contradicts a statement of fact contained in the Statement of Facts and which the Office imputes to the Company. Thereafter, the Company may avoid breach of this Agreement by repudiating, publicly if requested by the Office, such statement within forty-eight (48) hours after such notification. This paragraph does not apply to any statement by any present or former Company employee, officer or director, in any proceeding in an individual capacity and not on behalf of the Company. Consistent with the foregoing, the Company shall be permitted to raise defenses and to assert affirmative claims in civil, regulatory, or other proceedings related to the matters set forth in the Statement of Facts.

7. The Company shall make a payment of $20,000,000 as a criminal penalty. The Company is simultaneously entering into an agreement with the Office and the United States Department of Justice's Civil Division, Fraud Section (the "Civil Settlement Agreement") regarding the payment of money to settle certain civil claims. The Company received more than approximately $61,000,000 to which the Company was not entitled as a result of its conduct as described in the Criminal Complaint and the Statement of Facts. Under agreements related to this matter, including the Civil Settlement Agreement, the Company has agreed to pay more than approximately $130,000,000, including interest. In light of the Civil Settlement Agreement, no additional restitution shall be paid by the Company. The Company is also simultaneously entering into a Corporate Integrity Agreement ("CIA") with the United States Department of Health and Human Services, Office of Inspector General ("HHS-OIG") to implement certain specified compliance measures. The Company shall be subject to potential exclusion from participation in government health care programs in the event the CIA is violated. Any debarment decision is in the sole discretion of the exclusion official of the United States Department of Health and Human Services. The Office in its sole discretion may determine that failure by the Company to comply fully with those material terms of the Civil Settlement Agreement scheduled to occur during the Effective Period of this DPA constitutes a breach of this DPA. The Office in its sole discretion may, but need not necessarily, determine that a breach of the CIA referenced in the Civil Settlement Agreement constitutes a breach of this DPA. Any disputes arising under the CIA shall be resolved exclusively through the dispute resolution provisions of the CIA.

8. In light of the Company's remedial actions to date and its willingness to (a) undertake additional remediation as necessary; (b) acknowledge responsibility for its behavior; (c) continue its cooperation with the Office and other government agencies; and (d) demonstrate its good faith and commitment to full compliance with federal health care laws, the Office shall recommend to the Court that prosecution of the Company on the Criminal Complaint be deferred for a period of twenty-four (24) months from the filing date of such Criminal Complaint. If the Court declines to defer prosecution for any reason, this DPA shall be null and void, and the parties will revert to their pre-DPA positions.

9. Beginning particularly in May 2009, the Company has undertaken extensive reforms and remedial actions in response to the conduct at the Company that is and has been the subject of the investigation by the Office. These reforms and remedial actions have included:

(a) Retaining independent counsel to conduct a comprehensive review of the implementation and effectiveness of the internal controls and related compliance functions of the Company, and a review of the conduct and effectiveness of the Company's senior management, with a particular focus on ensuring appropriate levels of patient care and preventing and detecting fraudulent practices;

(b) Making significant personnel changes after the Office commenced its investigation, including the termination of senior executives and other employees the Company identified as responsible for the misconduct;

(c) Establishing and filling the 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;

(d) Expanding its Board of Directors to include Independent Directors with backgrounds in health care compliance;

(e) Establishing a Compliance Committee consisting of three Directors, two of whom are Independent Directors;

(f) Undertaking a review of the existing incentive compensation structure for both sales and clinical employees to ensure that the structure promotes patient care and compliance;

(g) Undertaking a review of the policies and standard operating procedures regarding, among other things, claims for payment to federal and state health care programs, documentation pertinent to health care services furnished by the Company to federal and state health care program beneficiaries, provision and supervision of patient care, and employee training and compliance programs; and

(h) Identifying and disclosing voluntarily to law enforcement the misconduct of certain former Company employees.

General Commitment to Compliance and Remedial Actions

10. The Company commits itself to exemplary corporate citizenship, best practices of effective corporate governance, the highest principles of honesty and professionalism, the integrity of the operation of federal health care programs including Medicaid, Medicare, and the Veterans Affairs Program, and a culture of openness, accountability, and compliance throughout the Company. To advance and underscore this commitment, the Company agrees to take, or has acknowledged that it has taken, the remedial and compliance measures set forth herein.

11. In matters relating to federal health care laws, and as set forth in paragraph 28, below, the Company will cooperate fully with all federal law enforcement and regulatory agencies, including but not limited to: the Criminal and Civil Divisions of the Office; the United States Department of Justice, Criminal and Civil Divisions; HHS-OIG; the Federal Bureau of Investigation ("FBI"); and the United States Department of Veterans Affairs, Office of Inspector General ("VA-OIG"); provided, however, that such cooperation shall not require the Company's waiver of attorney-client and work product protections or any other applicable legal privileges. Nothing in this DPA shall be construed as a waiver of any applicable attorney-client or work product privileges (hereafter "privilege").

12. The Company shall communicate to its employees and clients that Company personnel and agents are required to report to the Company any suspected violations of any federal laws, regulations, federal health care program requirements, or internal policies and procedures.

13. As set forth in paragraphs 22-23, below, the Company shall continue to develop and operate an effective corporate compliance program and function to ensure that internal controls are in place to prevent recurrence of the activities that resulted in this DPA. The Company shall also develop and implement policies, procedures, and practices designed to ensure compliance with federal health care program requirements, including the Health Care Fraud Statute.

14. The Company agrees that its Chief Executive Officer, General Counsel, Chief Quality Officer/Chief Medical Officer, Chief Operations Officer/Chief Clinical Officer, Chief Compliance Officer, and appropriate Company executives will meet quarterly with the Office and the Monitor, in conjunction with the Monitor's quarterly reports described in paragraph 19(c) herein, unless the Office concludes that a meeting is not necessary. At such meetings, which may be conducted telephonically at the discretion of the Office, representatives of the Company may raise any suggestions, comments, or improvements the Company may wish to discuss with or propose to the Office, including with respect to the scope or costs of the monitorship.

Retention and Obligations of a Monitor

15. Following the selection of a Monitor as set forth below, the Company agrees that until the expiration of this DPA, it will retain at its own expense an outside, independent individual (the "Monitor") to evaluate and monitor the Company's compliance with this DPA. The Monitor will be selected by the Office consistent with United States Department of Justice guidelines, including review and approval by the Office of the Deputy Attorney General, and after consultation with the Company. The Office and the Company will endeavor to complete the monitor selection process within sixty (60) days of the execution of the DPA. The Monitor is an independent third party, and not an employee or agent of the Company, and no attorney-client relationship shall be formed between the Monitor and the Company. The Office will endeavor to select a highly-qualified Monitor, free of any potential or actual conflict of interest, and suitable for the assignment at hand, from a pool of candidates proposed by the Company. The Office will

make efforts to select a Monitor with the following qualifications: (1) access to sufficient resources to carry out the duties of the Monitor as described in this DPA; (2) experience with internal investigations or the investigative process in a prior capacity; (3) absence of a prior relationship with the Company from January 1, 1997 to the present; and (4) absence of a conflict of interest relative to the Office based on involvement in other matters. The following qualifications will also be considered: (1) prior monitorship or oversight experience; (2) experience with the federal regulations and standards relating to the provision of health care services; and (3) experience with the health care industry. The Company agrees that it will not employ or be affiliated with any selected Monitor for a period of not less than one year from the date the monitorship is terminated.

16. The Monitor shall have access to all non-privileged Company documents and information the Monitor determines are reasonably necessary to assist in the execution of his or her duties. The Monitor shall have the authority to meet with any officer, employee, or agent of the Company. The Company shall use its best efforts to have its employees and agents fully cooperate and meet with the Monitor as requested.

17. The Monitor shall conduct a review and evaluation of all Company policies, practices, and procedures relating to compliance with the DPA and the following subjects, and shall report and make written recommendations as necessary ("Recommendations") to the Company and the Office concerning:

a. The effectiveness of the procedures and practices at the Company relating to the submission of true, accurate, and complete claims for payment to all federal and state health care programs, including the Medicaid, Medicare, and Veterans Affairs programs;

b. The effectiveness of the procedures and practices at the Company relating to the creation and maintenance of true, accurate, and complete documentation pertinent to any health care services furnished by the Company to federal and state health care program beneficiaries;

c. The effectiveness of the procedures and practices at the Company relating to the setting of sales and compliance goals, and incentive compensation arrangements with Company employees;

d. The effectiveness of training relating to the above topics, and on the obligation of each Company employee to provide federal and state health care programs with true, accurate, complete, and transparent information; and

e. The effectiveness of the procedures and practices at the Company relating to patient care.

In carrying out his responsibilities, the Monitor is encouraged to coordinate, as appropriate, with Company personnel, including auditors and compliance personnel, and may, in conducting his

review, rely upon and incorporate the findings, conclusions, and recommendations of the Independent Review Organization established in accordance with the CIA.

18. The Monitor shall, *inter alia*:

a. Monitor and review the Company's compliance with this DPA and all applicable federal health care laws, statutes, regulations, and programs;

b. As requested by the Office, cooperate with the Criminal and Civil Divisions of the Office, the United States Department of Justice, Criminal and Civil Divisions, HHS-OIG, the FBI and VA-OIG, and, as requested by the Office, provide information about the Company's compliance with the terms of this DPA;

c. Provide written reports to the Office, on at least a quarterly basis, concerning the Company's compliance with this DPA. In these reports or at other times the Monitor deems appropriate, the Monitor shall make Recommendations to the Company to take any steps he or she reasonably believes are necessary for the Company to comply with the terms of this DPA and enhance future compliance with federal health care laws, and, as agreed by the Company or mandated by the Office pursuant to paragraph 26, require the Company to take such steps when it is agreed that such steps are reasonable and necessary for compliance with the DPA. The first report to the Office shall be due three (3) months after the Effective Date, but in any event, no less than sixty (60) days after the appointment of the Monitor, in accordance with paragraph 15, above, and subsequent reports shall be made quarterly thereafter;

d. Immediately report[1] the following types of misconduct directly to the Office and not to the Company: (1) any misconduct that poses a significant risk to public health or safety; (2) any misconduct that involves senior management of the Company; (3) any misconduct that involves obstruction of justice; (4) any misconduct that involves a violation of any federal or state criminal statute, or otherwise involves criminal activity; or (5) any misconduct that otherwise poses a significant risk of harm to any person or to any federal or state entity or program. On the other hand, in instances where the allegations of misconduct are not credible or involve actions of individuals outside the scope of the Company's business operations, the Monitor may decide, in the exercise of his or her discretion, that the allegations need not be reported directly to the Office;

e. After consultation with the Company and the Office, and allowing reasonable time for the Company or the Office to object, the Monitor may retain, at the Company's expense, consultants, accountants or other professionals the Monitor reasonably deems necessary to assist the Monitor in the execution of the Monitor's duties. Before retention, these

[1] This Office will determine whether to also immediately report said misconduct to the Company.

consultants, accountants or other professionals shall provide to the Monitor and the Company a proposed budget. If the Company believes the costs to be unreasonable, the Company may bring the matter to the Office's attention for dispute resolution by the Office and the Monitor shall not retain such professionals until the Office has resolved the dispute; and

f. Monitor the information received by the confidential hotline and e-mail address as described in paragraph 23 herein.

19. The Company shall promptly notify the Monitor and the Office in writing of any credible evidence of criminal conduct or serious wrongdoing by, or criminal investigations of, the Company, its officers, directors, employees and agents, of any type that become known to the Company after the Effective Date. The Company shall provide the Monitor and the Office with all relevant non-privileged documents and information concerning such allegations, including but not limited to internal audit reports, letters threatening litigation, "whistleblower" complaints, civil complaints, and documents produced in civil litigation. In addition, the Company shall report to the Monitor and the Office concerning its planned investigative measures and any findings and resulting remedial measures, internal and external. The Monitor in his or her discretion may conduct an investigation into any such matters, and nothing in this paragraph shall be construed as limiting the ability of the Monitor to investigate and report to the Company and the Office concerning such matters.

Remedial Measures

Responsibilities of Chief Compliance Officer

20. The Chief Compliance Officer shall be responsible for monitoring the day-to-day compliance activities of the Company. The Chief Compliance Officer shall be a member of senior management of the Company who reports directly to the Board of Directors and indirectly to the Chief Executive Officer, and shall not be a subordinate to the General Counsel, the Chief Financial and Strategy Officer, or any sales or clinical officers. The Chief Compliance Officer shall make periodic (at least quarterly) reports regarding compliance matters to the Company Board of Directors and is authorized to report on such matters directly to the Company Board of Directors at any time.

21. The Chief Compliance Officer shall have the authority to meet with, and require reports and certifications on any subject from, any officer or employee of the Company.

Compliance, Training, Hotline

22. The Company agrees to enhance, support, and maintain its existing training and education programs, including any programs recommended by the Monitor pursuant to paragraph 17, above. The programs, which shall be reviewed and approved by the Chief Executive Officer, Board of Directors, General Counsel, Chief Compliance Officer, and the Monitor, shall be designed to advance and underscore the Company's commitment to exemplary corporate citizenship, to best practices of effective corporate governance and the highest

principles of integrity and professionalism, and to fostering a culture of openness, accountability and compliance with federal health care laws throughout the Company. Completion of such training shall be mandatory for all Company officers, executives, and employees who are involved in Sales, Clinical, Billing, Legal, Compliance, and other senior executives at the Company as proposed by the Compliance Officer and approved by the Monitor (collectively the "Mandatory Participants"). Such training and education shall be consistent with the requirements set forth in the CIA and cover, at a minimum, all relevant federal health care laws and regulations, internal controls in place concerning the submission of claims for payment to all federal and state health care programs, the creation and maintenance of true, accurate, and complete documentation pertinent to any health care services furnished by the Company to federal and state health care program beneficiaries, and the obligations assumed by, and responses expected of, the Mandatory Participants upon learning of improper, illegal, or potentially illegal acts relating to the Company's practices. The Chief Executive Officer and Board of Directors shall communicate to the Mandatory Participants, in writing or by video, their review and endorsement of the training and education programs. The Company shall commence providing this training within ninety (90) calendar days after the Effective Date of this DPA.

23. The Company agrees to maintain a confidential hotline and e-mail address, of which Company employees, agents, and clients are informed, and which they can use to notify the Company of any concerns about unlawful conduct, other wrongdoing, or evidence that Company practices do not conform to the requirements of this Agreement. Subject to Monitor approval, the Company may retain a vendor to assist in the maintenance of the Company's confidential hotline and e-mail address. This hotline and e-mail address shall be reviewed by the Monitor. The Company shall post information about this hotline on its website and shall inform all those who avail themselves of the hotline of the Company's commitment to non-retaliation and to maintain confidentiality and anonymity with respect to such reports.

Disclosure of Monitor Reports

24. The Company agrees that the Monitor may disclose his or her written reports, as directed by the Office, to any other federal law enforcement or regulatory agency in furtherance of an investigation of any other matters discovered by, or brought to the attention of, the Office in connection with the Office's investigation of the Company or the implementation of this DPA. The Company may identify any trade secret or proprietary information contained in any report, and request that the Monitor redact such information prior to disclosure.

Replacement of Monitor

25. The Company agrees that if the Monitor resigns or is unable to serve the balance of his or her term, a successor shall be selected by the Office consistent with United States Department of Justice guidelines and paragraph 15, above, within forty-five (45) calendar days. The Company agrees that all provisions in this DPA that apply to the Monitor shall apply to any successor Monitor.

Adopting Recommendations of Monitor

26. The Company shall adopt all Recommendations contained in each report submitted by the Monitor to the Office, unless the Company objects to the Recommendation and the Office agrees that adoption of the Recommendation should not be required. The Monitor's reports to the Office shall not be received or reviewed by the Company prior to submission to the Office; such reports will be preliminary until the Company is given the opportunity, within ten (10) calendar days after the submission of the report to the Office, to comment to the Monitor and the Office in writing upon such reports, and the Monitor has reviewed and provided to the Office responses to such comments, upon which such reports shall be considered final. In the event the Company disagrees with any Recommendation of the Monitor, the Company and the Monitor may present the issue to the Office for its consideration and final decision, which is non-appealable. The Company shall not be required to adopt any disputed Recommendation while the matter is subject to review. If a Recommendation is accepted, the Company will have a reasonable amount of time to implement the Recommendation.

Meeting with Representatives of the U.S. Attorney's Office for the District of New Jersey

27. Within thirty (30) calendar days of the Effective Date of this DPA, the Company agrees to call a meeting, on a date mutually agreed upon by the Company and the Office, of Company senior compliance, sales, and clinical executives, and any other Company employees whom the Company desires to attend, and such meeting is to be attended by representatives of the Office for the purpose of communicating the goals and expected effect of this DPA.

Cooperation

28. The Company agrees that its continuing cooperation during the term of this DPA shall include, but shall not be limited to, the following:

a. Not engaging in or attempting to engage in any criminal conduct;

b. Completely, truthfully and promptly disclosing all non-privileged information concerning all matters about which the Office and other government agencies designated by the Office may inquire with respect to the Company's compliance with health care laws, and continuing to provide the Office, upon request, all non-privileged documents and other materials relating to such inquiries;

c. Consenting to any order sought by the Office permitting disclosure to the Civil Division of the United States Department of Justice of any materials relating to compliance with federal health care laws that constitute "matters occurring before the grand jury" within the meaning of Rule 6(e) of the Federal Rules of Criminal Procedure. If the Company asserts that any such material contains trade secrets or other proprietary information, the Company shall propose redactions to the Office prior to disclosure to any other governmental entity, or the material shall be accompanied by a

prominent warning notifying the agency of the protected status of the material;

d. Making available current Company officers and employees and using its best efforts to make available former Company officers and employees to provide information and/or testimony at all reasonable times as requested by the Office, including sworn testimony before a federal grand jury or in federal trials, as well as interviews with federal law enforcement authorities as may relate to matters involving compliance with health care laws. The Company is not required to request of its current or former officers and employees that they forego seeking the advice of an attorney nor that they act contrary to that advice. Cooperation under this paragraph shall include, upon request, identification of witnesses who, to the Company's knowledge, may have material non-privileged information regarding the matters under investigation;

e. Providing testimony, certifications, and other non-privileged information deemed necessary by the Office or a court to identify or establish the original location, authenticity, or other evidentiary foundation necessary to admit into evidence documents in any criminal or other proceeding relating to compliance with health care laws as requested by the Office;

f. The Company acknowledges and understands that its future cooperation is an important factor in the decision of the Office to enter into this DPA, and the Company agrees to continue to cooperate fully with the Office, and with any other government agency designated by the Office, regarding any issue about which the Company has knowledge or information with respect to compliance with health care laws;

g. This agreement to cooperate does not apply to any information provided by the Company to legal counsel in connection with the provision of legal advice and the legal advice itself, or to information or documents prepared in anticipation of litigation, and nothing in this DPA shall be construed to require the Company to provide any such information or advice to the Office or any other government agency; and

h. The cooperation provisions in this Agreement shall not apply in the event that the Office pursues a criminal prosecution against the Company.

Breach of Agreement

29. Should the Office determine, in good faith and in its sole discretion, during the term of this DPA that the Company has committed any criminal conduct subsequent to the Effective Date of this DPA, the Company shall, in the discretion of the Office and consistent with paragraph 30, thereafter be subject to prosecution for any federal crimes of which the Office has knowledge, including crimes relating to the matters set forth in the Criminal Complaint and the Statement of Facts. Except in the event of a breach of this Agreement, it is the intention of

the parties to this Agreement that all investigations of the Company relating to the matters set forth in the Criminal Complaint and the Statement of Facts shall not be pursued further as to the Company.

30. Should the Office determine in good faith and in its sole discretion that the Company has knowingly and willfully breached any material provision of this DPA, the Office shall provide written notice to the Company of the alleged breach and provide the Company with a three-week period from receipt of such notice in which to make a presentation to the Office to demonstrate that no breach occurred, or, to the extent applicable, that the breach was not material or knowingly and willfully committed or has been cured. The parties understand and agree that should the Company fail to make a presentation to the Office within the three-week period after receiving written notice of an alleged breach, it shall be conclusively presumed that the Company is in breach of this DPA. The parties further understand and agree that the determination whether the Company has breached this DPA rests solely in the discretion of the Office, and the exercise of discretion by the Office under this paragraph is not subject to review in any court or tribunal outside the United States Department of Justice. In the event of any breach of this DPA that results in a prosecution of the Company, such prosecution may be premised upon any information provided by or on behalf of the Company to the Office at any time, unless otherwise agreed at the time the information was provided.

31. In the event of breach of this DPA as defined in paragraphs 29 and 30 above, the Office shall have sole discretion to extend the term of the Monitor by a period of up to 12 months, with a total term not to exceed 36 months, in lieu of prosecuting the Company.

32. In the event that the Company can demonstrate to the Office that there exists a change in circumstances sufficient to eliminate the need for a Monitor, the Office may exercise its discretion, consistent with United States Department of Justice policy, to terminate the monitorship.

Waivers and Limitations

33. The Company shall expressly waive all rights to a speedy trial pursuant to the Sixth Amendment of the United States Constitution, Title 18, United States Code, Section 3161, Federal Rule of Criminal Procedure 48(b), and any applicable Local Rules of the United States District Court for the District of New Jersey, for the period that this DPA is in effect for any prosecution of the Company relating to the allegations set forth in the Criminal Complaint and the Statement of Facts.

34. If the Office undertakes a prosecution under paragraphs 29 and 30, above, any prosecution of the Company relating to the allegations set forth in the Criminal Complaint and the Statement of Facts that are not time-barred by the applicable statute of limitations as of the Effective Date of this DPA may be commenced against the Company notwithstanding the expiration of any applicable statute of limitations during the term of the DPA. The Company agrees to waive any claims of improper venue with respect to any prosecution of the Company relating to the allegations set forth in the Criminal Complaint and the Statement of Facts. This waiver is knowing and voluntary and in express reliance on the advice of counsel. Any such waiver shall terminate upon final expiration of this DPA.

35. Absent the express written consent of the Office to conduct itself otherwise, and consistent with United States Department of Justice policy, the Company agrees that if, after the Effective Date of this Agreement, the Company sells all or substantially all of its business operations as they exist as of the Effective Date of this Agreement to a single purchaser or group of affiliated purchasers during the term of this Agreement, or merges with a third party in a transaction in which the Company is not the surviving entity, the Company shall include in any contract for such sale or merger a provision binding the purchaser, successor, or surviving entity to continue to comply with the Company's obligations as contained in this DPA.

36. Nothing in this DPA restricts in any way the ability of the Office to investigate and prosecute any current or former Company officer, employee, agent or attorney.

Dismissal of Complaint

37. The Office agrees that if the Company complies fully with all of its obligations under this DPA, the Office, within ten (10) calendar days of the expiration of the term of this DPA, will seek dismissal with prejudice of the Criminal Complaint.

38. Except as otherwise provided herein, during and upon the conclusion of the term of this DPA, the Office agrees that it will not prosecute the Company further for conduct which falls within the scope of the grand jury investigation of the Office, or was known to the Office as of the date of the execution of this DPA. The non-prosecution provisions of this DPA are binding on the Office, the United States Attorney's Offices for each of the other 93 judicial districts of the United States, and the Criminal Division of the United States Department of Justice. The non-prosecution provisions of this DPA shall not affect any actions taken by the United States, civil or criminal, relating to federal tax matters.

The Full Agreement

39. This DPA constitutes the full and complete agreement between the Company and the Office and supersedes any previous agreement between them. No additional promises, agreements, or conditions have been entered into other than those set forth in this DPA, and none will be entered into unless in writing and signed by the Office, Company counsel, and a duly authorized representative of the Company. It is understood that the Office may permit exceptions to or excuse particular requirements set forth in this DPA at the written request of the Company or the Monitor, but any such permission shall be in writing.

40. This DPA may be executed in counterparts, each of which shall be deemed an original but all of which taken together shall constitute one and the same agreement. The exchange of copies of this DPA and of signature pages by facsimile or electronic transmission shall constitute effective execution and delivery of this DPA as to the parties and may be used in lieu of the original DPA for all purposes. Signatures of the parties transmitted by facsimile or electronic transmission shall be deemed to be their original signatures for all purposes.

AGREED TO:

W. Bradley Bennett
Chief Executive Officer
Maxim Healthcare Services, Inc.

9/6/11
Date

J. Gilmore Childers
Attorney for the United States
Acting Under Authority
Conferred by 28 U.S.C. § 515
District of New Jersey

9/12/11
Date

DIRECTOR'S CERTIFICATE

I have read this agreement and carefully reviewed every part of it with counsel for Maxim Healthcare Services, Inc. (the "Company"). I understand the terms of this Deferred Prosecution Agreement and voluntarily agree, on behalf of the Company, to each of the terms. Before signing this Deferred Prosecution Agreement, I consulted with the attorney for the Company. The attorney fully advised me of the Company's rights, of possible defenses, of the Sentencing Guidelines' provisions, and of the consequences of entering into this Deferred Prosecution Agreement. No promises or inducements have been made other than those contained in this Deferred Prosecution Agreement. Furthermore, no one has threatened or forced me, or to my knowledge any person authorizing this Deferred Prosecution Agreement on behalf of the Company, in any way to enter into this Deferred Prosecution Agreement. I am also satisfied with the attorney's representation in this matter. I certify that I am a director of the Company, and that I have been duly authorized by the Board of Directors of the Company to execute this certificate on behalf of the Company.

Maxim Healthcare Services, Inc.
By: W. Bradley Bennett

9/6/11
Date

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CERTIFICATE OF COUNSEL

I am counsel for Maxim Healthcare Services, Inc. (the "Company"). In connection with such representation, I have examined relevant Company documents, and have discussed this Deferred Prosecution Agreement with the authorized representative of the Company. Based on my review of the foregoing materials and discussions, I am of the opinion that:

1. The undersigned counsel is duly authorized to enter into this Deferred Prosecution Agreement on behalf of the Company; and

2. This Deferred Prosecution Agreement has been duly and validly authorized, executed and delivered on behalf of the Company, and is a valid and binding obligation of the Company.

Further, I have carefully reviewed every part of this Deferred Prosecution Agreement with directors of the Company. I have fully advised these directors of the Company's rights, of possible defenses, of the Sentencing Guidelines' provisions, and of the consequences of entering into this Agreement. To my knowledge, the Company's decision to enter into this Agreement is an informed and voluntary one.

Robert D. Luskin, Esq.
Laura Laemmle-Weidenfeld, Esq.
Patton Boggs LLP

9/6/2011
Date

CERTIFIED COPY OF RESOLUTION

Upon motion duly made, seconded, and unanimously carried by the affirmative vote of all the Directors present, the following resolutions were adopted:

WHEREAS, Maxim Healthcare Services, Inc. (the "Company") has been engaged in discussions with the United States Attorney's Office for the District of New Jersey (the "Office") in connection with an investigation being conducted by that Office;

WHEREAS, the Board of the Company consents to resolution of these discussions by entering into a Deferred Prosecution Agreement that the Company Board of Directors has reviewed with outside counsel representing the Company, relating to a criminal complaint to be filed in the U.S. District Court for the District of New Jersey charging the Company with conspiracy to commit violations of the federal health care fraud statute;

NOW THEREFORE, BE IT RESOLVED that outside counsel representing the Company from Patton Boggs LLP be, and they hereby are authorized to execute the Deferred Prosecution Agreement on behalf of the Company substantially in the same form as reviewed by the Company Board of Directors at this meeting and as attached hereto as Exhibit A, and that a Director of the Company is authorized to execute the Director's Certificate attached thereto.

SECRETARY'S CERTIFICATION

I, Toni-Jean Lisa, the duly elected Secretary of Maxim Healthcare Services, Inc. (the "Company") a corporation duly organized under the laws of the State of Maryland, hereby certify that the following is a true and exact copy of a resolution approved by the Board of Directors of the Company by Written Consent in Lieu of Special Meeting on the 6th of September, 2011

WHEREAS, Maxim Healthcare Services, Inc. has been engaged in discussions with the United States Attorney's Office for the District of New Jersey (the "Office") in connection with an investigation being conducted by the Office into activities of the Company relating to fraudulent practices related to billing and documentation of patient care;

WHEREAS, the Board of Directors of the Company consents to resolution of these discussions on behalf of the Company by entering into a deferred prosecution agreement that the Board of Directors has reviewed with outside counsel representing the Company, relating to a criminal complaint to be filed in the U.S. District Court for the District of New Jersey charging the Company with conspiracy to commit violations of the federal health care fraud statute;

NOW THEREFORE, BE IT RESOLVED that outside counsel representing the Company from Patton Boggs LLP be, and they hereby are authorized to execute the Deferred Prosecution Agreement on behalf of the Company substantially in the same form as reviewed by the Board of Directors at this meeting and as attached hereto as Exhibit A, and that a Director of the Company is authorized to execute the Director's Certificate attached thereto.

IN WITNESS WHEREOF, I have hereunto signed my name as Secretary and affixed the Seal of said Corporation this 6th day of Sept, 2011.

Toni-Jean Lisa, Secretary

Appendix A – Statement of Facts

Beginning in or about 2003, and continuing through in or about 2009, within the District of New Jersey, and elsewhere, MAXIM HEALTHCARE SERVICES, INC. (referred to herein as "MAXIM"), acting through certain of its former officers and employees, including senior employees, knowingly and willfully conspired, confederated and agreed with others to execute a scheme and artifice to defraud health care benefit programs, including state Medicaid programs and health care programs administered by the U.S. Department of Veterans Affairs (together referred to herein as "government health care programs"). Additionally, MAXIM knowingly and willfully conspired, confederated and agreed with others to defraud government health care programs of more than approximately $61 million by means of materially false and fraudulent pretenses, representations, and promises in connection with the delivery of and payment for health care benefits, items, and services.

Government Health Care Programs

At all times relevant to this Statement of Facts, the Medicaid Program, as established by Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations, authorized federal grants to states for medical assistance to low-income persons who are blind, disabled, or members of families with dependent children or qualified pregnant women or children (herein referred to as "Medicaid beneficiaries" or "Medicaid recipients").

States electing to participate in the Medicaid program had to comply with the requirements imposed by the Social Security Act and regulations of the Secretary of the United States Department of Health and Human Services. States participating in the Medicaid program created various state Medicaid programs, reimbursing health care practitioners, health care facilities, or health care plans for rendering Medicaid-covered services to Medicaid beneficiaries.

The federal government reimbursed states for a portion of the states' Medicaid expenditures based on a formula tied to the per capita income in each state. The federal share of Medicaid expenditures (otherwise referred to as "federal financial participation" or "FFP") varied from a minimum of approximately 50% to as much as approximately 74% of a state's total Medicaid expenditures.

The U.S. Department of Veterans Affairs (referred to herein as "Veterans Affairs"), through various programs, reimbursed health care practitioners, health care facilities, and/or health care plans for rendering Veterans Affairs-covered services to eligible veterans and their eligible dependents.

MAXIM's Participation in Government Health Care Programs

MAXIM conducted business in a number of different segments within the health care industry. MAXIM derived a substantial portion of its revenue and profits from the staffing of healthcare providers to patients requiring health care services. Within this market segment, MAXIM provided staffing of care providers to facilities, such as hospitals, nursing homes, and schools, as well as directly to patients requiring care at home.

Beginning in or about 2003, and continuing through in or about 2009, MAXIM participated in more than 500 government health care programs, receiving reimbursement from these programs for health care provided to patients. During that time, MAXIM received more than $2 billion in reimbursements from government health care programs in 43 states based on billings submitted by MAXIM for services.

MAXIM derived more than half of its annual revenue from reimbursement by government health care programs for care provided through MAXIM's Homecare Division to patients in their homes. MAXIM provided various levels of in-home care, ranging from assistance with daily living activities and personal care by unskilled home health aides, to the provision of a full range of nursing services by Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses, and Certified Nursing Assistants.

At all times relevant to this Statement of Facts, government health care programs required that providers such as MAXIM meet certain qualifications. In addition, government health care programs required that, in order to receive reimbursement, providers submit and/or maintain certain documentation verifying that those qualifications had been met. Specific requirements varied among health care programs, but all generally had licensing requirements, enabling the health care program to monitor the providers. In order to obtain a license, providers were generally required to provide documentation verifying, among other things, that they had adequate staff to provide care to patients and to supervise the provision of care to patients. In addition to the licensing requirement, providers were generally required to submit and/or maintain documentation verifying, among other things: (1) care provided to patients; and (2) required training and qualifications of caregivers.

The Conspiracy

Beginning in or about 2003, and continuing through in or about 2009, certain aspects of MAXIM's operations emphasized sales goals at the expense of clinical and compliance responsibilities, as reflected in certain aspects of its culture, training, incentive compensation, and allocation of personnel resources. In addition, during this time period, MAXIM did not have in place appropriate training and compliance programs to prevent and identify fraudulent conduct.

Beginning in or about 2003, and continuing through in or about 2009, MAXIM, through certain of its former officers and employees, including senior employees, conspired to defraud government health care programs. It was part of the conspiracy that:

(a) MAXIM, through certain of its former officers and employees, including senior employees, acting within the scope of their duties and authorities, would and did submit materially false and fraudulent billings to government health care programs for services not rendered or otherwise not reimbursable by government health care programs in order to fraudulently increase reimbursements from government health care programs, and correspondingly benefit MAXIM through an increase in profits.

(b) MAXIM, through certain of its former officers and employees, including senior employees, acting within the scope of their duties and authorities, in order to conceal MAXIM's submission of false and fraudulent billings to government health care programs, engaged in and utilized various acts and strategies including, but not limited to:

i. falsely and fraudulently creating or modifying timesheets to support billings to government health care programs for services not rendered;

ii. falsely and fraudulently submitting billings through licensed offices for care actually supervised by unlicensed offices whose existence was concealed from auditors and investigators operating on behalf of government health care programs; and

iii. falsely and fraudulently creating or modifying documentation relating to required administrative functions associated with billings submitted to government health care programs, including documentation reflecting required training and qualifications of caregivers – for example: creating documentation to make it appear caregivers had received mandated training which, in fact, they had not received; creating documentation to make it appear caregivers' skills had been evaluated by supervisors when, in fact, they had not been; and falsifying documentation regarding caregivers' qualifications.

(c) MAXIM, through certain of its former officers and employees, including senior employees, acting within the scope of their duties and authorities, would and did engage in conduct in a concerted and organized effort to conceal and cover-up the false and fraudulent nature of various MAXIM billings to government health care programs.

Attachment I

Gentiva Payor Mix

Payor Mix: Gentiva Home Health Agencies, Eastern NC Locations, FY 2012

City (County)	Greeneville (Pitt)				Kinston (Lenoir)				Morehead City (Carteret)			
	Clients	Visits	% Total Clients	% Total Visits	Clients	Visits	% Total Clients	% Total Visits	Clients	Visits	% Total Clients	% Total Visits
Medicare	1,135	23,325	77.69%	79.34%	884	22,850	76.14%	75.07%	428	11,400	72.42%	76.95%
Medicare HMO												
Medicaid	162	3,516	11.09%	11.96%	223	6,688	19.21%	21.97%	70	1,533	11.84%	10.35%
Medicaid HMO												
Private Insurance	58	616	3.97%	2.10%	21	251	1.81%	0.82%	37	615	6.26%	4.15%
Private Insurance HMO	8	159	0.55%	0.54%					9	141	1.52%	0.95%
Indigent Non-Pay												
Other (specify):												
Workers Comp	6	101	0.41%	0.34%					2	45	0.34%	0.30%
Staffing Institutional Agency	1	2	0.07%	0.01%	1	10	0.09%	0.03%				
Private Pay	14	132	0.96%	0.45%	2	10	0.17%	0.03%	10	125	1.69%	0.84%
Home Care Contract	77	1,549	5.27%	5.27%	30	629	2.58%	2.07%	35	956	5.92%	6.45%
TOTAL	**1,461**	**29,400**	**100.00%**	**100.00%**	**1,161**	**30,438**	**100.00%**	**100.00%**	**591**	**14,815**	**100.00%**	**100.00%**

Source:
Section D, Home Health Agency Annual Data Supplement to 2013 License Renewal Applications for Home Care, Nursing Pool, and Hospice
Sites selected from lsited locations on Gentiva website: http://www.gentiva.com/location_finder/

City (County)	Pink Hill (Lenoir)				Pollocksville (Jones)				Rocky Mt. (Nash)			
	Clients	Visits	% Total Clients	% Total Visits	Clients	Visits	% Total Clients	% Total Visits	Clients	Visits	% Total Clients	% Total Visits
Medicare	282	7,694	68.61%	70.30%	715	16,366	74.40%	78.96%	1,369	32,178	73.09%	78.99%
Medicare HMO												
Medicaid	90	2,666	21.90%	24.36%	151	2,914	15.71%	14.06%	274	4,769	14.63%	11.71%
Medicaid HMO												
Private Insurance	16	152	3.89%	1.39%	37	433	3.85%	2.09%	88	1,441	4.70%	3.54%
Private Insurance HMO	4	31	0.97%	0.28%	4	193	0.42%	0.93%	30	480	1.60%	1.18%
Indigent Non-Pay												
Other (specify):												
Workers Comp									2	21	0.11%	0.05%
Staffing Institutional Agency									1	10	0.05%	0.02%
Private Pay	1	9	0.24%	0.08%	8	56	0.83%	0.27%	12	100	0.64%	0.25%
Home Care Contract	18	393	4.38%	3.59%	46	764	4.79%	3.69%	97	1,737	5.18%	4.26%
TOTAL	**411**	**10,945**	**100.00%**	**100.00%**	**961**	**20,726**	**100.00%**	**100.00%**	**1,873**	**40,736**	**100.00%**	**100.00%**

Source:
Section D, Home Health Agency Annual Data Supplement to 2013 License Renewal Applications for Home Care, Nursing Pool, and Hospice
Sites selected from lsited locations on Gentiva website: http://www.gentiva.com/location_finder/

City (County)	Washington (Beaufort)				All Sites Combined			
	Clients	Visits	% Total Clients	% Total Visits	Clients	Visits	% Total Clients	% Total Visits
Medicare	613	13,738	67.73%	60.59%	5,426	127,551	73.69%	75.15%
Medicare HMO								
Medicaid	169	3,592	18.67%	15.84%	1,139	25,678	15.47%	15.13%
Medicaid HMO								
Private Insurance	56	3,592	6.19%	15.84%	313	7,100	4.25%	4.18%
Private Insurance HMO	7	144	0.77%	0.64%	62	1,148	0.84%	0.68%
Indigent Non-Pay								
Other (specify):								
Workers Comp	9	420	0.99%	1.85%	19	587	0.26%	0.35%
Staffing Institutional Agency	1	5	0.11%	0.02%	4	27	0.05%	0.02%
Private Pay	3	35	0.33%	0.15%	50	467	0.68%	0.28%
Home Care Contract	47	1,148	5.19%	5.06%	350	7,176	4.75%	4.23%
TOTAL	**905**	**22,674**	**100.00%**	**100.00%**	**7,363**	**169,734**	**100.00%**	**100.00%**

Source:
Section D, Home Health Agency Annual Data Supplement to 2013 License Renewal Applications for Home Care, Nursing Pool, and Hospice
Sites selected from lsited locations on Gentiva website: http://www.gentiva.com/location_finder/

Attachment J

Certification Conversation Log

PDA

C O N V E R S A T I O N L O G

DATE: 4/11/12 **TIME:** 11:00 am **PDA Job #:** 6006-12

CLIENT: Singh **PROJECT:** Wake County Home Health Agency

SUBJECT: Medicaid Payment
INITIATED BY: TA

WITH: Lovel- CSC

PHONE #: 866-844-1113 **Telephone** X **In Person** ___

AGENDA

- Discuss Medicare-Certified home health agency Medicaid payments.

NOTES

- TA asked Lovel how long it takes to get a Medicaid number.
- Lovel stated that it varies by provider but, if all paper work is correct, it can take four to six weeks.
- TA asked Lovel if a provider can submit a Medicaid application before a Medicare number is issued. Lovel responded no.
- TA asked Lovel if an agency can bill for services provided to Medicaid beneficiaries before a Medicaid number is issued. Lovel responded yes.
- Lovel stated that a provider can bill for services provided up to a year before a Medicaid number is issued.

PDA

C O N V E R S A T I O N L O G

DATE: 4/10/12 **TIME:** 10:00 am **PDA Job #:** 6006-12

CLIENT: Singh **PROJECT:** Wake County Home Health Agency

SUBJECT: Medicare Payment
INITIATED BY: TA

WITH: Shandreca –Palmetto GBA

PHONE #: 866-830-3925 **Telephone** X **In Person** ___

AGENDA

- Discuss Medicare-Certified home health agency Medicare payments.

NOTES

- TA asked Shandreca how long it takes to get a tie-in notice once an agency has been recommended for certification.
- Shandreca stated that it varies by provider but she has seen it taken one to three months.
- TA asked Shandreca if an agency can expect back payments from the date an agency is recommended for certification.
- Shandreca stated that a provider cannot bill for services provided until a provider number is issued but a provider can expect to be reimbursed for all services provided from the date an agency is recommended for certification.

Attachment K

NHRMC Home Health, Patient Origin, License Renewal Application2013

For questions regarding this page, call the Division of Health Service Regulation, Medical Facilities Planning Branch at (919) 855-3865.

Home Health Services Reporting

SECTION B Client Residence (Part-time Intermittent Home Health)

Instructions:

- Report data related to clients who are receiving Part-time Intermittent Home Health services through your Medicare certified agency **regardless of payer source.**
- These are services provided on a per visit basis (Nursing, PT, OT, ST, MSW and IN-HOME AIDE [HOME HEALTH AIDE]).
- Report any other types of services such as Medicaid CAP and PCS in-home aide or private duty nursing on the next page.
- Report **number of clients by county of residence** for each age category shown. Use each client's age on the first day of services during the reporting period.
- **This is an unduplicated count. Clients may be counted only once during the reporting period regardless of the number of times admitted.**
- **Do not use other age groups.**
- **Report number of Part-time/Intermittent Home Health visits (all payor sources) by county during the reporting period.**

Number of Home Health Clients by Age by County of Residence & Total Visits By County

County of Residence	0-17	18-40	41-59	60-64	65-74	75-84	85+	Total Numbers of Clients	Total Visits by County
Bladen	0	0	2	6	12	1	0	21	676
Brunswick	0	15	71	44	122	81	45	380	3058
Columbus	0	2	6	6	8	11	3	36	991
Duplin	2	9	41	16	58	49	13	188	4440
New Hanover	4	75	282	119	422	298	248	1448	20441
Onslow	0	8	21	18	32	62	5	146	415
Pender	8	32	129	86	160	175	140	730	15106
Sampson	0	3	3	3	1	1		11	112

Copy and attach additional page(s) as needed.

For questions regarding this page, call the Division of Health Service Regulation, Medical Facilities Planning Branch at (919) 855-3865.

Home Health Services Reporting

SECTION D Clients/Visits by Payer Source for your Designated Reporting Period

Instructions:

- **Report data related to clients who are receiving PART-TIME INTERMITTENT HOME HEALTH * services through your Medicare certified agency regardless of payer source.**
- These are services provided on a per visit basis: Nursing, PT, OT, ST, MSW and In-Home Aide (Home Health Aide). This includes patient services reimbursed by Medicare, Medicaid, private insurance, etc.
- Clients admitted twice during the reporting period and reimbursed by the same payer should be counted only once.
- Clients admitted once during the reporting period, for whom payment was obtained from two sources, should be reported twice, once for each payment source.
- **Do not provide data here related to clients on page 3 of this report.**

Examples	Mrs. Brown was admitted on four different occasions to the home health agency. Medicare was the only payor for each admission. Therefore, Mrs. Brown would be reported as one Medicare client, but the number of visits would include all visits from the four admissions.
	Mrs. Smith was admitted once to the home health agency, but received services paid for by both Medicare and Medicaid. Mrs. Smith would be reported as one Medicare client and one Medicaid client. Her visits should reflect the number of visits paid by each of the payers.
	Mr. Jones was admitted to the home health agency on six different occasions during this reporting period. Three admissions were under Medicare and three were under Medicaid. Mr. Jones would be reported as one Medicare client and one Medicaid client. His visits should reflect the number of visits paid by each of the payers.

Payment Source	Number of Clients	Number of Visits
Medicare	1808	31272
Medicare HMO	258	3537
Medicaid	336	6392
Medicaid HMO	—	—
Private Insurance	439	3330
Private Insurance HMO	—	—
Indigent Non-Pay	53	258
Other (specify):	—	—
Contract	57	382
Worker Comp	9	68

"Other" may include Self-pay, Worker's Comp, VA/Champus, Title III, Title XX & United Way/Grants.

For questions regarding this page, call the Division of Health Service Regulation, Medical Facilities Planning Branch at (919) 855-3865.

SECTION D Clients/Visits by Payer Source for your Designated Reporting Period (continued)

1. The following information may either be collected off your system or requested by you from the Centers for Medicare and Medicaid Services (CMS) or Palmetto Government Benefits Administrators (PGBA). It is expected that your system data will be more up-to-date.

Please specify the 12-month reporting period, by month and year, of the following information:

From Oct 1, 2011 **To** Sept 30, 2012
Month/Year **Month/Year**

a. **Number of Medicare Episodes** = 2683

b. **Average Number of Medicare episodes per beneficiary** = 1.298

c. **Average Number of Medicare Visits per Episode (all disciplines)** = 12.97

d. **For Medicare – the Percent of Lupus** = 11.1%

Attachment L

Sequestration Articles

AMA
AMERICAN MEDICAL ASSOCIATION

FAQs on the 2013 Sequestration

On Monday, April 1, a 2 percent across-the-board cut in Medicare provider payments will take effect. The sequestration is required by the Budget Control Act that was signed into law in August 2011. It was originally intended as an incentive for the so-called Super Committee convened that year to design an alternative package to achieve $1.2 trillion in budget savings.

How will Medicare physician payments be affected?

- All Medicare physician claims with a date of service on or after April 1 will be subject to a 2 percent payment cut.
- Costs for physician-administered drugs included on the physician claim will also be subject to the 2 percent cut.
- The cut will be applied to the payment itself, not the underlying "allowed charge" in the Medicare fee schedule. As a result, beneficiary copayments and deductibles will not change. In other words, the 2 percent cut is imposed only on the 80 percent of the allowed charge that a participating physician would receive directly from Medicare. The 20 percent copayment amount (and any deductible) that the physician collects from the patient will be based on the full allowed charge amount.
- With respect to unassigned claims for services provided by nonparticipating physicians, the 2 percent cut will be applied to the Medicare payment made to the beneficiary (but not to the limiting charge amount).

How will Medicare payments to other providers be affected?

- Hospitals, home health services, durable medical equipment suppliers, and all others who provide services to Medicare patients will receive the same 2 percent payment cut for dates of discharge, rental agreements, etc., beginning on or after April 1.
- This reduction will also affect Medicare direct and indirect graduate medical education payments.

How are other (non-Medicare) programs being affected?

- The Budget Control Act specifies that half the budget savings must be achieved through defense spending cuts. Medicare provider cuts are limited to 2 percent, so the lion's share of the non-Defense savings will come at the expense of domestic discretionary programs.
- The $85.4 billion in 2013 sequester savings breaks down as follows:
  - 7.9 percent cuts in defense spending, for a savings of $43 billion
  - A 5.3 percent reduction in domestic discretionary spending, for savings of $29 billion
  - 2 percent cuts in Medicare provider payments that will save about $10 billion
  - A 5.8 percent cut to defense and non-defense mandatory programs to save about $4 billion

- Certain safety net programs, including Medicaid, are exempt from the cuts, as are military personnel salaries.

- The precise impact on specific public health and other programs will vary, although staff furloughs are being implemented by many federal agencies. The savings targets for the defense and domestic discretionary programs are based on the federal fiscal year, which began October 1, so the impact severity for the remainder of FY 2013 depends on what steps individual agencies and programs may have taken since last October to reduce spending.

How long will the sequestration last?

- The Budget Control Act requires that $1.2 trillion in federal spending cuts be achieved over the course of **nine** years. So, unless Congress takes action to change the law, federal spending will be subject to sequestration until **2022**.

- Because the American Taxpayer Relief Act that was signed into law in January delayed the 2013 sequester for two months (with a budget offset), the Defense and discretionary program cuts are less severe now than they will be in coming years.

- As an entitlement program, the Medicare payment cut is treated a little differently than the cuts being imposed on programs subject to the appropriations process. The Medicare cut will never be higher than 2 percent.

- Importantly, the Medicare cuts each year are **not** cumulative. So, the 2 percent cut this year will **not** be followed by another 2 percent cut next year, and so forth, producing a cumulative double-digit cut at the end of the sequestration period. In other words, this year's 2 percent cut will simply remain in place every year through 2022 (unless Congress takes action to stop it).

What are the prospects of Congressional action to stop the sequester?

- With all the fiscal deadlines facing Congress this year, the sequester will remain a subject for debate. However, we are mid-way through the fiscal year and, barring a major backlash, it is expected that the sequester cuts will remain in effect through at least Sept 30, 2013.

- The future of sequestration beyond 2013 is likely to depend on whether or not Congress and the White House are able to reach a new budget agreement to address deficit and spending concerns.

What has the AMA done to address the sequester?

- The AMA initiated a campaign last fall to educate Members of Congress about the negative consequences of sequestration. In addition to repeated direct communications with Congressional offices, the AMA took the following actions:

    - We cosponsored a study and media event with the American Hospital Association and the American Nurses Association, detailing the impact that the cuts will have on employment in the health care sector, including employees in

physician practices, over the course of the nine year sequester. Joint advertisements were placed in inside-the-beltway publications highlighting the study's findings.

- We organized two letters to Congress, cosigned by Federation groups, explaining the impact that sequestration will have on practices, on patients, and on health care programs generally.

- We activated our patient and physician grassroots networks.

- Information about these activities is posted on the AMA web site, at www.ama-assn.org/go/medicarepayment.

- We encourage physicians to contact their Representatives and Senators emphasizing the impact of the Medicare program's instability on their practices and their patients, using the support material that is routinely updated and posted on the AMA's web site.

newswise

Sequestration Cuts Medicare Reimbursement Beginning April 1

Released: 3/7/2013 12:00 PM EST
Source Newsroom: American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM)

more news from this source

Newswise — The federal budget sequester went into effect March 1 after a lack of Congressional action to avoid the automatic spending cuts. Effective April 1, Medicare payments to hospitals, doctors, and other health care providers will be reduced by 2%.

In the weeks leading up to the March 1 deadline, the Senate twice voted down proposals to halt the automatic, across-the-board spending cuts to government programs. Their lack of agreement on a deficit-reduction policy was followed by the signing of an executive order to initiate broad cuts to government spending.

The sequestration order directs government agencies, including Medicare, to cut their budgets. Most cuts to federal agencies and programs will not begin overnight—some agencies will have until October 1 to determine where to cut spending. However, it's anticipated that Medicare providers will see the impact of sequestration by mid-April. The Center for Medicare and Medicaid Services (CMS) will implement the 2% cut, reimbursing Medicare claims at 98 cents on the dollar. A CMS spokesperson anticipates that the sequester reductions will result in $11 billion in lost revenue to Medicare doctors, hospitals, and other providers.

Sections: Medicine

Channels:

Keywords:

Contact Information

Available for logged-in reporters only
(more news from this source)

Description

The federal budget sequester went into effect March 1 after a lack of Congressional action to avoid the automatic spending cuts. Effective April 1, Medicare payments to hospitals, doctors, and other health care providers will be reduced by 2%.

Related Stories

Channel Keywords Source

More stories from these channels:
Government/Law, Sequester Budget Cuts

Specific details of the Medicare sequester have not yet been made public, including: Whether the 2% cut will be applied to allowed charges under the Medicare physician fee schedule (and so affect beneficiary copayments); If the 2% cut will be applied only to the physician's Medicare claims payment; Whether the cuts will be applied to claims with a *date of service* on or after April 1, or to *all claims payments* made on or after April 1.

In a statement released on March 1, American Medical Association President Jeremy Lazarus said, "Both Medicare beneficiaries and providers will feel real pain from the cuts. Sequestration will widen the already enormous gap between what Medicare pays and the actual cost of caring for seniors."

Congress and the president could halt some or all of the spending cuts, but it may take a surge of public indignation to motivate them to do so. Members of the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) have been encouraged to contact their elected officials to share their concerns over the impending cuts, which come on the heels of a significant decrease in Medicare reimbursement for EDX services.

Comment/Share

Share

Leave a comment...

1. Sequester Summer Takes a Bite Out of Morale?
2. NCI Director's Message to Grantees About NCI Funding and Grant Support for FY2013
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4. NIH Saves Lives: Fred Hutchinson Cancer Research Center Calls on Congress to Restore Full Funding
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4. Plea for a Correct Use of Stem Cells in Therapy
5. Race and Gender Influence Diagnosis of COPD
6. Source of Infection Affects Hospital Mortality in Septic Shock Patients in the ICU

Attachment M

Duplicate Medicaid and Medicare Home Health Payments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

DUPLICATE MEDICAID AND MEDICARE HOME HEALTH PAYMENTS: MEDICAL SUPPLIES AND THERAPEUTIC SERVICES

Daniel R. Levinson
Inspector General

May 2008
OEI-07-06-00640

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

OBJECTIVE

1. To determine, in five States, the extent to which both Medicaid and Medicare paid home health providers for the same medical supplies and therapeutic services.
2. To identify the controls that these five States have established that are intended to prevent duplicate payments.

BACKGROUND

Home health services seek to restore health and minimize the effects of illness and disability, thereby enabling beneficiaries to reside in community settings and avoid institutionalization. These services include nursing care, speech therapy, and physical therapy. Both Medicaid and Medicare pay home health providers for services specified in the plans of care for beneficiaries; however, both should not pay for the same medical supplies or services for the same beneficiary.

Medicaid is the payor of last resort; therefore, Medicaid should pay for home health services only if Medicare or another payor does not pay for them. Medicare pays home health providers through the Prospective Payment System (PPS) for qualified home health services provided during episodes of care.

We examined Medicaid and Medicare home health claims in five States: Florida, Maryland, North Carolina, Ohio, and Texas. During the period of our review, these Medicaid programs paid a total of $184 million for 2.2 million claims for home health supplies and services coverable by Medicare. We matched Medicaid home health claims against Medicare home health PPS claims using Social Security numbers and dates of service and identified duplicatively paid home health claims; we did not rely on the dual eligibility indicator field, which may have been incorrect. For the purposes of this study, we defined a duplicate payment as any Medicaid payment for a PPS-covered service or supply on a date falling within a Medicare episode of care. We did not attempt to determine medical necessity or appropriateness.

FINDINGS

In four of the five States reviewed, Medicaid inappropriately paid $1 million in 2005 for nonroutine medical supplies and therapeutic

services that were paid by Medicare. Of the 84,061 inappropriately paid claims, 98 percent were for nonroutine medical supplies and 2 percent were for therapeutic services. All inappropriately paid claims were for supplies and services included on the publicly available list of Medicare-covered PPS services for 2005.

Medicaid paid $6.6 million for routine supplies on the same dates as home health services; Medicare coverage of routine supplies cannot be determined from claims data. Because Medicare PPS covers the cost of routine medical supplies that are customarily used in small quantities during the course of a therapeutic or assistive home health service, it is possible that these medical supplies were included in the Medicare payment and Medicaid should not have paid for them. However, claims data do not indicate whether a routine supply was provided during the course of another service. Therefore, the State Medicaid agency cannot determine whether Medicaid or Medicare should pay for these routine supplies leading to a potential vulnerability.

All States reported having controls to prevent duplicate payments, but these did not eliminate all inappropriate payments. All five States relied on Medicare eligibility indicators and payment system edits to compare claims for home health services to Medicare eligibility information; however, incomplete eligibility information and payment system edit overrides may still allow inappropriate payments.

Despite Medicaid being the payor of last resort, State officials reported that they lacked direct access to Medicare claims data to determine whether Medicare had already paid. Most inappropriately paid claims were likely paid after Medicare made the initial payments for the episodes, and Medicaid paid 10 percent of inappropriate claims after the final Medicare payments. The order of claims submission dates and payment dates indicates that some home health providers are submitting Medicaid claims for medical supplies and therapeutic services when they have already received Medicare payments. States requiring Medicare denial notices had fewer inappropriately paid claims.

RECOMMENDATIONS

Our results show that Medicaid inappropriately paid for some home health supplies and therapeutic services for which Medicare also paid.

Therefore, we recommend that CMS:

Ensure that Medicaid does not pay providers for Medicare-paid nonroutine medical supplies and therapeutic services. CMS could accomplish this by: working with States and the Regional Home Health Intermediaries to determine the costs and benefits of requiring providers to request from Medicare denial of payment notices that would then be submitted to the Medicaid program, addressing the cause of the inadequate Medicare eligibility data, determining the utility of allowing providers to override Medicaid payment denials for home health services, requesting States to reeducate providers on the requirement that Medicaid be the payor of last resort, and making current Medicare home health payment information available directly to States.

Clarify CMS policy on Medicare PPS coverage of routine medical supplies. CMS should clarify what constitutes Medicare-covered routine medical supplies used in the course of a therapeutic or assistive service and provide greater specificity on when routine medical supplies are paid for under Medicare PPS. Specifically, definitions of "required in quantity" and "recurring need" with respect to whether routine supplies should be considered nonroutine are needed.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on the report, CMS stated that it "did not disagree" with our first recommendation and recognized the importance of preventing duplicate Medicaid and Medicare billings. CMS offered what it believes is a simplification of one of our suggestions to address the first recommendation, which involves Medicare sending a copy of the denial of payment notice to the State Medicaid program. CMS concurred with our second recommendation to clarify policy on coverage of routine medical supplies under Medicare's home health PPS.

CMS commented on the methodology of this review, stating that the absence of medical record review limits the findings. However, our claims analysis was sufficient to definitively identify $1 million in inappropriate Medicaid payments, as well as to identify vulnerabilities that CMS should address to prevent duplicate payments. CMS also stated that our second finding is an assumption rather than fact. Our second finding is factual. We make no assumption about whether these payments were inappropriate.

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OBJECTIVE

1. To determine, in five States, the extent to which both Medicaid and Medicare paid home health providers for the same medical supplies and therapeutic services.
2. To identify the controls that these five States have established that are intended to prevent duplicate payments.

BACKGROUND

Home Health Services

Home health services are intended to restore health and minimize the effects of illness and disability, thereby enabling beneficiaries to reside in community settings and avoid institutionalization. These services include:

- nonroutine and routine medical supplies;[1]
- therapeutic services—speech, occupational, and physical therapy and medical social services; and
- assistive services—home health aide and skilled nursing services.

Both Medicaid and Medicare pay home health providers for home health services specified in the plans of care for beneficiaries; however, both should not pay for the same medical supplies or services for the same beneficiary.[2] Each program has specific payment structures and limitations on the services covered. This study examined Medicaid and Medicare payments for medical supplies and therapeutic services. A companion study will examine Medicaid and Medicare payments for assistive services.

[1] The Centers for Medicare & Medicaid Services (CMS). "Medicare Home Health Agency Manual" defines medical supplies as items that, because of their therapeutic or diagnostic characteristics, are essential in enabling home health agency personnel to conduct home visits or to effectively carry out the services on the plan of care. "Medicare Home Health Agency Manual," Pub. 11, section 206.4.

[2] Both Medicare and Medicaid cover only home health services ordered on a written plan of care for a specific beneficiary that a physician reviews every 60 days. CMS, "Medicare Home Health Agency Manual," Pub. 11, section 204.2(F). A plan of care is the medical treatment plan that contains all diagnoses, types of services, supplies, and equipment required; the frequency of visits to be made; and all medication and treatments.

Coverage and Payment of Home Health Services

States must offer home health services to Medicaid beneficiaries who meet the States' criteria for nursing home coverage.[3] Under the home health benefit, States must provide medical supplies and assistive services.[4] States may provide therapeutic services at their option.[5] All five States included in this study provided therapeutic services during the period of our review.

For medical supplies and services Medicaid covers, Medicaid ". . . will take all reasonable measures to ascertain the legal liability for third parties . . . to pay for care and services available under the plan. . . ."[6] Medicare qualifies as a third-party payor as defined above, and Medicaid should always be the payor of last resort.

For the five States included in our review, Tables 1 and 2 (next page) present total Medicaid claims and expenditures for home health supplies and services coverable by both Medicaid and Medicare in 2005.[7] Medicaid paid a total of $184 million for 2.2 million claims for these supplies and services ($37.2 million for nonroutine medical supplies, $75.6 million for therapeutic services, and $71.8 million for routine supplies). Excluded from these totals are supplies and services that Medicaid home health programs covered but that the Medicare Prospective Payment System (PPS) did not cover. The 2.2 million claims were for all beneficiaries regardless of dual eligibility.[8]

To be covered as part of the Medicare home health benefit, services must be reasonable, medically necessary, and specified on a plan of care.[9] Other than these requirements, Medicare does not limit the amount of nonroutine medical supplies or therapeutic services that a

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[3] Social Security Act (the Act) § 1902(a)(10)(D).

[4] 42 CFR § 441.15.

[5] Section 1905(a)(7) of the Act, 42 CFR §§ 440.70 and 441.15.

[6] Section 1902(a)(25)(A) of the Act.

[7] We define coverable supplies and services as those that Medicare could pay if the beneficiary was dually eligible; however, as noted in the Methodology section, our population was not restricted to beneficiaries identified as dually eligible on Medicaid claims and included all supplies and services paid by Medicaid regardless of whether the beneficiary was identified as dually eligible.

[8] Maryland enrolls all home health beneficiaries in managed care programs, except for dually eligible beneficiaries. Thus, Maryland's fee-for-service expenditures represent only expenditures for dually eligible beneficiaries.

[9] CMS. "Medicare Home Health Agency Manual," Pub. 11, sections 203.1(A) and 203.1(B).

beneficiary can receive through the home health benefit. Nonroutine medical supplies include items such as catheters, dressings, syringes, and needles.

Table 1: Medicaid Claims and Expenditures for Home Health Nonroutine Medical Supplies and Therapeutic Services Coverable by Both Medicaid and Medicare for All Medicaid Beneficiaries in 2005

State	Nonroutine Medical Supplies (Dollars)	Nonroutine Medical Supplies (Claims)	Therapeutic Services (Dollars)	Therapeutic Services (Claims)
Florida	$10,902,160	103,382	$3,436,109	51,397
Maryland	$5,333	136	$53,304	1,239
North Carolina	$3,170,079	90,659	$7,750,288	77,631
Ohio	$9,765,963	90,241	$12,847,646	184,593
Texas	$13,351,263	547,933	$51,554,385	403,037
Total	**$37,194,798**	**832,351**	**$75,641,733**	**717,897**

Source: Office of Inspector General analysis of State Medicaid claims data, 2007.

Medicare also covers routine medical supplies used in small quantities, such as cotton balls, gloves, and incontinence items, when they are provided during the course of a therapeutic or assistive home health service. For the five States included in our review, Table 2 presents total Medicaid claims and expenditures for home health routine medical supplies. See Appendix A for further details on Medicare coverage rules for medical supplies.

Table 2: Medicaid Claims and Expenditures for Home Health Routine Medical Supplies Coverable by Both Medicaid and Medicare for All Medicaid Beneficiaries in 2005

State	Routine Medical Supplies (Dollars)	Routine Medical Supplies (Claims)
Florida	$2,173	37
Maryland	$0	$0
North Carolina	$11,053,572	91,890
Ohio	$1,068	7
Texas	$60,782,007	551,527
Total	**$71,838,820**	**643,461**

Source: Office of Inspector General analysis of State Medicaid claims data, 2007.

The Centers for Medicare & Medicaid Services (CMS) maintains a list of the services that Medicare covers and codes to be used in billing for them. This list is publicly available on the CMS Web site and is updated annually. Medicare contractors are notified of these updates through program memorandums.[10]

Effective October 1, 2000, Medicare began paying for home health services through a PPS. Under the Medicare home health PPS, home health providers are paid for all home health services provided to eligible beneficiaries during each 60-day episode of care, provided that the services meet coverage criteria. The Medicare payment for each episode of care may be split into two portions; home health providers typically receive approximately half the payment at the beginning of each episode and the balance at the end of the episode.

Dually Eligible Beneficiaries and Home Health Payments

As of January 1, 2006, CMS data indicated that approximately 6.1 million individuals were dually eligible for both Medicaid and Medicare.[11] Dual eligibility occurs when an individual meets both Medicaid and Medicare eligibility requirements. When both Medicare and Medicaid cover a particular supply or service, Medicare should pay first for services provided to dually eligible beneficiaries. Medicaid is the payor of last resort and therefore pays only for services that are covered by Medicaid but not covered by Medicare.

Previous Studies and Related Work

A 2005 Office of Inspector General (OIG) study entitled "Review of Medicaid Home Health Payments Rendered During a Medicare Covered Stay for Dual-Eligible Beneficiaries—State of Connecticut" (A-01-04-00011), identified $1.8 million in Medicaid payments for Medicare-paid services from 2001 to 2003.

CMS is conducting two projects to identify duplicate Medicaid and Medicare payments. CMS began the Medi-Medi project in 2001 to reduce fraud, waste, and abuse by matching Medicaid and Medicare data to identify improper billing and utilization patterns. Medi-Medi is

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[10] "Home Health Consolidated Billing Master Code List." Available online at http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp. Accessed November 6, 2007.

[11] "Overview of the Many Steps That CMS Has Taken To Make Sure All Dual Eligibles Have Medicare Prescription Drug Coverage, January 1, 2006." Retrieved online at http://cms.hhs.gov. Accessed on August 16, 2006; no longer available online.

currently reviewing claims in 10 States: California, Florida, Illinois, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Texas, and Washington. When we conducted our analysis, Medi-Medi had not yet reviewed any home health claims in the States included in this study.[12] A pilot program streamlining States' third-party liability efforts is underway in Connecticut, Massachusetts, and New York. In this program, the Regional Home Health Intermediary reviews samples of Medicaid claims to determine whether Medicare should have paid them. If Medicare is identified as the appropriate payor, States receive refunds of their Medicaid payments from CMS.

METHODOLOGY

State Selection

We examined Medicaid and Medicare claims for beneficiaries in five States: Florida, Maryland, North Carolina, Ohio, and Texas. We selected States that represented fee-for-service Medicaid expenditures for home health services in 2004 ranging from $58,000 to $126 million. To avoid overlapping with the efforts of the Regional Home Health Intermediary, we avoided selecting States that were participating in that pilot program.

State Medicaid Agencies

We conducted structured interviews with Medicaid agency staff in each of the five selected States. During these interviews, we collected information and requested documentation regarding the home health services that each State provided through its Medicaid program. We also collected information on the postpayment audits that each State conducted and the controls that each State had in place intended to prevent Medicaid payments for home health services that Medicare paid.

Claims Data and Analysis

Medicaid Data. We collected all final-action Medicaid Management Information System claims data for home health services in the five selected States for 2005. From these data, we extracted beneficiary identifiers, service dates, procedure codes, and payment amounts for all claims. A lack of complete Medicare eligibility indicators in the

[12] Florida, North Carolina, Ohio, and Texas were included in our study and are participating in Medi-Medi.

Medicaid claims data prevented us from calculating expenditures for only the dually eligible population.

Medicare Data. We used the National Claims History file to identify paid Medicare claims data representing episodes of care provided to beneficiaries in the five selected States for 2005. From these data, we extracted Health Insurance Claims Numbers (HICN) and service dates for all paid episodes and matched the HICNs from the claims against the Enrollment Database[13] to obtain each beneficiary's Social Security number.

Medicaid-Medicare Data Match. We matched claims for all beneficiaries who had home health claims, rather than limiting our data collection to beneficiaries with dual eligibility indicators, to ensure that we captured all beneficiaries receiving services that both programs paid for regardless of whether the indicator was present. Because Medicare covers routine medical supplies provided during the course of a therapeutic or assistive service, we determined how many of the routine supply claims fell on dates on which the beneficiaries also received therapeutic or assistive services.[14]

In each of the five selected States, we did the following:

(1) We merged the Medicaid home health claims with the Medicare home health claims using Social Security numbers. The Medicaid claims had either specific service dates or date ranges, while the Medicare claims always had date ranges. The Medicaid dates and date ranges were matched against the Medicare date ranges for each beneficiary to identify potential duplicate claims. We then excluded any claims for services not covered under the PPS, because Medicaid payments for such services would not be duplicative.

(2) We identified paid claims for Medicaid medical supplies and services that occurred within Medicare episodes of care, analyzed payment trends for types of services and dates of payments, and calculated

[13] The CMS Enrollment Database contains current and historical Medicare enrollment and entitlement information for all beneficiaries ever enrolled.

[14] For this review, our only examination of assistive services was related to dates of service so that we could determine whether routine supply claims fell on the same dates as assistive services and therefore were likely covered by Medicare.

duplicate payment amounts.[15] We also reviewed the dates of claims submission, receipt, and payment from each provider to determine temporal relationships between Medicaid and Medicare claims.

(3) We conducted conference calls with the selected States to inquire about the reasons for duplicate payments. We also spoke with CMS officials to verify policy.

Limitations

This study was limited to fee-for-service Medicaid and Medicare PPS payments for the same home health medical supplies and therapeutic services. We did not attempt to determine the medical necessity or appropriateness of any of the services provided, nor did we review the beneficiaries' plans of care.

Standards

This study was conducted in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

[15] For the purposes of this study, we define a duplicate payment as any Medicaid payment for a PPS-covered therapeutic service or nonroutine medical supply on a date falling within a Medicare episode of care.

FINDINGS

In four of the five States reviewed, Medicaid inappropriately paid a combined $1 million in 2005 for nonroutine medical supplies and therapeutic services that were paid by Medicare

Four of the five States included in our review made $1 million in Medicaid payments for 84,061 claims in 2005 for nonroutine medical supplies and/or therapeutic services that were paid by Medicare. Maryland had no inappropriately paid claims. These payments represent nearly 1 percent of the $113 million that these States spent on reviewed home health nonroutine medical supplies and therapeutic services, and 6 percent of the 1.5 million total claims.[16]

All inappropriately paid claims were for supplies and services included on the publicly available list of Medicare-covered PPS services for 2005. Of these inappropriately paid claims, 98 percent were for nonroutine medical supplies, and 2 percent were for therapeutic services. Texas represented 58 percent of the total expenditures for home health nonroutine medical supplies and therapeutic services that we reviewed, but 89 percent of the total dollars inappropriately paid.

States inappropriately paid $802,039 for 82,081 claims for nonroutine medical supplies

Texas accounted for 96 percent of the inappropriate expenditures for nonroutine medical supplies, followed by North Carolina and Florida (see Table 3 on the following page). Of Texas's nonroutine claims, 92 percent were billed with procedure code A4335 (nonroutine incontinence supplies).

Texas officials stated that a claims-level review would be the only way to determine why it had a disproportionate number of inappropriately paid medical supply claims when compared to those of the other four States. Texas did, however, lack indicators of dual eligibility for more than 99 percent of its inappropriately paid claims. Texas officials stated that Medicare or other third-party liability information may have been added to the eligibility file after the claims were paid.

[16] These percentages should not be interpreted as error rates. As explained in the methodology, we are unable to determine total expenditures or total claims for only the dually eligible population. The percentages above represent proportions of total expenditures and claims for Medicare-coverable services for all beneficiaries, not dually eligible beneficiaries only.

Table 3: Inappropriately Paid Medicaid Nonroutine Medical Supplies		
State	**Dollars**	**Claims**
Florida	$16,009	212
Maryland	$0	0
North Carolina	$15,847	450
Ohio	$0	0
Texas	$770,183	81,419
Total	**$802,039**	**82,081**

Source: OIG analysis of State Medicaid claims data, 2007.

States inappropriately paid $219,125 for 1,980 claims for therapeutic services

Ohio and Texas accounted for 93 percent of the inappropriate expenditures for therapeutic services, with North Carolina paying 7 percent of the identified inappropriate payments (see Table 4 below). Sixty-six percent of the identified therapeutic services were for physical therapy; Ohio accounted for 63 percent of the inappropriate expenditures for physical therapy claims. Ohio, Texas, and North Carolina used local codes for billing physical therapy claims. Although these were not the same as the codes included on the listing of Medicare PPS covered services, Medicare covers all therapeutic services provided to a beneficiary during home health episodes irrespective of the code used to bill that service. Thus, the Medicaid payments for these claims are duplicative.

Table 4: Inappropriately Paid Medicaid Therapeutic Service Claims		
State	**Dollars**	**Claims**
Florida	$0	0
Maryland	$0	0
North Carolina	$14,891	149
Ohio	$67,694	967
Texas	$136,540	864
Total	**$219,125**	**1,980**

Source: OIG analysis of State Medicaid claims data, 2007.

Medicaid paid $6.6 million for routine supplies on the same dates as home health services; Medicare coverage of routine supplies cannot be determined from claims data

Two States paid $6.6 million for 74,648 claims for routine medical supplies on the same dates as therapeutic or assistive services. Texas represented 85 percent of the total expenditures for home health routine medical supplies, but accounted for 98 percent of the expenditures for these claims (see Table 5 below). All of these claims were for various sizes of incontinence briefs and liners, which are typically covered by Medicare as routine medical supplies. Because Medicare PPS covers the cost of routine medical supplies that are customarily used in small quantities during the course of a therapeutic or assistive home health service, it is possible that these medical supplies were included in the Medicare payment and Medicaid should not have paid for them. However, claims data do not specify whether a routine supply was provided during the course of a therapeutic or assistive service or just on the same day as a service. Therefore, without reviewing medical records, neither OIG nor the State Medicaid programs can determine whether these medical supplies were in fact provided during the course of a therapeutic or assistive service.[17]

Table 5: Paid Medicaid Claims for Routine Medical Supplies on the Same Dates as Home Health Services

State	Amount Paid	Number of Claims
Florida	$0	0
Maryland	$0	0
North Carolina	$164,231	1,780
Ohio	$0	0
Texas	$6,486,272	72,868
Total	**$6,650,503**	**74,648**

Source: OIG analysis of State Medicaid claims data, 2007.

States paid an additional $8.3 million for 93,082 claims for routine medical supplies that home health providers billed during Medicare episodes of care but that did not fall on the same dates as therapeutic or assistive services. The "Medicare Benefit Policy Manual" states, "There

[17] Reviewing medical records was outside the scope of this study.

are occasions when [routine supplies] would be considered nonroutine and thus would be considered a billable supply, i.e., if they are required in quantity, for recurring need, and are included in the plan of care."[18] However, the Manual does not define "required in quantity" or "recurring need" with respect to whether routine supplies should be considered nonroutine. Lacking this definition, OIG cannot determine whether any or all of these claims should have been covered by Medicare as nonroutine supplies.

All States reported having controls to prevent duplicate payments, but these did not eliminate all inappropriate payments

Prior to our review, all five States had established payment system edits to compare claims for home health services to Medicare eligibility information. However, incomplete eligibility information and payment system edit overrides may still allow inappropriate payments.

States reported problems with eligibility information

Medicare eligibility information was incomplete on many inappropriately paid claims. As previously stated, more than 99 percent of the inappropriately paid claims for Texas did not have a Medicare eligibility indicator populated—the field was empty. Maryland reported that the Medicare eligibility data may not indicate that a beneficiary became eligible for Medicare until a year after Medicare coverage began. CMS officials confirmed that because of retroactive eligibility determinations, Medicare eligibility data may not be up-to-date.

States' payment systems may allow payment despite Medicare eligibility

Even when Medicare eligibility information was complete and correct, payment system edits failed to prevent some duplicate payments from being made. In North Carolina, 98 percent of inappropriately paid claims were for beneficiaries with Medicare eligibility indicators correctly populated. Home health providers in North Carolina can insert condition codes on claims to override the need for a Medicare denial when Medicaid criteria are met (e.g., beneficiary is receiving incontinence supplies but no therapeutic or assistive services). Providers must have documentation supporting the override available

[18] CMS. "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 7, section 50.4.1.2(E). See Appendix A for further details on the definitions of nonroutine and routine supplies.

upon request.[19] This may explain how the claims in North Carolina that correctly indicated the beneficiaries' eligibility for Medicare were paid; however, we did not request data on what claims providers overrode. A similar process exists in Ohio; if Medicare eligibility is indicated for a beneficiary, the provider may submit an appropriate adjustment code for Medicaid to process the claim.

Despite Medicaid being the payor of last resort, State officials reported that they lacked direct access to Medicare claims data to determine whether Medicare had already paid

Officials in the reviewed States indicated that they did not have direct access to Medicare PPS payment data, which would provide information about whether and when a beneficiary was receiving Medicare-paid services. Most inappropriately paid claims were likely paid after Medicare made the initial payments for episodes, and Medicaid paid 10 percent of inappropriate claims after the final Medicare payment. At the time of our review, States lacked direct access to Medicare claims data. If States had direct access, they would be able to determine whether a beneficiary has an open episode of care before processing a Medicaid home health service claim.

The order of claims submission dates and dates of payment indicates that some home health providers are submitting Medicaid claims for medical supplies and therapeutic services when they have already received Medicare payments. This may be true for many inappropriately paid Medicaid claims, given that Medicare makes both an initial and a final payment for each 60-day episode of care. Providers submitting Medicaid claims during open episodes of care may have already received the initial Medicare payments for those episodes.

Maryland and Florida, which had fewer claims paid in error compared to the other States reviewed, require home health providers to show that Medicare denied the claims for beneficiaries with Medicare eligibility information before Medicaid pays. Ohio does not require a denial of payment notice; however, it does require providers to submit claims for dually eligible beneficiaries to Medicaid with adjustment

[19] In many cases, overriding the denials may be appropriate because Medicaid often covers services that Medicare does not. However, it is also possible that providers may override denials to collect additional Medicaid payments.

codes showing why payment is due (e.g., Medicare denied the claim).[20] The majority of claims that Medicaid paid during and after Medicare episodes of care occurred in Texas, where the Medicaid program does not require a denial of payment notice from Medicare. North Carolina also does not require a denial of payment notice from Medicare.

[20] In limited circumstances, Ohio allows Medicaid payments for dually eligible beneficiaries without adjustment codes—for instance, if the provider has previously billed Medicare for the service and has documentation showing that Medicare previously denied the payment.

RECOMMENDATIONS

Our results show that Medicaid inappropriately paid for some supplies and therapeutic services for which Medicare had paid. In 2005, the five States reviewed made $1 million in inappropriate Medicaid payments to home health agencies for therapeutic services and nonroutine medical supplies; two State Medicaid programs paid another $6.6 million for routine medical supplies on the same dates as Medicare-covered home health services, but it is not possible to determine from the claims data alone whether these payments were appropriate. Although all States had controls in place to prevent duplicate payments, these controls did not prevent all inappropriate payments. Further, States reported that they lacked direct access to Medicare claims data to determine whether Medicare had already paid. As a result, despite Medicaid being the payor of last resort, Medicaid likely made most of the inappropriate home health payments after the initial Medicare payments and 10 percent of the inappropriate payments after the final Medicare payments.

We recommend that CMS:

Ensure That Medicaid Does Not Pay Providers for Medicare-Paid Nonroutine Medical Supplies and Therapeutic Services

CMS could accomplish this through:

- working with States and Regional Home Health Intermediaries to determine the costs and benefits of requiring providers to request from Medicare denial of payment notices that would then be submitted to the Medicaid program,
- investigating and addressing the causes of States' incomplete Medicare eligibility data,
- working with States to determine the utility of allowing providers to override Medicaid denials for home health services for dually eligible beneficiaries,
- requesting States to reeducate providers on the requirement that Medicaid be the payor of last resort and that Medicaid not be billed for services that Medicare covers, and
- making current Medicare home health payment information available directly to States to allow States to determine whether Medicaid providers are billing for beneficiaries during Medicare-covered home health episodes of care.

Clarify CMS Policy on Medicare PPS Coverage of Routine Medical Supplies
CMS should clarify what constitutes Medicare-covered routine medical supplies used in the course of a therapeutic or assistive service and provide greater specificity on when routine medical supplies are paid for under Medicare PPS. Specifically, definitions of "required in quantity" and "recurring need" with respect to whether routine supplies should be considered nonroutine are needed.

We note that this review was conducted as a statistical match of computerized data. Under the provisions of the Computer Matching and Privacy Protection Act of 1988, we cannot forward the results to CMS or the States for collection of the inappropriate payments.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on the report, CMS stated that it "did not disagree" with our first recommendation and recognized the importance of preventing duplicate Medicaid and Medicare billings. CMS offered what it believes is a simplification of one of our suggestions to address the first recommendation, which involves Medicare sending a copy of the denial of payment notice to the State Medicaid program. CMS concurred with our second recommendation to clarify the policy on coverage of routine medical supplies under Medicare's home health PPS.

CMS commented on the methodology of this review, stating that the absence of medical record review or further analysis of potential duplicate payments limits the findings. Medical record review and follow-up analysis could provide additional useful information about inappropriate payments. However, our claims analysis was sufficient to definitively identify $1 million in inappropriate Medicaid payments, as well as to identify vulnerabilities that CMS should address to prevent duplicate payments.

CMS also stated that our second finding is an assumption rather than fact. Our second finding, which states that Medicaid paid $6.6 million for routine supplies on the same dates as home health services, is factual. We make no assumption about whether these payments were inappropriate. As stated in the finding, ". . . without reviewing medical records, neither OIG nor the State Medicaid programs can determine

whether these medical supplies were in fact provided during the course of a therapeutic or assistive service."

CMS stated that the Medicaid and Medicare matches were not exact. The nature of PPS payments, which include all supplies and services that Medicare covers, makes it impossible to find one-to-one matches between Medicaid and Medicare payments. As described in our methodology, it is nonetheless possible to identify duplicate payments using these matches.

CMS also stated that we were unable to calculate expenditures for only the dually eligible population. The lack of accurate dual eligibility indicators on claims data makes this calculation impossible. Consequently, our first recommendation suggests that CMS investigate and address the causes of States' incomplete Medicare eligibility data.

Finally, CMS requested further elaboration on Maryland's success in preventing duplicate payments for home health services. Our discussions with Maryland Medicaid officials did not reveal any significant differences between their efforts to prevent duplicate payments and the efforts of the other four States reviewed. Maryland's lack of inappropriate payments is due most likely to the significantly smaller number of beneficiaries who were receiving services paid by both Medicaid and Medicare rather than differences in States' prevention efforts.

We made technical corrections to the report based on CMS's comments. The full text of CMS's comments is provided in Appendix B.

APPENDIX - A

Medicare Coverage of Nonroutine and Routine Medical Supplies

Medicare covers nonroutine medical supplies under the following conditions: (1) the home health agency follows a consistent charging practice for Medicare and other patients receiving the item, (2) the item is directly identifiable to an individual patient, (3) the cost of the item can be identified and accumulated separately from other services, and (4) the item is furnished at the direction of the patient's physician and is specifically identified in the plan of care. Examples of nonroutine medical supplies include catheter supplies, dressings, syringes, needles, and certain incontinence supplies.[21]

Routine medical supplies are defined as those that are customarily used in small quantities during the course of most home care visits, which are usually included in the staff's supplies and not designated for a specific patient. Routine medical supplies are included in Medicare Prospective Payment System if they are provided during the course of a therapeutic or assistive service (i.e., a physical therapy or skilled nursing visit). Examples of routine medical supplies include gloves, cotton balls, and certain incontinence supplies. If a supply that is normally considered routine is required in quantity for recurring need and is specified in the plan of care, it may be considered a nonroutine supply.[22]

[21] Centers for Medicare & Medicaid Services (CMS). "Medicare Benefit Policy Manual," Pub 100-02, Chapter 7, section 50.4.1.3.

[22] CMS. "Medicare Benefit Policy Manual," Pub 100-02, Chapter 7, section 50.4.1.2.

APPENDIX - B

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: MAR 25 2008

TO: Daniel R. Levinson
Inspector General

FROM: Kerry Weems
Acting Administrator

RECEIVED
2008 MAR 26 PM 4:56
OFFICE OF INSPECTOR GENERAL

SUBJECT: Office of Inspector General (OIG) Draft Report: "Duplicate Medicaid and Medicare Home Health Payments: Medical Supplies and Therapeutic Services" (OEI-07-06-00640)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to comment on the OIG Draft Report entitled, "Duplicate Medicaid and Medicare Home Health Payments: Medical Supplies and Therapeutic Services" (OEI-07-06-00640). The objectives of the report were to--1) Determine, in five States, the extent to which Medicare and Medicaid paid home health providers for the same medical supplies and therapeutic services; and 2) Identify the controls that these five States have established that are intended to prevent duplicate payments.

The CMS recognizes that duplicate billing of Medicare and Medicaid by providers is an area of concern, and we have undertaken new and expanded initiatives to combat fraud and abuse in Medicare and Medicaid. Medicaid program integrity provisions in the Deficit Reduction Act of 2005 (DRA) provided additional funding and staffing to better address fraud, waste, and abuse in the Medicaid program. The DRA also provided additional funding to expand the Medicare-Medicaid (Medi-Medi) data match pilot program to all States. Moreover, the DRA created the Medicaid Integrity Program (MIP). This program is overseen by the Medicaid Integrity Group (MIG) within CMS' Center for Medicaid and State Operations (CMSO). We welcome the challenges to reduce Medicaid fraud and abuse and are grateful for the resources to take on this significant program initiative.

OIG Recommendation

Ensure that Medicaid does not pay providers for Medicare-paid nonroutine medical supplies and therapeutic services.

CMS Response

The CMS does not disagree with this OIG recommendation. However, accomplishing this by requiring that providers request a Medicare "denial of payment" notice, which would then be submitted to the Medicaid program along with their claim, could be simplified. An improvement

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would be to have Medicare send a copy of the denial of payment notice to the State Medicaid program. We also concur with the OIG's recommendation of making current Medicare home health payment information available directly to the States. This would facilitate the States' abilities to identify duplicate claims.

OIG Recommendation

Clarify CMS policy on Medicare Prospective Payment System (PPS) coverage of routine medical supplies.

CMS Response

The CMS concurs with this recommendation to clarify the policy on coverage of routine medical supplies under Medicare's home health PPS as it relates to what constitutes Medicare-covered routine medical supplies used in the course of a therapeutic or assistive service. The costs of both routine and non-routine medical supplies are accounted for in the Medicare home health PPS 60-day episode rate. Consolidating existing policy guidance on the coverage and reporting of routine and non-routine medical supplies may help address the concerns raised in this report.

We have the following general comments on the draft report:

• Any publicly released statements about the report should emphasize that the study was conducted in only five States and cannot be extrapolated nationally to other States or beyond the timeframe of the report evaluation.

• The report looked at "potential duplicate claims" in five States: Florida, Maryland, North Carolina, Ohio, and Texas. However, only two of the States, North Carolina and Texas, had potential duplicate payments identified. These payments warranted further investigation to substantiate if they were indeed duplicative and inappropriate. Unfortunately, reviewing medical records was outside the scope of this study.

• For purposes of the study, the OIG defined a duplicate claim or payment as any Medicaid payment for a Medicare PPS covered therapeutic service or non-routine medical supply on a date falling within a Medicare "episode of care." The "episode of care" in this case is 60 days. The duplicate claim or payment was determined by a data match occurring anywhere within the 60-day period. The methodology of the study was severely limited because no further analysis was done on the "potential duplicate payments" other than the data match identification.

• A further complication to the results of the study is that the five States reviewed were paying home health claims using a fee-for-service coding system whereas Medicare was using a bundled PPS payment system that does not differentiate the claim. The data matches, on a claim-by-claim basis, were, therefore, not always exact.

• As a consequence of the suspect methodology, the second finding in the report - *Medicaid paid $6.6 million for routine medical supplies on the same dates as home health services. Medicare coverage of routine supplies cannot be determined from claims data* - is problematical because it

is more of an assumption than a substantiated fact. Medicare claims do not specify whether a routine supply was provided during the course of a home health service or just within the 60-day episode of care. Without reviewing the associated beneficiaries' medical records, this finding cannot be corroborated.

• Another limitation in the report is that the OIG was not able to determine total expenditures for only the affected dual-eligible population. Consequently, the percentages in the report are proportions of total expenditures and claims for Medicare-coverable services for all beneficiaries, not just dually eligible beneficiaries.

• Page 4, paragraph 5. The statement, "CMS began the Medi-Medi project in 2001 to identify duplicate Medicaid and Medicare payments for selected services..." is not clear. The identification of duplicate payments is an outcome of the program rather than its purpose. The report should state that the purpose of the Medi-Medi project is to reduce fraud, waste, and abuse by matching Medicaid and Medicare data to identify improper billing and utilization patterns. Moreover, the program enhances collaboration with our State partners and identifies program vulnerabilities.

• Page 8, paragraph 1. The report states that "Maryland had no inappropriately paid claims." It would be interesting to find out what Maryland was doing correctly or differently from the other four States that allowed it to avert any duplicate payments. In keeping with the second objective of the report (to identify the controls these five States have established that are intended to prevent duplicate payments), we would encourage you to elaborate on this. Good work like Maryland's should be annotated so that it can be shared with the other States and noted among best practices.

Once again, CMS thanks the OIG for the opportunity to review and comment on this report.

ACKNOWLEDGMENTS

This report was prepared under the direction of Brian T. Pattison, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office.

Brian Whitley served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the Kansas City regional office who contributed to the report include Michael Barrett, Michala Walker, and Julie Dusold; central office staff who contributed include Scott Horning, Kevin Manley, and Jennifer Jones.