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August 30, 2013

Mr. Craig Smith, Section Chief
Celia Inman, Project Analyst
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 Forsyth County, Health Service Area II; CON Project ID Numbers:

G-10156-13, Maxim Healthcare Services, Inc.
G-10159-13, Well Care, LLC
G-10160-13, Liberty Home Care VI, LLC

Dear Ms. Inman and Mr. Smith:

On behalf of UniHealth Home Health (UniHealth), Project ID G-10161-13, thank you for the opportunity to comment on the above-referenced applications for development of a new Medicare-certified home health agency in Forsyth County.

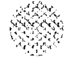
A successful application must meet all statutory criteria and should exemplify the strongest combination of the ***2013 SMFP* basic principles: Value, Access, and Quality.** No one applicant will rank highest in all of the competitive criteria, so it is important to consider the entirety of all applications when determining who should be approved. UniHealth's application best supports all three of the *2013 SMFP* Basic Principles: Value, Access, and Quality. 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.

After a complete review of all the applications, it is clear that UniHealth's application is competitively superior to the other competing applications in this review batch. UniHealth's application conforms to all statutory criteria and planning objectives. In addition to this Cover Letter, we have included in Attachment A 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.

COMPETITIVE OVERVIEW

As will be demonstrated later in this document, UniHealth presents the most competitive application in this review batch. UniHealth continually ranks the highest in the 14 comparative metrics that the CON Section has traditionally used in reviewing home health CON applications. UniHealth ranks first in more of the comparative metrics than the next closest applicant (seven versus six). Further, in a similar home health review in Wake County (J-8817-12) in 2012 (five applicants versus four applicants in the Forsyth review batch), the CON Section determined that the most effective applicant was the applicant that ranked first the most times in the aforementioned 14 comparative metrics. Because UniHealth is Number 1 the most times in this review batch, it is also the most effective applicant.

UniHealth also outperforms all applicants in this review batch in a number of *additional* comparative metrics, including some metrics that the CON Section has used to evaluate home health applications in the past. Among the additional comparative metrics that have past precedent with the CON Section, UniHealth ranks very high in regard to total number of projected duplicated Medicare and Medicaid patients and the total projected duplicated Medicare and Medicaid patients as a percent of total patients. Finally, UniHealth outperforms the other applicants in regard to other important home health CON metrics, including charity care, administrator salaries, and letters of support. Therefore, we believe that after the CON Section does a complete review of all of the applications, it will determine that UniHealth is the most effective applicant based on all of the criteria presented above.



VALUE METRICS

Traditional CON Comparisons

UniHealth's proposal demonstrates its commitment to value. It consistently outperforms competing proposals in 14 comparative metrics that the CON Section used to review home health CON applications in Wake County (J-8817-12). UniHealth ranks first in seven of these 14 comparative metrics. UniHealth proposes the:

- Highest visits per unduplicated patient;
- Lowest ratio of net revenue per visit to cost per visit;
- Lowest administrative cost per visit (see discussion below);
- Highest average direct care operating cost as a percent of average total cost per visit;
- Highest RN salary;
- Highest unduplicated Medicare patients as a percent of total unduplicated patients; and the
- Highest number of unduplicated Medicare patients.

UniHealth also ranks in the top two among all applicants in:

- Net revenue per visit;
- Home health aide salary;
- Unduplicated Medicaid patients as a percent of total unduplicated patients; and
- Number of unduplicated Medicaid patients.

The following table ranks applicants from highest to lowest in all 14 comparative metrics, with a Number 1 representing the most effective applicant. Accordingly, the applicant with the most Number 1's represents the most consistent commitment to value. Because the best rank may be the highest or the lowest in a particular metric, we have identified the position associated with the top rank.

Please note that UniHealth and Well Care both rank Number 1 in Administrative Cost per Visit. UniHealth's Administrative Cost per Visit is $30.875. Well Care's Administrative Cost per Visit is $30.867 for a difference of $0.008/visit, not even one cent. Because this represents a mere 0.012% difference, we believe that the CON Section should regard this difference as negligible and give both applicants the same rank for this comparative metric. Please see Attachment B for more detailed comparative metrics.

Table 1 – Applicant Ranking Based on Traditional Comparative Metrics

Comparative Metric	Best	UniHealth	Liberty	Maxim	Well Care
Visits per Unduplicated Patient	Highest	1	4	3	2
Net Revenue Per Visit	Lowest	2	4	3	1
Net Revenue Per Unduplicated Patient	Lowest	3	1	4	2
Ratio of Net Revenue per Visit to Cost per Visit	Lowest	1	2	4	3
Total Operating Cost Per Visit	Lowest	3	4	2	1
Direct Cost Per Visit	Lowest	4	1	3	2
Administrative Cost Per Visit	Lowest	1*	4	3	1*
Average Direct Care Operating Cost as a Percent of Average Total Cost per Visit	Highest	1	4	3	2
RN Salary – Year 2	Highest	1	4	3	2
HHA Salary – Year 2	Highest	2	4	3	1
Unduplicated Medicare Patients as a Percent of Total Unduplicated Patients	Highest	1	3	4	2
Unduplicated Medicaid Patients as a Percent of Total Unduplicated Patients	Highest	2	4	3	1
Number of Unduplicated Medicare Patients – Year 2	Highest	1	4	3	2
Number of Unduplicated Medicaid Patients – Year 2	Highest	2	4	3	1
Total Number 1's		**7**	**2**	**0**	**6**

* *UniHealth and Well Care are separated by only $0.008/visit; such a negligible difference warrants the same ranking for both applicants.*

As one can see, UniHealth ranks Number 1 in the most comparative metrics. These metrics show the intensity of services proposed as well as commitment to underserved groups identified in the statute.

ACCESS METRICS - ADDITIONAL COMPARATIVE METRICS

Metrics with Past Precedent: Duplicated Medicare and Medicaid Patients

In the most recent home health CON Findings in Mecklenburg County (F-7221-05), the CON Section considered other comparative metrics as part of the 14 comparative metrics, namely the total number of duplicated Medicare and Medicaid patients and the total duplicated Medicare and Medicaid patients as a percent of total patients. These metrics are integral to a complete analysis, because they incorporate recertification rates and scope of services provided by each applicant. To calculate these four comparative metrics, the CON Section used the Project Year 2 payor mix from Section VI.12 of the application (duplicated patients as a percent of total projected utilization) and projected duplicated patients in Project Year 2 from Table IV.2. The number of duplicated patients in each discipline (e.g. nursing, PT, OT) was summed across all disciplines in Table IV.2 to calculate total number of duplicated patients. The Medicare and Medicaid percentages from Section VI.12 were then multiplied by the total number of duplicated patients in Project Year 2. Table 2 and Table 3 show the results of applying this same methodology to the Forsyth applicant batch.

Table 2 – Number of Duplicated Medicare Patients – Project Year 2

Applicant	Total Number of Duplicated Patients (Table IV.2)	Projected Duplicated Medicare Patients as % of Total Projected Utilization (Payor Mix, Section VI.12)	Total Number of Duplicated Medicare Patients [A*B]
	A	B	C
Liberty	**786**	**73.4%**	**577**
UniHealth	3,538	71.7%	2,537
Maxim	2,720	65.1%	1,771
Well Care	1,241	68.0%	844

Note : Liberty combines Medicare and Medicare HMO

Table 3 – Number of Duplicated Medicaid Patients – Project Year 2

Applicant	Total Number of Duplicated Patients (Table IV.2)	Projected Duplicated Medicaid Patients as % of Total Projected Utilization (Payor Mix, Section VI.12)	Total Number of Duplicated Medicaid Patients [A*B]
	A	B	C
UniHealth	**3,538**	**19.1%**	**676**
Maxim	2,720	17.8%	484
Well Care	1,241	26.8%	332
Liberty	786	5.9%	46

As demonstrated above, this analysis will add four important differentiating comparative metrics that have past precedent with the CON Section and will separate competitors who are otherwise similar on other metrics. In summary, the Forsyth Comparative Review should incorporate four more comparative metrics in its evaluation of this review batch. The four, included in Table 4 below, are:

- Duplicated Medicare patients as a percent of total duplicated patients;
- Duplicated Medicaid patients as a percent of total duplicated patients;
- Number of duplicated Medicare patients; and
- Number of duplicated Medicaid patients.

Table 4 – Value and Access Comparison with Past Precedent Comparative Metrics

Comparative Metric	Best	UniHealth	Liberty	Maxim	Well Care
Visits per Unduplicated Patient	Highest	1	4	3	2
Net Revenue Per Visit	Lowest	2	4	3	1
Net Revenue Per Unduplicated Patient	Lowest	3	1	4	2
Ratio of Net Revenue per Visit to Cost per Visit	Lowest	1	2	4	3
Total Operating Cost Per Visit	Lowest	3	4	2	1
Direct Cost Per Visit	Lowest	4	1	3	2
Administrative Cost Per Visit	Lowest	1*	4	3	1*
Average Direct Care Operating Cost as a Percent of Average Total Cost per Visit	Highest	1	4	3	2
RN Salary – Year 2	Highest	1	4	3	2
HHA Salary – Year 2	Highest	2	4	3	1
Unduplicated Medicare Patients as a Percent of Total Unduplicated Patients	Highest	1	3	4	2
Unduplicated Medicaid Patients as a Percent of Total Unduplicated Patients	Highest	2	4	3	1
Number of Unduplicated Medicare Patients – Year 2	Highest	1	4	3	2
Number of Unduplicated Medicaid Patients – Year 2	Highest	2	4	3	1
Duplicated Medicare Patients as a % of Total Duplicated Patients	Highest	2	1	4	3
Duplicated Medicaid Patients as a % of Total Duplicated Patients	Highest	2	4	3	1
Number of Duplicated Medicare Patients – Year 2	Highest	1	4	2	3
Number of Duplicated Medicaid Patients – Year 2	Highest	1	4	2	3
Total Number 1's		**9**	**3**	**0**	**7**

* *UniHealth and Well Care are separated by only $0.008/visit; such a negligible difference warrants the same ranking for both applicants.*

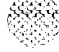
Further, the Agency should place greater emphasis on service to Medicare than Medicaid patients. Only Medicare requires a provider to have a Certificate of Need to serve North Carolina patients. Moreover, the stated purpose of a home health agency on page 327 of the *2013 SMFP* identified need is Medicare certification. Under North Carolina Medicaid provisions, a licensed, but not certified home *care* agency can serve Medicaid beneficiaries without a Certificate of Need. UniHealth outperforms all applicants in both duplicated and unduplicated Medicare patients served. UniHealth also proposes to serve more Medicare patients as a percent of total patients than all other applicants.

Basic Principles

The Basic Principles 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. [emphasis added]*

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.



Medically Indigent - Charity Care

In 2010, the US Census Bureau found almost one in five (19 percent[1]) of Forsyth County residents under 65 were uninsured whereas the national average was 11 percent.[2] The Census Bureau did not measure the persons over 65. However, UniHealth uncovered evidence through local interviews that many over 65 in this area are also uninsured and do not have the knowledge to enroll in Medicare (see UniHealth application page 159). Clearly, uninsured groups are medically underserved as defined in Statutory Criterion 13 and access to charity care will important for residents of Forsyth County. UniHealth outperforms all other applicants in regard to this factor. UniHealth proposes to offer approximately twice the amount of charity care proposed by Well Care and Maxim, and three times as much charity care as Liberty. Not only does UniHealth propose the greatest amount of charity care, it also proposes the highest charity care as a percent of gross revenues and the most total indigent (charity) care admissions in this review batch. Therefore, UniHealth should be found competitively superior with regard to access to services by this medically underserved group.

[1] County Health Rankings and Roadmaps, Forsyth County, http://www.countyhealthrankings.org/app/north-carolina/2013/forsyth/county/outcomes/overall/snapshot/by-rank
[2] Ibid.

Please note that Maxim proposes $55,684 in charity care (page 139) for 54 charity care visits in Project Year 2 (page 83). The amount listed in the application would suggest an access of $1,000 per indigent visit. This is unreasonable and is not supported by facts in the Maxim application. The amount of charity care that Maxim proposes can be validated by multiplying the charge per visit by discipline on page 126 by Maxim's proposed Project Year 2 indigent visits by discipline on page 86. The amount calculated in Table 5 below is used for comparison in Table 7.

Table 5 – Adjusted Maxim Charity (Indigent) Revenue Adjustment

Discipline	Year 2 Proposed Charge (p. 126)	Projected Charity (Indigent) Visits by Service Discipline (p. 86)	Gross Charity (Indigent) Revenue Adjustment
Nursing	$125	25	$3,125
Physical Therapy	$130	22	$2,860
Occupational Therapy	$130	4	$520
Speech Therapy	$130	1	$130
Medical Social Work	$175	0	$0
Home Health Aide	$70	2	$140
Total			**$6,775**

QUALITY METRICS – ADDITIONAL COMPARATIVE METRICS

Administrator Salaries

UniHealth proposes the second highest salary for an Administrator and equivalent positions.

The administrator is a critical non-clinical position responsible for managing the business operations of the home health agency. Good nursing judgment is critical in a certified home health agency. In order to offer a comprehensive service package that focuses on care management, a home health agency must recruit top caliber, experienced and/or highly trained administrators. In a competitive market like Forsyth County, a high salary is one way to recruit and retain such talent. As one can see from the table below, UniHealth ranks second in Administrator salary. Though it ranks second behind Maxim, it should be noted that UniHealth will employ a full time Administrator whereas Maxim will only employ 0.5 FTEs for this position.

Table 6 – Administrator Salaries – Project Year 2

Applicant	Position	Average Salary for a FTE	FTEs
Maxim	Administrator	$ 82,000	0.50
UniHealth	Administrator	$ 80,019	1.00
Well Care	Clinical Manager/Branch Manager	$ 79,722	1.00
Liberty	Manager of Branch Operations	$ 78,648	0.33

After inclusion of the additional charity care and administrator salary comparative metrics discussed above, UniHealth ranks first in 12 of 22 comparative metrics and is clearly the most effective applicant in the review batch. Please see Table 7.

Table 7 – Value, Access and Quality Comparison with Additional Metrics

Comparative Metric	Best	UniHealth	Liberty	Maxim	Well Care
Visits per Unduplicated Patient	Highest	1	4	3	2
Net Revenue Per Visit	Lowest	2	4	3	1
Net Revenue Per Unduplicated Patient	Lowest	3	1	4	2
Ratio of Net Revenue per Visit to Cost per Visit	Lowest	1	2	4	3
Total Operating Cost Per Visit	Lowest	3	4	2	1
Direct Cost Per Visit	Lowest	4	1	3	2
Administrative Cost Per Visit	Lowest	1*	4	3	1*
Average Direct Care Operating Cost as a Percent of Average Total Cost per Visit	Highest	1	4	3	2
RN Salary – Year 2	Highest	1	4	3	2
HHA Salary – Year 2	Highest	2	4	3	1
Unduplicated Medicare Patients as a Percent of Total Unduplicated Patients	Highest	1	3	4	2
Unduplicated Medicaid Patients as a Percent of Total Unduplicated Patients	Highest	2	4	3	1
Number of Unduplicated Medicare Patients – Year 2	Highest	1	4	3	2
Number of Unduplicated Medicaid Patients – Year 2	Highest	2	4	3	1
Duplicated Medicare Patients as a % of Total Duplicated Patients	Highest	2	1	4	3
Duplicated Medicaid Patients as a % of Total Duplicated Patients	Highest	2	4	3	1
Number of Duplicated Medicare Patients – Year 2	Highest	1	4	2	3
Number of Duplicated Medicaid Patients – Year 2	Highest	1	4	2	3
Total Dollar Amount of Indigent Care Provided	Highest	1	4	2	3
Indigent Care as a % of Gross Revenues	Highest	1	4	2	3
Total Indigent Care Admissions	Highest	1	3	4	2
Administrator Salaries	Highest	2	4	1	3
Total Number 1's		**12**	**3**	**1**	**7**

** UniHealth and Well Care are separated by only $0.008/visit; such a negligible difference warrants the same ranking for both applicants.*

UniHealth's high count of Number 1's confirms the strength of UniHealth's application. UniHealth demonstrates that it excels at developing a home health agency with the appropriate balance of clinical coordinators who maintain, review and validate quality measures, and appropriate resources for direct patient care. UniHealth's leadership in these comparative metrics demonstrates its commitment to value.

Medical Social Workers

UniHealth proposes to employ the most medical social workers. Medical social workers (MSW) are important in assisting clients' emotional, financial, and social wellbeing. The MSW will also be involved in non-visit activities that increase the agency's capacity to manage total patient care and will offer services such as charity care coordination, liaison activities with community and charitable foundations, assistance with benefits eligibility, care transitions, behavioral health, and training of staff in performance or assistance with these responsibilities. This role is increasingly important in sustaining patient capacity to stay at home.

Table 8 – Medical Social Work FTEs – Project Year 2

Applicant	MSW FTEs
UniHealth	**1.0**
Liberty	0.2
Well Care	0.2
Maxim	0.1

Documented Letters of Support and Referral Sources

It should also be noted that UniHealth is the only applicant to document a significant effort to contact and offer services to organizations that care for low income, uninsured, and underinsured individuals. UniHealth contacted the Guilford County Department of Social Services, the Community Care Center, and the Northwest Community Care Network, among many other organizations. UniHealth also reached out to organizations that support immigrant populations. These organizations will also provide UniHealth with referrals to persons in need of charity care.

UniHealth is the only applicant that documents sources of sufficient referrals to substantiate its utilization projections. A provider's ability to demonstrate that it can reasonably reach its census forecasts is of the utmost importance. Industry experts have expressed concerns in the past that agencies are going to find it increasingly difficult to sustain operations in the face of decreasing Medicare and Medicaid reimbursement and increasing costs. As such, providing justified utilization projections is more important than ever.

Table 9 – Documented Referral Comparison

Applicant	Year 2 Unduplicated Census	Promised Referrals from Service Area	Deficit (-) Surplus(+)
Liberty	330	0	-330
Maxim	542	0	-542
Well Care	591	0	-591
UniHealth	**582**	**2,424**	**1,842**

<u>Surveys</u>

UniHealth representatives devised, distributed and then collected 29 surveys from a wide cross-section of Forsyth County and surrounding area providers. The primary objective of the surveys was to get a first-hand, unfiltered view 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 questions related to the current home health services available and needed in Forsyth County and the surrounding area, and specifically to underserved populations. Further, each provider was asked to score service types needed from a new home health provider in the county on a scale of 0 to 4 with 0 being not needed and 4 being most needed. Please see UniHealth Exhibit 71, pages 1196-99.

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. In addition, UniHealth held a Get to Know Us event in Winston-Salem in June 2013. UniHealth representatives invited local health care providers to share their questions and concerns regarding home health in the local area. As such, UniHealth's application boasts a carefully tailored care plan that specifically addresses the services needed in Forsyth County and the surrounding area.

<u>Care Management</u>

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 the table below.

Table 10 - 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
Liberty	Yes	No	Yes	No	No	No	No	No	No
Maxim	No	Yes	Yes	Yes	Yes	No	No	No	No
Well Care	Yes	Yes	Yes	Yes	Yes	No	No	No	No
UniHealth	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**

REVISED COMPARISON

One applicant, Well Care, proposes to serve six patients in Project Year 2 from counties that show a surplus in the 2013 SMFP and provides no information to show why those counties will have unmet need. If Project Year 2 unduplicated patients are reduced by those six patients, the comparative metrics and related rankings change. In order to adjust Well Care's comparative metrics for counties that have actual home health need, UniHealth assumed that visits for these patients would be proportionate to the total patients that these patients represent, or one percent (6/591 = 1.0%).

Following this logic, Table 7 rankings would be revised and Well Care's count of Number 1's drops from seven to six: Other applicants' counts do not change, but UniHealth, alone, would have Number 1 rank in Administrative Cost per Visit. UniHealth continues to have the most Number 1's 12, of 22, double the nearest competitor.

Table 11 – Value, Access and Quality Comparison with All Metrics

Comparative Metric	Best	UniHealth	Liberty	Maxim	Well Care
Visits per Unduplicated Patient	Highest	1	4	2	3
Net Revenue Per Visit	Lowest	2	4	3	1
Net Revenue Per Unduplicated Patient	Lowest	3	1	4	2
Ratio of Net Revenue per Visit to Cost per Visit	Lowest	1	2	4	3
Total Operating Cost Per Visit	Lowest	3	4	2	1
Direct Cost Per Visit	Lowest	4	1	3	2
Administrative Cost Per Visit	Lowest	1	4	3	2
Average Direct Care Operating Cost as a Percent of Average Total Cost per Visit	Highest	1	4	3	2
RN Salary – Year 2	Highest	1	4	3	2
HHA Salary – Year 2	Highest	2	4	3	1
Unduplicated Medicare Patients as a Percent of Total Unduplicated Patients	Highest	1	3	4	2
Unduplicated Medicaid Patients as a Percent of Total Unduplicated Patients	Highest	2	4	3	1
Number of Unduplicated Medicare Patients – Year 2	Highest	1	4	3	2
Number of Unduplicated Medicaid Patients – Year 2	Highest	2	4	3	1
Duplicated Medicare Patients as a % of Total Duplicated Patients	Highest	2	1	4	3
Duplicated Medicaid Patients as a % of Total Duplicated Patients	Highest	2	4	3	1
Number of Duplicated Medicare Patients – Year 2	Highest	1	4	2	3
Number of Duplicated Medicaid Patients – Year 2	Highest	1	4	2	3
Total Dollar Amount of Indigent Care Provided	Highest	1	4	2	3
Indigent Care as a % of Gross Revenues	Highest	1	4	2	3
Total Indigent Care Admissions	Highest	1	3	4	2
Administrator Salaries	Highest	2	4	1	3
Total Number 1's		**12**	**3**	**1**	**6**

Attachment C to this Cover Letter provides the supporting details.

CONCLUSION

It is clear that, of the projects under review, UniHealth's application best demonstrates the ***2013 SMFP*** **Basic Principles: Value, Access, and Quality,** and supports the need for the services it proposes.. While all applicants possess the ability to provide care to the residents of Forsyth County, UniHealth is the only applicant that excels in all three Basic Principles and is also the best alternative when considering the comparative metrics. The application from UniHealth is competitively superior. This application:

- Increases accessibility to medically underserved groups including medically indigent, low income and elderly residents;
- Offers salaries that will ensure high quality, well trained direct care and administrative staff are employed;
- Demonstrates a commitment to quality and to providing appropriate levels of care;
- Provides programming or defines specific arrangements for home health services currently needed in Forsyth County;
- Provides a continuously improved care management program that will make UniHealth an ideal partner for area health care providers that are working with the state and CMS to decrease the area's high hospital readmission rates and set a competitive benchmark for other providers; 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

Application Analysis for compliance with CON Review Criteria,
and applicable Home Health Rules: 10A NCAC 14C .2000 .... A

Detailed Comparative Metrics .... B

Recalculated Rankings C

Certification Conversation Log .... D

CMS Psychiatric Care Regulations .... E

National Association of Home Care and Hospice Productivity Benchmarks .... F

Maxim Deferred Prosecution Agreement and Other Federal Settlement Documents .... G

Maxim Medicare Home Health Agency Organization Chart,
Exhibit 3,Project No. F-10003-12 .... H

Attachment A

Application Analysis for compliance with CON Review Criteria and Applicable Home Health Rules: 10A NCAC 14C .2000

COMPETITIVE REVIEW OF –
WELL CARE, LLC, G-10159-13

OVERVIEW

Well Care, LLC, proposes to develop a new home health agency in Kernersville, NC, and begin providing home health agency services on October 1, 2014. Well Care has two home health offices, in Raleigh and Wilmington, North Carolina. Well Care proposes to serve 378 and 591 unduplicated patients in Project Year 1 and 2, respectively.

Per the North Carolina statute § 131E-183, the application is non-conforming with Criteria 3, 4, 5, 6, 7, 13c, and 18a, for the reasons listed below.

CON 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.**

Well Care's proposed service area includes Forsyth County and seven contiguous counties, including Davidson, Guilford, and Rockingham (page 54). Well Care acknowledges the absence of need in Davidson, Guilford, and Rockingham, but tries to justify its projected patients served from those counties by simply and arbitrarily stating that "most of the existing providers in Forsyth County provide home health services to most of the adjoining counties" (page 41).

See additional discussion of this issue in Criterion 6.

The Well Care application indicates a need for pediatric care (pages 35-37). Page 37 of the application proposes that five percent of Well Care patients will be pediatric, based on its analysis of the history of existing agencies. In Project Year 2, five percent of Well Care's total patients translates to 30 patients, spread across eight counties (591 patients * 0.05 = 29.5). Not only will such an expansive service area with so few patients be difficult to staff for a single pediatric nurse, but serving so many counties will contradict the foundation for Well Care's argument that pediatric patients in Forsyth County are not well served because their providers are from outside their home county. Please see further discussion of pediatric staffing in Criterion (7).

Well Care estimates that 2.6 percent of the home health patients in the service area need psychiatric care (page 38), but the application falls short of identifying the proportion of its projected patients who will receive psychiatric nursing services. The application also fails to provide documentation that it will provide nursing staff with the qualifications needed to meet Medicare requirements for a psychiatric nurse. The referenced Exhibit 14 of the Well Care application does not provide this documentation. Attachment E with these Comments provides a description of the very specific staffing requirements imposed by Palmetto GBA for Medicare payment for psychiatric nursing care. As one can see, the application fails to demonstrate that Well Care will meet those requirements.

Please see further discussion of psychiatric staffing in Criterion (7).

Thus, for both quantitative and qualitative reasons, the application is not conforming to Criterion 3.

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 Well Care application is non-conforming to other applicable statutory and regulatory review criteria. Additionally, UniHealth outperforms Well Care in more home health comparative metrics (discussed in the attached Cover Letter), as well as in duplicated Medicare patients, charity care, letters of support, and administrator salaries. Because the 2013 SMFP reports a need for only one home health agency in Forsyth County, , Well Care did not demonstrate that the least costly or most effective alternative has been proposed.

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.

On page 113, the Well Care application accounts for contractual adjustments for Insurance and Medicaid payors, but not for Medicare. It is not clear from the assumptions how the application treats Medicare HMO. The application includes no contractual adjustment for this payor group; so, net revenue on Form B may be overstated.

In Section XII, page 102, Well Care schedules only two weeks between licensure of the proposed agency and certification. Well Care does not provide documentation to demonstrate that this is reasonable. After licensure, it will take at least a month to obtain NC DHSR Certification Section recommendation for 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 usually takes another one to three months for a Medicare number to be issued. Therefore, Well Care has not allowed for enough time in regard to Certification. Longer time for Certification could have a substantial impact on actual revenues received n Project Year 1. Please see Attachment D.

On page 118, Well Care provides for a 90-day lag in Medicare payments and shows no payment in the first quarter of Project Year 1. The application asserts that the proposed agency will be certified in the second month, which, based on UniHealth Home Heath's previous experience in North Carolina, is highly unlikely. Further, the Cash Flow statement on page 118 shows no lag in Medicare payments in Quarter 2 through Quarter 4. On page 118, Medicare Receipts for these quarters are approximately equal to Medicare charges for the same quarters on page 108. Taken together, these facts suggest that working capital for the project is underfunded. Sources of working capital in Exhibits 21 and 22 leave no extra margin for a possible shortfall.

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

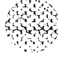
The presentation in the Well Care application suggests that the applicant has no recent experience with start up in a Medicare home health agency and has not anticipated the delays that are associated with licensure and certification. Information presented does not appear to include sufficient allowances to support the required "reasonable projections" of costs and charges required by 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.

Well Care proposes to serve counties with surplus capacity and provides no documentation to indicate that existing agencies cannot meet the need. Most notable is its proposal to serve Rockingham County, which has surplus capacity of 119.67 patients in 2014.

The Well Care application includes data from the *2013 SMFP*, Table 12C in Exhibit 15 and application page 29 and 41, all demonstrating a surplus capacity of existing agencies to serve 5.70, 1.94, and 119.67 *more* patients than needed in Davidson, Guilford, and Rockingham County, respectively. However, the Well Care application includes no information to offset this data and justify the utilization it proposes in these areas.

Well Care proposes to serve four patients from Guilford County in Project Year 1 and in Project Year 2 (see page 42). For Project Year 1, the proposed patients exceed the 1.94 surplus patients from Guilford County that the *2013 SMFP* projects for 2014. The application provides no information to demonstrate why the proposed Well Care agency would be needed by Guilford patients. It states only that other Forsyth agencies have served Guilford patients in the past.



The documentation provided for the proposed relationship with UNC hospitals in Exhibit 7 fails to demonstrate that UNC will refer home health agency patients from the proposed service area to a new Well Care agency. The documentation shows a relationship with Well Care's two other offices and a patient origin for UNC Hospitals, but it provides no information about the home health agencies that are currently serving UNC patients from the service area, and/or why those agencies cannot meet the need.

Therefore, the application is non-conforming to Criterion (6).

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 proposes to provide two services that require specialized nursing: pediatric and psychiatric home care. Section VII provides no description of the requirements for staff to provide these specialized services. The application contains no information on the availability of these specialized providers to the applicant's proposed Forsyth County agency.

Well Care proposes inadequate staffing for pediatric nursing. On page 37, Well Care states that pediatric patients in Forsyth County are medically underserved because of "*the inadequate supply of clinicians and ancillary personnel, [and] shortages of home health nurses with pediatric expertise*." As discussed in Criterion (3), Well Care proposes five percent of its patients will be pediatric. Under the assumption that five percent of visits will be pediatric, UniHealth assumes the applicant proposes 659 pediatric visits (13,183 visits * 0.05 = 659.2). Well Care proposes 6 visits a day for nursing, PT, ST, OT, and HHA. Generously assuming that Well Care could reach 30 patients in eight counties at this high level of productivity, UniHealth calculated the required pediatric staffing. 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), Well Care proposes inadequate staffing for pediatric nursing.

Table 1 - Well Care Projected Required Pediatric Nurse FTE Positions – Project Year 2

Service	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)	FTE Shortfall
Pediatric	659	6.00	0.42	0.00	0.42

As discussed in Criterion (3), Well Care estimates that 2.6 percent of home health patients in the service area need psychiatric care. Under the assumption that 2.6 percent of visits will be psychiatric, UniHealth assumes the applicant proposes 343 psychiatric visits (13,183 visits * 0.026 = 342.8). Because Well Care proposes 6 visits a day for nursing, PT, ST, OT, and HHA, in the following table, UniHealth also generously assumes Well Care's nurses can provide 6 pediatric visits per day. Well Care proposes inadequate staffing for psychiatric nursing.

Table 2 - Well Care Projected Required Psychiatric Nurse FTE Positions – Project Year 2

Services	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)	FTE Shortfall
Pediatric	343	6.00	0.22	0.00	0.22

Finally, Well Care proposes aggressive visits per day for nursing and therapies as compared to other applicants. Well Care's proposed services will be impossible to achieve given the applicant's especially large service area of eight counties. The application provides no information to demonstrate how this will be possible.

Table 3 - Applicant Projected Average Visits per FTE per Day – Project Year 2

	UniHealth	Liberty	Maxim	Well Care
Registered Nurse	4.9	5.0	5.0	6.0
Physical Therapy	Contract	5.0	5.0	6.0
Occupational Therapy	Contract	5.0	5.0	6.0
Speech Therapy	Contract	5.0	5.0	6.0
LPN	5.6	N/A	N/A	6.0
Home Health Aide	5.2	5.0	5.2	6.0
Medical Social Work	3.4	4.0	3.5	4.0

Well Care's proposed productivity (visits per day), is higher than reported by the National Association for Home Care and Hospice and will be difficult to achieve with a small staff in such a large service area. Please see documentation in Attachment F to these Comments.

For these reasons, the application is non-conforming to Criterion (7).

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 most home health agency patients will be over the age of 65, charity patients admitted for home health services will be more likely to be under the age of 65 as, nationally, approximately 98 percent of people over 65 have coverage. Further, the most recent County Health Rankings research shows that 19 percent of persons under 65 in Forsyth County are uninsured compared to a national average of 11 percent.[2] Therefore, one may surmise that charity services will be needed more in Forsyth County than in other areas.

Despite the increased need for charity care in Forsyth County, the Well Care application Form B indicates that only a mere 0.32 percent of revenues will be charity care ($5,482/ $1,739,020 = 0.0032). This demonstrates that Well Care will provide very little access to services for a population that has a higher than normal proportion uninsured, low income persons.
Thus, the application should be found non-conforming to Criterion 13(c).

[2] http://www.countyhealthrankings.org/app/north-carolina/2013/forsyth/county/outcomes/overall/snapshot/by-rank

COMPETITIVE REVIEW OF – MAXIM, LLC, G-10156-13

OVERVIEW

Maxim, LLC, proposes to develop a new home health agency in Kernersville, NC, and begin providing home health agency services on October 1, 2014. Maxim has two home health agency offices in North Carolina, Raleigh and Wilmington. Maxim proposes to serve 378 and 591 unduplicated patients in Project Year 1 and 2, respectively.

Per the North Carolina statute § 131E-183, the application is non-conforming with Criteria 3, 4, 5, 7, 8, 13c, 14, 18a, and 20, as well as the Special Rules for the reasons listed below.

The application appears to mix home care services with home health agency services throughout, making it difficult to discern what is represented in the financial proformas.

CON 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.**

On page 10, Section II.1.(b), Maxim proposes a number of specialty nursing programs including:

- Wound and ostomy care;
- Pediatric care;
- Mental health nursing and assessment;
- Alzheimer's and dementia care;
- Foreign language interpreter services; and
- Intravenous/Infusion therapy.

However, as required by Section III.1.(a), Maxim fails to show 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." [Emphasis added.]

For example, the letter from Wake Forest University Baptist Children's Hospital in Exhibit 19 does not specify the need for more pediatric home health agency services. It speaks instead, to the need for more of the type of services for which Maxim is currently licensed. *"In fact, I have several pediatric patients who would benefit from home health based care on a daily basis and I consistently struggle to find a provider who can meet these complex needs."* In North Carolina, the home care license is designed for daily care. Home health agency care is intermittent, short term skilled care.

The Baptist letter states, *"It would be beneficial for other clients to receive continuity of care by enabling Maxim to provide Medicare-certified home health services in the transition from hospital to home... "* It does not specify what the writer means by *"other patients"* Moreover, Section III of the Maxim application includes no forecasts of need for pediatric services. That section of the application focuses on and emphasizes only the needs of an aging population.

Maxim proposes to offer foreign language interpreter services on page 10. It does not include a plan of care for non-English speaking residents. Maxim fails to demonstrate how it will adequately address language needs. The application did not include a plan of action, nor did the applicant demonstrate how it plans to locate bilingual staff.

With these shortcomings, this application is non-conforming to Criterion 3.

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.

Although the Maxim application describes alternatives considered in developing the agency, the CON Section has the option of choosing the more effective alternative, UniHealth. Maxim ranks first in only one comparative metric discussed in the final comparative metrics that UniHealth presents in the Cover Letter, Tables 7 and 11. Further, Maxim ranks in the last two in 16 of 22 comparative metrics. Specifically,

- Maxim ranks last in unduplicated Medicare patients as a percent of total unduplicated patients, duplicated Medicare patients as a percent of total duplicated patients, and total indigent care admissions. Clearly, Maxim is not the most effective alternative.
- Maxim ranks last in net revenue per unduplicated patient and ratio of net revenue per visit to cost per visit. Clearly, Maxim is not the least costly alternative.

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

Maxim fails to fully document the availability of accumulated reserves or owner's equity to meet the full funding requirements for the project. Section VIII.5 requires the applicant who proposes to use its own funds to demonstrate availability of funds in accumulated reserves. In the carefully worded letter in Exhibit 15, the CFO estimates the *"total capital and working capital cost of the project...at approximately $545,000."* However, the $545,000 expressed in the aforementioned letter covers working capital only. Section VIII lists another $75,000 in fixed capital costs that is not covered by the funding letter in Exhibit 15.

The Balance Sheet in Exhibit 16 shows the company is working within tight margins. By traditional measures, the Current Ratio looks healthy. However, should the $70.889 million in "Other accrued expenses" associated with the recorded liability for settlement of the US Department of Justice Civil Division civil investigation (Note 8 Litigation) become subject to immediate payment, the Current Ratio would drop to 1.07. Moreover, the Consolidated Statement of Operations on page 3 of Exhibit 16 demonstrates a pattern of increasing losses. The combination of these with the tight operating projections described below and the other project commitments listed on page 121 of this CON application, suggest that the applicant may have trouble meeting the cash requirements for the project.

Operational Projections

- Maxim projects unreasonable utilization assumptions in its application. Maxim, on page 72 of its CON application, forecasts a very high utilization in the first month of operation (34 unduplicated patients in July 2014) and, projects that its utilization will progressively increase from that level through the first year. By July 2015, and on page 73 of the Maxim CON application, Maxim projects 43 unduplicated patients per month and in June 2016, the number increases to 47 unduplicated patients per month. This immediate high utilization, especially in the first several months of operation, is not reasonable given the nature of establishing a new home health agency in a highly competitive market. Further, this aggressive, arbitrary and seemingly unattainable utilization that Maxim has projected only serves to make the proposed agency seem more financially viable than is reasonable.

- Maxim 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. Maxim has not provided a detailed furniture list to demonstrate that its assumption is reasonable and supported. Nor has Maxim demonstrated how such meager furnishings would support the proposed staff.

- Maxim fails to provide any detailed assumptions underlying its fixed capital costs beyond stating that the capital costs are based on the applicant's operating experience.

- On page 13, Maxim proposes to offer respite care. The applicant does not demonstrate how such a service would be considered eligible for home health agency coverage. In fact, the Medicare Regulations and Guidelines specifically indicate that respite is not a covered service for a home health agency:

  EXAMPLE 3:

  A patient who needs skilled nursing care on an intermittent basis also hires a licensed practical (vocational) nurse to provide nighttime assistance while family members sleep. The care provided by the nurse, as respite to the family members, does not require the skills of a licensed nurse (as defined in §40.1) and therefore has no impact on the beneficiary's eligibility for Medicare payment of home health services even though another third party insurer may pay for that nursing care.[1]

[1] http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf

- On page 15, Maxim's application indicates that it will offer "intensive behavior assistance from a Bachelor's level worker, as well as family and individual counseling by a Master or Clinical level therapist." These positions are under a heading of "Behavioral Health" for pediatric care. It is not clear that the applicant has included budget for this position in its operating pro forma.

- Maxim's application does not include a cash flow statement with which to validate the Section IX estimates of working capital requirements by quarter in the first operating year. Because the application indicates a lack of awareness of cash flows related to start up and service eligibility in this new agency, a reader must at least suspect similar lack of awareness in operating vulnerabilities in other aspects of its agencies.

Conclusion

The Maxim application fails to demonstrate that it can fund the full capital requirements it projects are needed for proposed the new agency and appears to project visits for non-covered services; thus, 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.**

- Maxim projects unreasonable administrative staff for the proposed agency. On page 109 of the Maxim application, Maxim projects that it can manage a patient load of 542 unduplicated patients in the second project year with only 0.5Administrator FTEs. Management of a home health agency of this size using only part time administrative staff would be very difficult, at best, and is in direct contrast to organizational charts for home health agencies that Maxim has produced in CON applications in the recent past. In fact, in a CON application submitted to provide home health services in Mecklenburg County in 2012, the Maxim organizational chart with that application called for 1.0 FTEs for Administrator and 1.0 FTEs for Manager of Branch Operations. Maxim, in its Forsyth CON application, provides only 0.5 FTEs for each of these two positions. Attachment H contains a copy of the Maxim Medicare Home Health Agency Organization Chart, Exhibit 3 from CON application, F -10003-12.

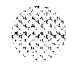
- On page 16, Maxim describes its Companion Care program that will assist individuals who may need extra help around the house. Maxim does not specify the staffing that will be required to offer this service. Like respite, this, too, is not an eligible Medicare Home Health Agency service. According to Table VII.2, Maxim proposes 0.44 FTE CNAs in Project Year 2. Not only is the service not included in Medicare Conditions of Participation, it is unlikely that these CNAs will be sufficient to offer the proposed companion service "with no minimum time constraints." The proposed Year 2 CNA staffing is the lowest among the applicants; and, would be insufficient to cover the home health aide services for 542 unduplicated patients described on page 11, sitter services on page 18 and companion care. Moreover, Form B shows no alternative source of revenue for these services.

- On page 15, Maxim describes a pediatric nursing program, proposing that its RNs, licensed practical or vocational nurses, nursing assistants, and companions will "have extensive pediatric experience". However, the job descriptions in Exhibit 9 do not list pediatric experience or education requirements. Maxim even goes as far as to propose pediatric behavioral health services on the same page. Although, this could meet requirements for pediatric care, it would not meet the CMS qualifications for psychiatric care experience described in Attachment E.

- According to Maxim application page 15, intensive behavioral assistance will be offered by a Bachelor's level social worker, as well as family and individual counseling by a Master or Clinical level therapist. Maxim requires that both of these positions have a minimum of one year of pediatric experience. In Table VII.2, Maxim proposes to have 0.10 FTE MSWs. The MSW on the staffing table is listed as one part-time employee and works only 208 hours per year, approximately 38 minutes per unduplicated patient per year. This seems hardly enough to meet the application's extensive service description for both adult and pediatric patients.

- As noted in the discussion of Criterion 5, on page 15, Maxim proposes to offer respite care; yet, the staffing tables do not appear to show costs, requirements, and/or staffing requirements that affect offering respite care.

For these reasons, this 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.

- On page 127, Maxim application states that oxygen will be provided to patients on a referral basis by an oxygen provider. Maxim also states on the same page that, "Infusion contractors will provide infusion therapy drugs...by the outpatient pharmacy service" and "durable medical equipment is billed directly to the patient by a DME provider". However, Maxim has not provided any documentation that demonstrates that the provider of the proposed services will make available or otherwise make arrangements for these ancillary and support services.

- On page 13, Section II.1.(b), the application states that the proposed agency will assist in coordinating foreign language interpreter services. However, the application provides no recruitment plan for bi-lingual staff and no contract or correspondence with any organization that can aide in interpreter services.

With these structural deficiencies, this application should be found 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:

(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

Please note that Maxim proposes $55,684 in charity care (page 139) for 54 charity care visits in Project Year 2 (page 83). The amount listed in the application would suggest an access of $1,000 per indigent visit. This is unreasonable and is not supported by facts in the Maxim application. The amount of charity care that Maxim proposes can be validated by multiplying the charge per visit by discipline on page 126 by Maxim's proposed Project Year 2 indigent visits by discipline on page 86. The true charity amount is calculated in the table below is only 0.38 percent of gross revenue ($6,775/ $1,763,146 = 0.0038).

Table 1 - Adjusted Maxim Charity Care

Discipline	Year 2 Proposed Charge (p. 126)	Projected Charity (Indigent) Visits by Service Discipline (p. 86)	Gross Charity (Indigent) Deduction
Nursing	$125	25	$3,125
Physical Therapy	$130	22	$2,860
Occupational Therapy	$130	4	$520
Speech Therapy	$130	1	$130
Medical Social Work	$175	0	$0
Home Health Aide	$70	2	$140
Total			$6,775

These important shortcomings in the face of high levels of uninsured in Forsyth County[2] should make this application non-conforming to Criterion 13(c).

[2] http://www.countyhealthrankings.org/app/north-carolina/2013/forsyth/county/outcomes/overall/snapshot/by-rank

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

In Exhibit 10, Maxim lists only two letters both addressed to Winston-Salem State University in order to demonstrate an effort to establish training relationships with local health professional training programs. UniHealth identified at least six area health professional training programs that could be potential candidates for a training agreement. Clearly, Maxim 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).

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

Section V.7.(a) asks applicants to describe how the proposed project will "foster competition by promoting (a) cost effectiveness, (b) quality, and (c) access to services in the proposed service area". However, Maxim fails to mention how its proposed project will foster competition.

Access

The collection agency policy identified on page 98 will make this proposed agency less accessible to low-income and uninsured persons, a group identified in the statute as "medically underserved."

Because the application falls short on the critical elements in this Criterion, it should be found non-conforming.

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

According to a criminal complaint with the U.S. District Court of New Jersey, from 2003 through 2009:

> *"Maxim knowingly and willfully conspired, confederated and agree 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"* [See Attachment G, Summary]

Maxim was charged with submitting fraudulent billings to government health care programs for services not rendered in order to increase reimbursements from government health care programs. Maxim was also charged with falsely modified timesheets; submitted billings through licensed offices for care actually supervised by unlicensed offices, and falsified training documentation to fraudulently support billings to government health care programs for services not rendered. Richard West, Maxim's whistleblower, presented a statement to the House of Representatives in a Joint Hearing entitled "A Medicaid Fraud Victim Speaks Out: What's Not Working and Why". In his statement on page 12, West describes his experience as a victim of Maxim's Medicaid fraud. Mr. West describes receiving services for only one year before reaching his monthly cap. Maxim had taken advantage of his disability to make a profit and had wrongfully overbilled and under delivered basic services. Meanwhile, Mr. West indicated that he received no home health services and became sicker and sicker.

Maxim entered into agreements with the federal government and involved states to resolve allegations of false claims related to certain Medicaid and Department of Veteran Affairs payments received from October 1998 through May 2009. 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. In summary, the charges against Maxim and the resulting settlement demonstrate that Maxim had widespread quality issues that must be considered by the CON Section. Details of the Maxim settlement and DPA are included in Attachment G to the Cover Letter.

The ability of Maxim to offer quality care must be seriously questioned, in light of the charges of such widespread quality violations, which included sites in North Carolina. Although CON Section has historically confined its quality review to a period of 18 months surrounding the decision date, these circumstances warrant special consideration; and, this application should be considered non-conforming to Criterion (20).

SECTION .2000 – CRITERIA AND STANDARDS FOR HOME HEALTH SERVICES

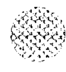
10A NCAC 14C .2002: Information Required of Applicant

(b) An applicant shall specify the proposed site on which the office is proposed to be located. If the proposed site is not owned by or under the control of the applicant, the applicant shall specify an alternate site. The applicant shall provide documentation from the owner of the sites or a realtor that the proposed and alternate site(s) are available for acquisition.

In Section XI.1, Maxim's proposed site is at 1399 Ashleybrook Lane, Suite 250, Winston Salem, NC. This is the same site as Maxim's existing Winston Salem home care agency. On page 132, Maxim states that "the Ashelybrook Lane facility has expansion space available for future need Maxim may have, including for this Medicare-certified home health agency project". However, the lease agreement in Exhibit 2 lists only Suite 250. Maxim provides no documentation that the applicant has obtained permission from Highwoods Realty leasing company for expansion. Further, rent amounts throughout the lease have been completely marked out. Maxim gives no explanation for their exclusion. Therefore, there is no way to verify the rent amount in the proforma.

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.



Maxim failed provide any copies of interest, preliminary agreements, or executed contractual agreements with health care providers for oxygen, infusion therapy, pharmacy, DME, or foreign language interpreter services. Please see further discussion in Criterion (8).

COMPETITIVE REVIEW OF –
LIBERTY HOME CARE VI, LLC, G-10160-13

OVERVIEW

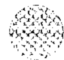
Liberty Home Care VI, LLC, proposes to develop a new home health agency in Winston Salem, NC. Liberty is a group of existing licensed and certified home health agencies with corporate offices in Wilmington and 22 agency offices in North Carolina, as well as offices in South Carolina and Virginia. Liberty proposes to serve 312 and 330 unduplicated patients in Project Year 1 and 2, respectively.

Per the North Carolina statute § 131E-183, the application is non-conforming with Criteria 4, 5, 6, 7, 8, 13c, 18a, and 20 as well as the Special Rules, for the reasons listed below.

CON REVIEW CRITERIA

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.

Although the Liberty application describes alternatives it considered in developing the agency, the Agency has the option of more effective alternatives. Specifically,



Liberty ranks last in 15 of 21 comparative metrics discussed in the UniHealth Cover Letter, **Table 5**. Liberty ranks last in the following seven comparative metrics. Clearly, Liberty is not the most effective alternative.

- Visits per unduplicated patient,
- Unduplicated Medicaid patients as a percent of total unduplicated patients,
- Number of unduplicated Medicare patients,
- Number of unduplicated Medicaid patients,
- Duplicated Medicaid patients as a percent of total duplicated patients,
- Number of duplicated Medicare patients, and
- Number of duplicated Medicaid patients.

Liberty ranks last in the following nine comparative metrics. Clearly, Liberty is not the least costly alternative.

- Net revenue per visit,
- Total operating cost per visit,
- Administrative cost per visit,
- Average direct care operating cost as a percent of average total cost per visit,
- RN salary – Project Year 2,
- HHA salary – Project Year 2,
- Dollar amount of indigent care provided,
- Indigent care as a percent of gross revenues, and
- Total indigent care admissions.

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

Liberty fails to fully document the availability of accumulated reserves or owner's equity. Liberty proposes $27,100 in fixed capital costs (Section VIII) and $298,652 in total working capital required (Section IX) for a total of $325,752. Exhibit 13 includes a letter from the McNeill's' CPA attesting that:

John A. McNeill, Jr. and Ronald B. McNeill *each* *have in excess of $250,000 in cash, stocks, or short term investments in order to fund the construction and operation of the proposed home health* [emphasis added]

However, a letter from the McNeills on the following page states that they "have both agreed and are both committed to personally funding the proposed project, including all capital expenditures and working capital, estimated to be approximately three-hundred thousand dollars ($300,000)". The letter from the McNeills commits less than the total capital requirements. Therefore, the application does not demonstrate that Liberty has available the funds for capital and operating needs of this project.

Liberty also failed to follow instructions in Section X.7.(a) to provide a balance sheet for the entire 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 from one year to the next.

The absence of a quarterly cash flow statement makes it impossible to determine how the applicant calculated the total working capital requirement for the initial operating period of the project in Section IX.

Operational Projections

Liberty's utilization projections stated in Tables IV.2 are unreliable for the following reasons: Duplicated occupational therapy patients decrease from 13 to 12 from Project Year 1 to 2. Liberty provides no information to demonstrate why this decrease is reasonable.

Duplicated Medical Social Work (MSW) visits decrease from 39 to 37 from Project Year 1 to 2. Liberty provides no information to demonstrate why the decrease is reasonable.

Liberty states that its proposed agency will utilize "telemonitoring and other technologies that allow Liberty clinicians to maximize the use of their time and minimize unnecessary visits and driving" on page 52. However, Liberty includes no budget for equipment or maintenance associated with telemonitoring. UniHealth, on the other hand, budgeted $50,000 for telemonitoring equipment as seen on UniHealth application page 273.

In Exhibit 16 of the application, Liberty budgets only one desktop and two laptops for two RNs, one HHA, one MSW, five administrative positions, and three additional clinical positions. This is unreasonable. This budget appears to be too sparse for the amount of proposed employees with the requisite purchase of a minimal number of computers and office supplies. Further, Liberty budgets only $27,100 in capital costs. In contrast, Well Care budgets $45,000, Maxim budgets $75,000, and UniHealth budgets $183,819.

On page 58, Liberty lists $9,900 in "Supplemental Staffing Revenue" as an additional line of revenue. Liberty does not define this item in its application. Liberty also fails to include expenses associated with this revenue. Therefore, Liberty's net revenue and thus, net income in Project Year 2 must be questioned.

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.**

Liberty proposes insufficient FTEs for the projected visits in speech therapy 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), inadequate staffing results in a finding of non-conformity.

Dividing projected visits by the visits per day projected for each discipline results in 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. This calculation is illustrated in the following table.

Table 1 - Liberty Projected Required Speech Therapy FTE Positions – Project Year 2

Service	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)	FTE Shortfall
Speech Therapy	253	5.00	0.19	0.03	**0.16**

The above calculation is 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 ST positions. Liberty's proposed low salary structure only adds to the unfeasible nature of this budget.

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

Table 2 - Registered Nurse FTE Salaries – Project Year 2

Applicant	RN Salary for a FTE
UniHealth	$78,056
Well Care	$77,662
Maxim	$77,080
Liberty	**$66,010.32**

Source: Tables VII.2

Table 3 - Home Health Aide FTE Salaries – Project Year 2

Applicant	RN Salary for a FTE
Well Care	$37,029
UniHealth	$36,159
Maxim	$33,245
Liberty	**$26,329.06**

Source: Tables VII.2

- Liberty under-budgets for nursing, physical therapy, and MSW staff expenses in Project Year 2. Liberty thereby under-budgets for these services, casting doubt on the entire proposed agency's net operating income in Project Year 2. Please see the following points for further discussion.

    - Liberty under-budgets for nursing staff expenses in Project Year 2. Multiplying RN and HHA FTEs provided in Column 3 of Table VII.2, by the salaries also in Table VII.2 provides the staffing budget required. Liberty under-budgets its Project Year 02 costs in Form B, page 58, by approximately $7,735. Please see the table below.

Table 4 - Liberty Nursing Salary Calculation – Project Year 2

	FTEs (Column 3, Table VII.2)	Salaries (Column 5, Table VII.2)	Cost
RN	2.00	$ 66,010.32	$ 132,021
Home Health Aide	1.00	$ 26,329.06	$ 26,329
Total Calculated Cost			***$ 158,350***
Total Staff Cost in Form B			*$ 150,615*
Amount Under-Budgeted			**$ 7,735**

    - Liberty also under-budgets for physical therapy staff expenses in Project Year 2 by approximately $21,766. Please see the table below.

Table 5 - Liberty Physical Therapy Salary Calculation – Project Year 2

	FTEs (Column 3, Table VII.2)	Salaries (Column 5, Table VII.2)	Cost
Physical Therapist	2.00	$ 75,820.68	$ 151,641
Total Staff Cost in Form B			***$ 129,875***
Amount Under-Budgeted			**$ 21,766**

- Liberty under-budgets for MSW staff expenses in Project Year 2 by approximately $6,744. Please see the table below. In addition, Liberty's MSW budget on page 59 decreases from $5,468 to $5,384 from Project Year 1 to 2. Liberty provides no further information to show why the decrease is reasonable.

Table 6 - Liberty Social Work Salary Calculation – Project Year 2

	FTEs (Column 3, Table VII.2)	Salaries (Column 5, Table VII.2)	Cost
Social Worker	0.20	$ 44,999.14	$9,000
Total Staff Cost in Form B			***$ 2,256***
Amount Under-Budgeted			**$ 6,744**

- Assumptions for administrative staff are unclear. If we assume that Liberty over-budgeted for occupational therapy and speech therapy staff expenses in Project Year 2 by $3,869 and $2,191, respectively. Liberty also over-budgets $4,960 in administrative staff expenses. However, the total $11,020 over-budgeted is not enough to cover the $36,245 under-budgeted in nursing, PT, and MSW. Please see the tables below.

Table 7 - Liberty Occupational Therapy Salary Calculation – Project Year 2

	FTEs (Column 3, Table VII.2)	Salaries (Column 5, Table VII.2)	Cost
Occupational Therapist	0.15	$ 79,560.00	$ 11,934
Total Staff Cost in Form B			***$ 15,803***
Amount Over-Budgeted			**$ 3,869**

Table 8 - Liberty Speech Therapy Salary Calculation – Project Year 2

	FTEs (Column 3, Table VII.2)	Salaries (Column 5, Table VII.2)	Cost
Speech Therapist	0.03	$86,190.00	$ 2,586
Total Staff Cost in Form B			***$ 4,777***
Amount Over-Budgeted			**$ 2,191**

Table 9 - Liberty Administrative Staff Salary Calculation – Project Year 2

	FTEs (Column 3, Table VII.2)	Salaries (Column 5, Table VII.2)	Cost
Operations Manager	0.33	$ 78,647.71	$ 25,954
Patient Care Coordinator	0.40	$ 65,896.90	$ 26,359
Secretary/Clerk	0.50	$ 24,419.62	$ 12,210
Scheduler	0.50	$ 24,419.62	$ 12,210
Home Health Liaison	0.60	$ 58,093.44	$ 34,856
Total Calculated Cost			***$ 111,588***
Total Staff Cost in Form B			*$ 116,548*
Total Amount Over-Budgeted			**$ 4,960**

Table 10 - Liberty Net Salary Calculation – Project Year 2

Discipline	Amount Over or (Under) Budgeted
Nursing	($ 7,735)
PT	($ 21,766)
MSW	($ 6,744)
OT	$ 3,869
ST	$ 2,191
Administrative	$ 4,960
Net Amount Under Budgeted	**($ 25,225)**

As the above calculations demonstrate, Liberty understates the costs and funds needed to provide the services it proposes. Liberty's statement of revenues and expenses is, therefore, incorrect. As a result, net income will decrease as expenses increase; and cash required to fund the project will increase.

For these reasons, Liberty 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.

- On pages 8 and 9, Liberty states its proposed agency will provide infusion therapy as part of its scope of services. On page 11, Liberty states that it "can provide infusion products through its sister company, Liberty Medical Specialties". However, Liberty does not provide a copy of an executed contract or letter of intent from Liberty Medical Specialties.

- On page 25, Liberty states it "will offer an interpreter on admission, as indicated by the patient's needs, preferences, and special circumstances at no cost to the impaired person". However, Liberty does not provide a copy of an executed contract or letter of intent from an interpreter service provider. The application, therefore, does not demonstrate an ability to make the service available. It is unclear if the application can provide this ancillary and support service. Moreover, assumptions for Proforma Form B do not indicate that the applicant has budgeted for interpreter services.

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

Liberty proposes the lowest percent Medicaid among the applicants. Please see the table below. Liberty's proposed proportion of Medicaid beneficiaries is below the county average. As stated on page 39, Liberty projects that 5.9 percent of duplicated patients will be covered by Medicaid. As noted in UniHealth application Exhibit 66, page 1162, on average 10.93 percent of patients provided by existing Forsyth County agencies were to Medicaid beneficiaries in 2011.

Table 11 - Applicant Medicaid Comparison – Project Year 2

Applicant	Duplicated Medicaid Patients as % of Total Duplicated Patients
Well Care	26.75%
UniHealth	19.10%
Maxim	17.8%
County Average	**10.93%**
Liberty	**5.9%**

In keeping with the CON Section's standard of meeting county or state Medicaid average, the application should be found 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.

Access

Liberty proposes that only 5.9 percent of its payor mix will be Medicaid beneficiaries. Such a low allocation to Medicaid services will affect access to home health services for a group that is already a medically underserved population. Please see further discussion in Criterion (13c).

The application is non-conforming to Criterion 18.

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

Liberty describes its ongoing performance improvement measures in Section II.7. (a); but provides no evidence that quality care has been provided in the past. The application is non-conforming to Criterion (20).

NORTH CAROLINA ADMINISTRATIVE CODE –
SECTION .2000 – CRITERIA AND STANDARDS FOR HOME HEALTH SERVICES

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.

Liberty proposes to offer infusion products through its sister company, Liberty Medical Specialties but does not provide a letter of interest, preliminary agreement, or executed contractual arrangement. Please see discussion in Criterion (8).

Attachment B

Detailed Comparative Matrix

Competitive Comparison
Forsyth County Competitive CON Review

Best	Comparative Metric	UniHealth	Liberty	Maxim	Well Care
Highest	Visits per Unduplicated Patient	22.83	16.98	22.22	22.31
Lowest	Net Revenue Per Visit	$ 126.10	$ 148.77	$ 139.71	$ 120.84
Lowest	Net Revenue/ Unduplicated Patient	$ 2,883.20	$ 2,526.78	$ 3,104.87	$ 2,695.79
Lowest	Ratio of Net Revenue per Visit to Cost per Visit	1.02	1.06	1.14	1.08
Lowest	Total Operating Cost/Visit	$ 123.05	$ 139.88	$ 122.13	$ 112.13
Lowest	Direct Cost Per Visit	$ 92.18	$ 75.24	$ 87.47	$ 81.26
Lowest	Admin Cost Per Visit	$ 30.875	$ 64.64	$ 34.65	$ 30.867
Highest	Average Direct Care Operating Cost as a % of Average Total Cost per Visit	74.91%	53.79%	71.63%	72.47%
Highest	RN Salary -Year 2	$ 78,056	$ 66,010	$ 77,080	$ 77,662
Highest	HHA Salary -Year 2	$ 36,159	$ 26,329	$ 33,245	$ 37,029
	Unduplicated Patients				
Highest	Unduplicated Medicare Patients as a % of Total Unduplicated Patients	71.20%	67.27%	65.1%	68.00%
Highest	Unduplicated Medicaid Patients as a % of Total Unduplicated Patients	19.00%	7.27%	17.7%	26.75%
Highest	Number of Unduplicated Medicare Patients - Year 2	415	222	353	402
Highest	Number of Unduplicated Medicaid Patients - Year 2	111	24	96	158
	Duplicated Patients				
Highest	Duplicated Medicare Patients as a % of Total Duplicated Patients	71.70%	73.40%	65.10%	68.00%
Highest	Duplicated Medicaid Patients as a % of Total Duplicated Patients	19.10%	5.90%	17.8%	26.75%
Highest	Number of Duplicated Medicare Patients - Year 2	2,537	577	1,771	844
Highest	Number of Duplicated Medicaid Patients - Year 2	676	46	484	332
	Indigent Care				
Highest	Dollar Amount of Indigent Care Provided	$ 17,742	$ 1,890	$ 6,775	$ 5,482
Highest	Indigent Care as a % of Gross Revenues	0.69%	0.21%	0.38%	0.32%
Highest	Total Indigent Care Admissions	10	6	4	7
Highest	Administrator Salary	$ 80,019	$ 78,648	$ 82,000	$ 79,722

	Ranking			
	UniHealth	Liberty	Maxim	Well Care
	1	4	3	2
	2	4	3	1
	3	1	4	2
	1	2	4	3
	3	4	2	1
	4	1	3	2
	1	4	3	1
	1	4	3	2
	1	4	3	2
	2	4	3	1
	1	3	4	2
	2	4	3	1
	1	4	3	2
	2	4	3	1
	2	1	4	3
	2	4	3	1
	1	4	2	3
	1	4	2	3
	1	4	2	3
	1	4	2	3
	1	3	4	2
	2	4	1	3
Number 1's	12	3	1	7

Attachment C

Recalculated Rankings

Competitive Comparison Revised
Forsyth County Competitive CON Review

Best	Comparative Metric	UniHealth	Liberty	Maxim	Well Care
Highest	Visits per Unduplicated Patient	22.83	16.98	22.22	22.31
Lowest	Net Revenue Per Visit	$ 126.10	$ 148.77	$ 139.71	$ 122.08
Lowest	Net Revenue/ Unduplicated Patient	$ 2,883.20	$ 2,526.78	$ 3,104.87	$ 2,723.43
Lowest	Ratio of Net Revenue per Visit to Cost per Visit	1.02	1.06	1.14	1.07
Lowest	Total Operating Cost/Visit	$ 123.05	$ 139.88	$ 122.13	$ 113.60
Lowest	Direct Cost Per Visit	$ 92.18	$ 75.24	$ 87.47	$ 82.10
Lowest	Admin Cost Per Visit	$ 30.875	$ 64.64	$ 34.65	$ 31.504
Highest	Average Direct Care Operating Cost as a % of Average Total Cost per Visit	74.91%	53.79%	71.63%	72.27%
Highest	RN Salary -Year 2	$ 78,056	$ 66,010	$ 77,080	$ 77,662
Highest	HHA Salary -Year 2	$ 36,159	$ 26,329	$ 33,245	$ 37,029
	Unduplicated Patients				
Highest	Unduplicated Medicare Patients as a % of Total Unduplicated Patients	71.20%	67.27%	65.1%	68.00%
Highest	Unduplicated Medicaid Patients as a % of Total Unduplicated Patients	19.00%	7.27%	17.7%	26.75%
Highest	Number of Unduplicated Medicare Patients - Year 2	415	222	353	398
Highest	Number of Unduplicated Medicaid Patients - Year 2	111	24	96	156
	Duplicated Patients				
Highest	Duplicated Medicare Patients as a % of Total Duplicated Patients	71.70%	73.40%	65.10%	68.00%
Highest	Duplicated Medicaid Patients as a % of Total Duplicated Patients	19.10%	5.90%	17.8%	26.75%
Highest	Number of Duplicated Medicare Patients - Year 2	2,537	577	1,771	844
Highest	Number of Duplicated Medicaid Patients - Year 2	676	46	484	332
	Indigent Care				
Highest	Dollar Amount of Indigent Care Provided	$ 17,742	$ 1,890	$ 6,775	$ 5,482
Highest	Indigent Care as a % of Gross Revenues	0.69%	0.21%	0.38%	0.32%
Highest	Total Indigent Care Admissions	10	6	4	7
Highest	Administrator Salary	$ 80,019	$ 78,648	$ 82,000	$ 79,722

	Ranking			
	UniHealth	Liberty	Maxim	Well Care
	1	4	3	2
	2	4	3	1
	3	1	4	2
	1	2	4	3
	3	4	2	1
	4	1	3	2
	1	4	3	2
	1	4	3	2
	1	4	3	2
	2	4	3	1
	1	3	4	2
	2	4	3	1
	1	4	3	2
	2	4	3	1
	2	1	4	3
	2	4	3	1
	1	4	2	3
	1	4	2	3
	1	4	2	3
	1	4	2	3
	1	3	4	2
	2	4	1	3
Number 1's	12	3	1	6

Attachment D

Certification Conversation Log

PDA

CONVERSATION LOG

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.

Certification Conversation Log *UniHealth Home Health (UniHealth) Project ID #* **G-10161-13**
Comments on Competing CON Proposals for a New Medicare-Certified Home Health Agency in Forsyth County

Attachment E

CMS Psychiatric Care Regulations

If you wish to save the PDF, please ensure that you change the file extension to .PDF (from .ashx).

Local Coverage Determination (LCD): Home Health - Psychiatric Care (L31531)

Contractor Information

Contractor Name	Contract Number	Contract Type
Palmetto GBA opens in new window	11004	HHH MAC

Back to Top

LCD Information

Document Information

LCD ID
L31531

LCD Title
Home Health - Psychiatric Care

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Jurisdiction opens in new window
Alabama
Arkansas
Florida
Georgia
Illinois
Indiana
Kentucky
Louisiana
Mississippi
North Carolina
New Mexico
Ohio
Oklahoma
South Carolina
Tennessee
Texas

Original Effective Date
For services performed on or after 01/24/2011

Revision Effective Date
For services performed on or after 03/07/2013

Revision Ending Date
N/A

Retirement Date
N/A

Notice Period Start Date
12/09/2010

Notice Period End Date
N/A

CMS National Coverage Policy
Title XVIII of the Social Security Act; §1862(a)(1)(A)allows coverage and payment for only those services that are considered to be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

CMS Manual System, Pub 100-01, Medicare General Information Eligibility, and Entitlement Manual, Chapter 4, §30.1

CMS Manual System, Pub 100-02, Medicare Benefit Policy Manual, Chapter 7, §§30.5.1.1 and 40.1.2.15

CMS Manual System, Pub 100-08, Medicare Program Integrity Manual, Chapter 13, §§13.1.1-13.13.14

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

The evaluation, psychotherapy and teaching activities needed by patients suffering from a diagnosed psychiatric disorder that requires active treatment by a psychiatrically trained nurse may be covered as skilled nursing care. Patients may also require medical social services, occupational therapy, home health aide visits or other home health services related to the treatment of their psychiatric diagnosis.

1. The patient must be confined to the home.

"The condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving the home would require a considerable and taxing effort."

A patient with a psychiatric disorder is considered to be homebound "...if his/her illness is manifested in part by a refusal to leave the home, or is of such a nature that it would not be considered safe for him/her to leave home unattended even if he/she has no physical limitations." The following conditions support the homebound determination:

a. Agoraphobia, paranoia or panic disorder

b. Disorders of thought processes wherein the severity of delusions, hallucinations, agitation and/or impairment of thoughts/cognition grossly affect the patient's judgment and decision making, and therefore the patient's safety

c. Acute depression with severe vegetative symptoms

d. Psychiatric problems associated with medical problems that render the patient homebound

"If a patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for relatively short duration, or are attributable to the need to receive medical treatment."

2. Services must be provided under a Home Health Plan of Care approved and signed by the treating physician.

3. Nursing services provided must meet the part-time or intermittent requirements for home health services. "In most instances, this definition will be met if a patient requires a skilled nursing service at least every 60 days."

4. Services must be reasonable and necessary for treating the patient's psychiatric diagnosis and/or symptoms.

5. The services of a skilled psychiatric nurse must be required to provide the necessary care, i.e., observation/assessment, teaching/training activities, management and evaluation of a patient care plan, or direct patient care of a diagnosed psychiatric condition which may include behavioral/cognitive interventions.

Note: Psychiatric nursing must be furnished by an agency that does not primarily provide care and treatment of mental disorders. These agencies are precluded from participating as Medicare home health agencies.

QUALIFICATIONS FOR PSYCHIATRICALLY TRAINED NURSES PROVIDING PSYCHIATRIC EVALUATION AND THERAPY IN THE HOME

1. Nurses who provide psychiatric evaluation and therapy as skilled nursing care to patients of a home health agency are required to have special training and/or experience beyond the standard curriculum required for an RN.

2. Palmetto GBA would consider the special training and/or experience requirements to be met, if the registered nurse (RN) meets one of the following criteria:

a. An RN with a Master's degree with a specialty in psychiatric or mental health nursing and licensed in the state where practicing would qualify. The RN must have nursing experience (recommended within the last three years) in an acute treatment unit in a psychiatric hospital, psychiatric home care, psychiatric partial hospitalization program or other outpatient psychiatric services.

b. An RN with a Bachelor's degree in nursing and licensed in the state where practicing would qualify. The RN must have one year of recent nursing experience (recommended within the last three years) in an acute treatment unit in a psychiatric hospital, psychiatric home care, psychiatric partial hospitalization program or other outpatient psychiatric services.

c. An RN with a Diploma or Associate degree in nursing and licensed in the state where practicing would qualify. The RN must have two years of recent nursing experience (recommended within the last three years) in an acute treatment unit in a psychiatric hospital, psychiatric home care, psychiatric partial hospitalization program or other outpatient psychiatric services.

d. An RN who has worked as a psychiatric Home Health (HH) Nurse within the last calendar year prior to the effective date of this policy will be grandfathered in.

3. On an individual basis, other combinations of education and experience may be considered.

4. It is highly recommended that psychiatric RNs also have medical/surgical nursing experience because many psychiatric patients meet homebound criteria due to a physical illness.

5. Home Health agencies should 1) submit the resume of any nurse currently providing psychiatric services under the Home Health Medicare benefit, 2) submit the resume of any RN that will be providing psychiatric services under the Home Health Medicare benefit. Send the resume to the following address:

Palmetto Government Benefits Administrators
J11 Part A, Medical Affairs
Mail Code AG-300
P. O. Box 100238
Columbia, SC 29202-3238

OR

Fax 1-803-935-0199

OR

Email J11A.Policy@PalmettoGBA.com

***Home Health Agencies should include a cover letter with each resume. The cover letter must include the agencies complete mailing address and the name and phone number of a contact person at the agency.**

The resume will be reviewed and you will be notified if the RN meets the requirements or not within 30 days.
***Note:** This notification should be in your files prior to the RN rendering psychiatric services.

6. Nurses with these qualifications would meet the requirements necessary to provide psychiatric evaluation and therapy to Medicare home health patients. The services of a psychiatric nurse are to be provided under a plan of care established and reviewed by the treating physician.

7. For additional information, see the ***BILLING WHEN SEPARATE VISITS WERE MADE FOR MEDICAL AND PSYCHIATRIC NURSING CARE*** section of this policy.

Diagnostic Criteria

1. A Patient must have an Axis I Diagnosis as defined in the Diagnostic and Statistical Manual of Mental Health Disorders, 4th Edition, DSM-IV-TR. This diagnosis must match the diagnosis that the ordering physician is treating and/or for which the patient was hospitalized. This diagnosis must be fully documented and available in the medical record.

The DSM-IV-TR utilizes a multiaxial assessment methodology and "Axis I" is defined as "Clinical disorders, other conditions that may be a focus of clinical assessment" as opposed to personality disorders, mental retardation, general medical conditions, psychosocial and environmental problems and global assessment of functioning.

2. The patient must be under the care of a physician who is qualified to sign the physician's certification and recertify the plan of care at least every 60 days (two months). The physician's evaluation and subsequent recertifications must become part of the patient's medical record.

3. If the skills of a psychiatric RN are required, the service must be reasonable and necessary and intermittent.

4. Reasonable goals must be established and there must be a reasonable expectation that the goals will be achieved. Decreasing and/or shortening in-patient and emergency room care may be a goal for the psychiatric patient's plan of care.

Home Health Plan of Care
The Plan of Care for a psychiatric patient must be completed. Emphasis must be placed on documentation of mental status and those skills necessary to treat the psychiatric diagnosis.

Psychiatric Interdisciplinary Team's Role

Physician:

1. Certifies/Recertifies the patient's homebound status

2. Approves Home Health Plan of Care which must be signed and dated prior to the home health agency billing for services.

3. Prescribes medications as necessary

4. Provides supplemental orders when medically necessary

Skilled Nursing Care:

Registered Psychiatric Nurse:

1. Makes initial assessment visit utilizing observation/assessment skills

2. Manages medical illness; performs psycho-biological interventions

3. Evaluates, teaches and reviews medications and compliance; administers IM or IV medication

4. Manages situational or other crises; performs assessments of potential self harm or harm to others, and refers to the treating physicians as necessary

5. Teaches self-care, mental and physical well-being, promotes independence and patient's rights

6. Promotes and encourages patient/caregiver to maintain a therapeutic environment

7. Provides supportive counseling psychotherapy and psycho-therapeutic interventions according to education and licensure. Provides psycho-education such as teaching/training with disease process, symptom and safety management, coping skills and problem solving

8. Provides evaluation and management of the patient's care plan

9. Counseling services may be rendered by either a trained psychiatric nurse or a social worker. These services should not be duplicative. Concurrent counseling or psychotherapy services by multiple providers are not medically necessary

10. Although intervention with family members may be appropriate on occasion, services by a trained psychiatric nurse to family members are not a covered home health benefit, even if the patient will benefit.

Medical Social Services

Medical social services provided by a qualified medical social worker (MSW) or a social work assistant under the supervision of a qualified MSW, may be covered as home health services when **all** of following apply:

1. The patient meets the qualifying criteria for coverage of Home Health services.

2. The services of these professionals are necessary to resolve social or emotional problems which are, or are expected to be, an impediment to the effective treatment of the patient's psychiatric condition or his/her rate of recovery.

. The plan of care clearly indicates that the skills of a qualified MSW (or a social worker assistant under the supervision of a qualified MSW) are required to safely and effectively provide the needed care.

When the above requirements are met, coverage for social worker visits may include, but are not limited to the following:

1. Assessment of the social and emotional factors related to the patient's illness, the need for care, response to treatment and adjustment to care

2. Assessment of the relationship of the patient's medical and nursing requirements to the individual's home situation, financial resources and availability of community resources

3. Counseling services that are required by the patient for the treatment of their psychiatric condition (Psychotherapy services, constituting active treatment of the psychiatric condition, may be provided by licensed clinical social workers.)

4. Brief counseling (two or three visits) of the patient's family or care-giver(s) when they are reasonable and necessary to resolve problems that are a clear and direct impediment to the treatment of patient's illness or injury or rate of recovery

5. Appropriate action to obtain available community resources to assist in resolving the patient's problem

Note: Medicare **does not** cover the services of an MSW to assist in filing the application for Medicaid or follow up on the application. Federal regulation requires the state to provide assistance in completing the application to anyone who chooses to apply for Medicaid.

Note: A patient may require separate and distinct services provided by a skilled psychiatric nurse and a medical social worker. However, care must be used to avoid duplication of services that could be provided by both of these disciplines, e.g., counseling of the patient.

Home Health Aide (HHA)

Home health aids may perform personal care or other covered home health aide services.

Occupational Therapist (OT)

1. The skills of an occupational therapist may be required to decrease or eliminate limitations in functional activity imposed by psychiatric illness or disability. Occupational therapists may address factors which interfere with the performance of specific functional activities due to cognitive, sensory, psychosocial or perceptual deficits.

2. The skills of an occupational therapist to assess and reassess a patient's rehabilitation needs and potential or to develop and/or implement an occupational therapy plan are covered when they are reasonable and necessary because of the patient's condition.

3. The planning, implementing and supervision of therapeutic programs (including, but not limited to those listed below) are skilled occupational therapy services. As such these services are covered if they are reasonable and necessary for the treatment of the patient's illness or injury.

a. Selecting and teaching task oriented therapeutic activities designed to restore and increase cognitive abilities and functional participation in ADLs and advanced ADLs

b. Planning, implementing and supervising therapeutic tasks and activities designed to restore sensory-integrative function

c. Planning, implementing and supervising of individualized therapeutic activity programs (as well as adapting the environment) as part of an overall "active treatment" program for a patient with a diagnosed psychiatric illness

d. Assessing and planning for improved home safety

Billing When Separate Visits Were Made for Medical and Psychiatric Nursing Care

Psychiatric nursing care is not separately billable from non-psychiatric nursing care. Both of these services constitute skilled nursing care and may be furnished by the psychiatric nurse, in the course of a single visit. Therefore, visits will not be covered for one nurse to provide psychiatric nursing care and another to provide non-psychiatric nursing care, unless the non-psychiatric nursing care is of such a highly specialized and technical nature, that the service could not be safely rendered by the psychiatric nurse (e.g. infusion therapy).

Concurrent Admission to Home Health and Partial Hospitalization Program

Because Partial Hospitalization services are intended to meet all of the patient's psychiatric care needs, patients admitted to a Partial Hospitalization Program (PHP) are not generally considered appropriate for psychiatric home health services. Medical necessity must be substantiated on a case by case basis. If there are concurrent admissions, the home health claims will be reviewed to verify the medical necessity of the service(s) provided and that the homebound criterion is met.

Discharge Criteria

Patients should cease receiving psychiatric home health services when:

1. Physician orders discharge

2. Patient discontinues/refuses service with physician or nurse

3. Patient is not compliant with the treatment plan, despite appropriate provider interventions

4. Patient/family requests discharge

5. The treatment objectives and stated functional outcome goals have been attained or are no longer attainable

6. The patient is no longer homebound

7. Other appropriate discharge protocols, e.g., the patient moves or is transferring to another agency, etc.

Psychiatric Nursing in Group Setting

Group interventions for psychiatric home health patients are not covered under the home health benefit. The plan of care and treatment must be individualized.

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Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

032x Home Health - Inpatient (plan of treatment under Part B only)
033x Home Health - Outpatient (plan of treatment under Part A, including DME under Part A)

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

0430 Occupational Therapy - General Classification
0550 Skilled Nursing - General Classification
0560 Home Health (HH) - Medical Social Services - General Classification
0570 Home Health (HH) Aide - General Classification

CPT/HCPCS Codes

Group 1 Paragraph: As of July 1999, Home Health agencies must use the following HCPCS codes when billing for Home Health services provider under a plan of treatment. These services must report time spent with the patient in 15-minute increments.

Group 1 Codes:

G0152	SERVICES PERFORMED BY A QUALIFIED OCCUPATIONAL THERAPIST IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES
G0154	DIRECT SKILLED NURSING SERVICES OF A LICENSED NURSE (LPN OR RN) IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES
G0155	SERVICES OF CLINICAL SOCIAL WORKER IN HOME HEALTH OR HOSPICE SETTINGS, EACH 15 MINUTES
G0156	SERVICES OF HOME HEALTH/HOSPICE AIDE IN HOME HEALTH OR HOSPICE SETTINGS, EACH 15 MINUTES

ICD-9 Codes that Support Medical Necessity

roup 1 Paragraph: Patients must have Axis I Diagnosis as defined in the DSM-IV-TR.

Group 1 Codes:

290.11	PRESENILE DEMENTIA WITH DELIRIUM
290.12	PRESENILE DEMENTIA WITH DELUSIONAL FEATURES
290.13	PRESENILE DEMENTIA WITH DEPRESSIVE FEATURES
290.20	SENILE DEMENTIA WITH DELUSIONAL FEATURES
290.21	SENILE DEMENTIA WITH DEPRESSIVE FEATURES
290.3	SENILE DEMENTIA WITH DELIRIUM
290.41	VASCULAR DEMENTIA, WITH DELIRIUM
290.42	VASCULAR DEMENTIA, WITH DELUSIONS
290.43	VASCULAR DEMENTIA, WITH DEPRESSED MOOD
291.0	ALCOHOL WITHDRAWAL DELIRIUM
291.1	ALCOHOL-INDUCED PERSISTING AMNESTIC DISORDER
291.2	ALCOHOL-INDUCED PERSISTING DEMENTIA
291.81	ALCOHOL WITHDRAWAL
291.89	OTHER SPECIFIED ALCOHOL-INDUCED MENTAL DISORDERS
292.0	DRUG WITHDRAWAL
292.11	DRUG-INDUCED PSYCHOTIC DISORDER WITH DELUSIONS
292.12	DRUG-INDUCED PSYCHOTIC DISORDER WITH HALLUCINATIONS
292.2	PATHOLOGICAL DRUG INTOXICATION
292.81 - 292.84 opens in new window	DRUG-INDUCED DELIRIUM - DRUG-INDUCED MOOD DISORDER
292.85	DRUG INDUCED SLEEP DISORDERS
292.89	OTHER SPECIFIED DRUG-INDUCED MENTAL DISORDERS
92.9	UNSPECIFIED DRUG-INDUCED MENTAL DISORDER
293.81 - 293.84 opens in new window	PSYCHOTIC DISORDER WITH DELUSIONS IN CONDITIONS CLASSIFIED ELSEWHERE - ANXIETY DISORDER IN CONDITIONS CLASSIFIED ELSEWHERE
293.89	OTHER SPECIFIED TRANSIENT MENTAL DISORDERS DUE TO CONDITIONS CLASSIFIED ELSEWHERE, OTHER
293.9	UNSPECIFIED TRANSIENT MENTAL DISORDER IN CONDITIONS CLASSIFIED ELSEWHERE

294.0	AMNESTIC DISORDER IN CONDITIONS CLASSIFIED ELSEWHERE
294.11	DEMENTIA IN CONDITIONS CLASSIFIED ELSEWHERE WITH BEHAVIORAL DISTURBANCE
294.20	DEMENTIA, UNSPECIFIED, WITHOUT BEHAVIORAL DISTURBANCE
294.21	DEMENTIA, UNSPECIFIED, WITH BEHAVIORAL DISTURBANCE
294.8	OTHER PERSISTENT MENTAL DISORDERS DUE TO CONDITIONS CLASSIFIED ELSEWHERE
295.00	SIMPLE TYPE SCHIZOPHRENIA UNSPECIFIED STATE
295.01 - 295.04 opens in new window	SIMPLE TYPE SCHIZOPHRENIA SUBCHRONIC STATE - SIMPLE TYPE SCHIZOPHRENIA CHRONIC STATE WITH ACUTE EXACERBATION
295.10	DISORGANIZED TYPE SCHIZOPHRENIA UNSPECIFIED STATE
295.11 - 295.14 opens in new window	DISORGANIZED TYPE SCHIZOPHRENIA SUBCHRONIC STATE - DISORGANIZED TYPE SCHIZOPHRENIA CHRONIC STATE WITH ACUTE EXACERBATION
295.30	PARANOID TYPE SCHIZOPHRENIA UNSPECIFIED STATE
295.31 - 295.34 opens in new window	PARANOID TYPE SCHIZOPHRENIA SUBCHRONIC STATE - PARANOID TYPE SCHIZOPHRENIA CHRONIC STATE WITH ACUTE EXACERBATION
295.40 - 295.45 opens in new window	SCHIZOPHRENIFORM DISORDER, UNSPECIFIED - SCHIZOPHRENIFORM DISORDER, IN REMISSION
295.50 - 295.55 opens in new window	LATENT SCHIZOPHRENIA UNSPECIFIED STATE - LATENT SCHIZOPHRENIA IN REMISSION
295.70	SCHIZOAFFECTIVE DISORDER, UNSPECIFIED
295.71 - 295.74 opens in new window	SCHIZOAFFECTIVE DISORDER, SUBCHRONIC - SCHIZOAFFECTIVE DISORDER, CHRONIC WITH ACUTE EXACERBATION
295.75	SCHIZOAFFECTIVE DISORDER, IN REMISSION
296.01 - 296.05 opens in new window	BIPOLAR I DISORDER, SINGLE MANIC EPISODE, MILD - BIPOLAR I DISORDER, SINGLE MANIC EPISODE, IN PARTIAL OR UNSPECIFIED REMISSION
296.11 - 296.15 opens in new window	MANIC AFFECTIVE DISORDER RECURRENT EPISODE MILD DEGREE - MANIC AFFECTIVE DISORDER RECURRENT EPISODE IN PARTIAL OR UNSPECIFIED REMISSION
296.21 - 296.25 opens in new window	MAJOR DEPRESSIVE AFFECTIVE DISORDER SINGLE EPISODE MILD DEGREE - MAJOR DEPRESSIVE AFFECTIVE DISORDER SINGLE EPISODE IN PARTIAL OR UNSPECIFIED REMISSION
296.31 - 296.35 opens in new window	MAJOR DEPRESSIVE AFFECTIVE DISORDER RECURRENT EPISODE MILD DEGREE - MAJOR DEPRESSIVE AFFECTIVE DISORDER RECURRENT EPISODE IN PARTIAL OR UNSPECIFIED REMISSION
296.41 - 296.45 opens in new window	BIPOLAR I DISORDER, MOST RECENT EPISODE (OR CURRENT) MANIC, MILD - BIPOLAR I DISORDER, MOST RECENT EPISODE (OR CURRENT) MANIC, IN PARTIAL OR UNSPECIFIED REMISSION
296.51 - 296.55 opens in new window	BIPOLAR I DISORDER, MOST RECENT EPISODE (OR CURRENT) DEPRESSED, MILD - BIPOLAR I DISORDER, MOST RECENT EPISODE (OR CURRENT) DEPRESSED, IN PARTIAL OR UNSPECIFIED REMISSION
296.61 - 296.65 opens in new window	BIPOLAR I DISORDER, MOST RECENT EPISODE (OR CURRENT) MIXED, MILD - BIPOLAR I DISORDER, MOST RECENT EPISODE (OR CURRENT) MIXED, IN PARTIAL OR UNSPECIFIED REMISSION
296.7	BIPOLAR I DISORDER, MOST RECENT EPISODE (OR CURRENT) UNSPECIFIED
296.80	BIPOLAR DISORDER, UNSPECIFIED
296.81	ATYPICAL MANIC DISORDER
296.82	ATYPICAL DEPRESSIVE DISORDER
296.89	OTHER AND UNSPECIFIED BIPOLAR DISORDERS, OTHER
296.90	UNSPECIFIED EPISODIC MOOD DISORDER
296.99	OTHER SPECIFIED EPISODIC MOOD DISORDER
297.0 - 297.9 opens in new window	PARANOID STATE SIMPLE - UNSPECIFIED PARANOID STATE
298.0 - 298.9 opens in new window	DEPRESSIVE TYPE PSYCHOSIS - UNSPECIFIED PSYCHOSIS
299.00 - 299.01 opens in new window	AUTISTIC DISORDER, CURRENT OR ACTIVE STATE - AUTISTIC DISORDER, RESIDUAL STATE
299.10	CHILDHOOD DISINTEGRATIVE DISORDER, CURRENT OR ACTIVE STATE
299.11	CHILDHOOD DISINTEGRATIVE DISORDER, RESIDUAL STATE
299.80	OTHER SPECIFIED PERVASIVE DEVELOPMENTAL DISORDERS, CURRENT OR ACTIVE STATE
299.81	OTHER SPECIFIED PERVASIVE DEVELOPMENTAL DISORDERS, RESIDUAL STATE
300.00 - 300.9 opens in new window	ANXIETY STATE UNSPECIFIED - UNSPECIFIED NONPSYCHOTIC MENTAL DISORDER
310.81	PSEUDOBULBAR AFFECT

310.89	OTHER SPECIFIED NONPSYCHOTIC MENTAL DISORDERS FOLLOWING ORGANIC BRAIN DAMAGE
311	DEPRESSIVE DISORDER NOT ELSEWHERE CLASSIFIED
331.11	PICK'S DISEASE
331.19	OTHER FRONTOTEMPORAL DEMENTIA
331.2	SENILE DEGENERATION OF BRAIN
331.6	CORTICOBASAL DEGENERATION
331.82	DEMENTIA WITH LEWY BODIES
332.1	SECONDARY PARKINSONISM
333.71	ATHETOID CEREBRAL PALSY
333.72	ACUTE DYSTONIA DUE TO DRUGS
333.85	SUBACUTE DYSKINESIA DUE TO DRUGS
333.90	UNSPECIFIED EXTRAPYRAMIDAL DISEASE AND ABNORMAL MOVEMENT DISORDER
333.92	NEUROLEPTIC MALIGNANT SYNDROME
333.94	RESTLESS LEGS SYNDROME
333.99	OTHER EXTRAPYRAMIDAL DISEASES AND ABNORMAL MOVEMENT DISORDERS
780.1	HALLUCINATIONS
780.33	POST TRAUMATIC SEIZURES

ICD-9 Codes that DO NOT Support Medical Necessity
N/A

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General Information

Associated Information

Documentation Requirements

1. Legible documentation should address the diagnoses and interventions identified on the Plan of Care.

2. Legible documentation should be brief and factual. Use descriptive charting: be problem-specific.

3. Legible documentation should clearly support the medical necessity for services.

4. Each visit note should include legible documentation of any psychiatric or medical assessment, an evaluation of the patient's mental status, level of function and progress toward goals. Document objectively when describing behaviors and/or findings.

5. Legibly document changes in the patient's condition and the actions taken, e.g., notification of the physician.

6. Legibly document the assessment of home milieu and supportive environment.

7. Teaching has to be directed to improving function. Document identified teaching needs in response to psychiatric symptoms. Document all patient/family education, the reason for education, what was taught, and the patient's response. If repetitive teaching is required, documentation must clearly show the medical necessity of that teaching.

8. Document the patient's understanding and compliance of the medication regimen and treatment plan, and how verified.

9. Document the administration of IM and/or IV medications, their effectiveness, and any side effects of the patient's medication regime.

10. Document patient safety issues.

11. Documentation should show that periodic venipuncture for blood levels for psychiatric medications, such as Lithium, Tegretol, Clozaril and others, and other related laboratory work, are performed when necessary and pertinent reports of results are in the medical record. This ensures patient compliance and appropriate therapeutic levels.

12. The person rendering the service must sign each visit note. If psychiatric services were rendered it must have been performed by a psychiatric RN, and their resume must have been reviewed and approved by Palmetto GBA.

Utilization Guidelines

1. Psychiatric skilled nursing care must be provided by a credential nurse (Services will be denied if their psychiatric credentials are not on file with Palmetto GBA.)

2. For patients with Alzheimer's disease please refer to the Local Coverage Determination (LCD) Home Health Skilled Nursing Care-Teaching and Training Alzheimer's Disease and Behavioral Disturbances L31532.

Sources of Information and Basis for Decision
Diagnostic and Statistical Manual of Mental Health Disorders, 4th Edition, DSM-IV, American Psychiatric Association, 2000

IASD Health Services Corporation policy on Home Health Psychiatric Care, 9/1/96

Diagnostic and Statistical Manual of Mental Health Disorders, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000.

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Revision History Information

Please note: The Revision History information included in this LCD prior to 1/24/2013 will now display with a Revision History Number of "R1" at the bottom of this table. All new Revision History information entries completed on or after 1/24/2013 will display as a row in the Revision History section of the LCD and numbering will begin with "R2".

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
03/07/2013	R2	***Documentation Requirements*** and ***Utilization Guidelines*** *have been moved under* ***Associated Information****. Under* ***Associated Information*** *statements #1 and #13 were deleted. Several of the statements have been re-worded to say "legible documentation".*	• Other
10/18/2012	R1	Revision #2, 10/18/2012 Under ***CMS National Coverage Policy*** CMS Internet-Only Manual, Pub 100-02, Medicare Benefit Policy Manual, Chapter 7, §30.5.1.1 was added. Under ***Indications and Limitations of Coverage and/or Medical Necessity*** in the section *Qualifications for psychiatrically trained nurses providing psychiatric evaluation and therapy in the home* added a fax number and/or email address for the submission of nurses' resumes for approval. Added a statement regarding submitting a cover letter with each resume and its contents. Under ***Documentation Requirements*** changed the word "Intermediary" to "A/B MAC'. Under ***Sources of Information and Basis for Decision*** changed the date from 1995 to 2000 in the first citation. Annual review completed. This revision becomes effective on 10/18/2012. Revision #1, 10/01/2011 Under ***ICD-9 Codes That Support Medical Necessity*** the following ICD-9 codes have been added: 294.20, 294.21, 310.81, 310.89 and 331.6. This revision becomes effective on 10/01/2011	• Maintenance (annual review with now changes, formatting, etc) • Narrative Change

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
		01/24/2011 - In accordance with Section 911 of the Medicare Modernization Act of 2003, Palmetto GBA Title 18 RHHI (00380) was removed from this LCD and implemented to Palmetto GBA J11 HH and H MAC (11004). Effective date of this Implementation is January 24, 2011.	

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Associated Documents

Attachments
N/A

Related Local Coverage Documents
N/A

Related National Coverage Documents
N/A

Public Version(s)
Updated on 03/07/2013 with effective dates 03/07/2013 - N/A
Updated on 10/11/2012 with effective dates 10/18/2012 - 03/06/2013
Updated on 09/23/2011 with effective dates 10/01/2011 - 10/17/2012
Updated on 11/30/2010 with effective dates 01/24/2011 - N/A
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Keywords

- Home Health Psychiatric Care

Read the **LCD Disclaimer opens in new window**
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Certification Conversation Log *UniHealth Home Health (UniHealth) Project ID #* **G-10161-13**
Comments on Competing CON Proposals for a New Medicare-Certified Home Health Agency in Forsyth County

Attachment F

National Association of Home Care and Hospice Productivity Benchmark

BASIC STATISTICS ABOUT HOME CARE
Updated 2010

Prepared by: The National Association for Home Care & Hospice
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Home care is a diverse and dynamic service industry that began in US in the 1880's. Approximately 12 million individuals[1] currently receive care from more than 33,000 providers[2] (for causes including acute illness, long-term health conditions, permanent disability, or terminal illness). In 2009, annual expenditures for home health care were projected to be $72.2 billion.[3]

HOME CARE PROVIDERS

"Home care organizations" include home health care agencies, home care aide organization, and hospices. Some of these organizations are Medicare certified, which allows providers to bill Medicare for reimbursement. Agencies that are not Medicare certified cannot be reimbursed through Medicare.

Medicare-certified Agencies

While home care agencies have been providing services to Americans for more than a century, Medicare's 1965 enactment accelerated the industry's growth by covering home health care services for the elderly. Services were then extended to certain disabled Americans in 1973. Between 1967 and 1985, Medicare-certified agencies grew more than three-fold (1,753 to 5,983); however, in the mid-1980s, Medicare-certified home health care agencies reached a plateau (approximately 5,900) due to Medicare administrative burden and unreliable payments. This led to a 1987 lawsuit brought against the then-Health Care Financing Administration (HCFA) by US Representatives Harley Staggers (D-WV) and Claude Pepper (D-FL), consumer groups, and the National Association for Home Care (NAHC). The successful lawsuit gave NAHC the opportunity to participate in rewriting Medicare coverage policies, which significantly increased Medicare's annual home care outlays, and the number of agencies rose to over 10,000. Prior to clarifications in coverage, public health agencies dominated the ranks of certified entities. After that, the number of hospital-based and freestanding proprietary agencies grew faster than any other types of organizations. Currently, more than 62 percent of agencies are freestanding proprietary agencies 12 percent are hospital-based. Table 1 (see Appendix A) shows the changes over time in types of agencies participating in Medicare.

[1] This estimate comes from a June 2008 NAHC study of cost report information to determine the number of home health and in-home hospice patients served, and a private survey of NAHC members to obtain an estimate of private duty patients served.

[2] This number is a combination of Medicare certified home health agencies, Medicare certified hospices, and an estimate of non-Medicare agencies providing care in the home.

[3] Centers for Medicare & Medicaid Services, Office of the Actuary (March 2010).

By the end of 2001, the number of Medicare-certified home health agencies declined to 6,861. NAHC believes the 30.4 percent decline in agencies between 1997 and 2001 can be attributed to changes in Medicare home health coverage and reimbursement enacted as part of the Balanced Budget Act of 1997 (BBA) (P.L. 105-33). With the advent of the home health prospective payment system (PPS) in 2000, financial stability returned, and the number of agencies rebounded to 10,581 by the end of 2009, for the first time surpassing the number of agencies in 1997.

Medicare-certified Hospices

Medicare added hospice benefits in October 1983, 10 years after the first hospice opened in the US. Hospices provide palliative care and social, emotional, and spiritual support services to terminally ill patients and their families. The number of Medicare-certified hospices has grown from 31 in 1984 to 3,407 as of December 31, 2009.

Non-Medicare-certified Agencies

Because of variation in licensing and oversight among states, it is difficult to assess the number of non-certified agencies. Non-certified home care agencies, home care aide organizations, and hospices that remain outside of Medicare do so for a variety of reasons. For example, some do not provide the breadth of services that Medicare requires, such as home health aide organizations that do not provide skilled nursing care.

HOME CARE EXPENDITURES AND UTILIZATION

The Centers for Medicare & Medicaid Services (CMS) projects that total national expenditures for health care in 2009 were $2.5 trillion (17.3 percent of the gross domestic product—the result of a combined 5.7 percent growth in health spending and a decline in gross domestic product of 1.1 percent).
Health spending by public payers is projected to have grown 8.7 percent in 2009, in contrast to 3.0 percent growth in spending for private payers. A main element driving public payer acceleration is anticipated growth in Medicaid enrollment (6.5 percent) and spending (9.9 percent) as a result of increasing unemployment due to the recession.
Private insurance enrollment was anticipated to decline 1.2 percent, slowing the growth in private payer spending in 2009. Despite expected economic growth in 2010, private health spending growth is projected to further slow—to 2.8 percent, related to reduced enrollment in private health insurance as a result of a continuing high rate of unemployment and an expiration of subsidies for coverage provided through the Consolidated Omnibus Budget Reconciliation Act (COBRA).
Public spending is projected to grow more slowly as well—5.2 percent in 2010, much of which can be attributed to a deceleration in Medicare spending growth to 1.5 percent, from 8.1 percent in 2009.[4]

Figure 1 provides projected 2009 national expenditures for personal health care by type. Of the more than $2 trillion attributed to personal health care spending in 2009, only a small fraction (approximately 4 percent) was spent on freestanding home care. (Hospital-

[4] Truffer, Christopher, et al. "Health Spending Projections Through 2019: The Recession's Impact Continues," Health Affairs): March 2010.

based home care is included with hospital expenditures.)

Total home care spending is difficult to estimate due to limitations of data sources. The Centers for Medicare & Medicaid Services (CMS) estimated total spending for home care to be $65 billion in 2008.[5] These estimates do not include spending for home care services that are unavailable in the national health accounts data; for example, payments made by consumers directly to independent providers.

Medicare Home Health

Medicare is the largest single payer of home health care services. In 2009, Medicare spending accounted for approximately 41 percent of home health expenditures. (See Figure 2. Note: Medicare expenditures for home health include expenditures for hospice and home health care.) Other public funding sources for home health include Medicaid, the Older Americans Act, Title XX Social Services Block Grants, the Veterans' Administration, and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). While Medicare pays the largest share for home health care, combined federal-state Medicaid outlays for in-home services (including personal care services that Medicare does not pay for) are actually greater. However, Medicaid is projected to become the largest payer of such services by 2010, following nearly a decade of double-digit growth associated with shifting preferences away from institutional care toward home and community-based settings. While Medicaid spending growth for home health is expected to slow as the shift toward home-based care continues at a lesser pace, it is still expected to remain strong, averaging 11.4 percent per year over the projection period.[6]

As recently as 1997, home health spending was 9 percent of Medicare's benefit payments. Growth in the Medicare home health benefit between 1990 and 1996 can be attributed to specific legislative expansions of the benefit, court decisions, and to myriad socio-demographic trends that fostered growth in the program from the beginning. The percent of spending, however, has declined since 1997. In 2009, the home health benefit accounted for 4.2 percent of total Medicare spending ($434 billion). Nearly 37 percent was spent for hospital care, 14 percent for physician services, and nearly three percent for hospice care (See Figure 3).

Between 1998 and 2000, Medicare home health spending fell from $14 billion to $9.2 billion (-34 percent) through the BBA. The BBA's interim payment system (IPS) introduced a per-beneficiary limit designed to limit growth in home health expenditures by excluding a two-year inflation adjustment. Finally, agency payments under the IPS were restricted to the lowest of the agency's actual costs, the per-visit cost limits, or per-beneficiary cost limits. The Lewin Group, a health care consulting firm, estimated that 90 percent of agencies had costs that exceeded BBA limits by an average of 32 percent without changing practice patterns.[7]

The Medicare Payment Advisory Commission (MedPAC) calculated a total reduction of 1.3 million beneficiaries between 1997 and 2001. Visits per client and per client reimbursement had also declined since 1996. Two studies conducted by researchers at The George Washington University identified beneficiary access problems resulting from the BBA.[8,9] Additional studies from MedPAC and the Government Accountability Office (GAO) also suggest that access is a growing problem for patients who require intensive services.[10] In June 2003, MedPAC issued a report, indicating that skilled nursing facility (SNF) care is now substituting for home health care for some patients, most likely at a much higher cost to Medicare.[11] In June 2007, MedPAC issued another report, indicating that 78 percent of beneficiaries had no problems accessing home health services in 2004, up from 74 percent in 2001, while 12 percent had a small problem and 11 percent had a big problem in 2004, in contrast to 13 and 12 percent, respectively, in 2001.

Table 2 shows changes in utilization and expenditures in the Medicare home health benefit that have occurred since 1996. An estimated 3.6 million Medicare enrollees received fee-for-service home health services in 1997, twice the number of recipients in 1990. Between 1996 and 2001, utilization of Medicare home health services decreased from 3,599,700 to 2,402,500, a 33 percent drop. By 2008, utilization had risen to 3,171,600, a 32 percent recovery.[12]

Medicare Home Health Prospective Payment

The BBA mandated that CMS develop a PPS (implemented October 1, 2000) for Medicare home health, which set a national payment rate and enticed providers to deliver more efficient care.[13] The findings of a final evaluation of CMS' episode-based PPS demonstration identified a reduction in overall episode costs, which was accompanied by an increase in per-visit costs when agencies were paid prospectively based on an episode of care. This is due in large part to fewer visits over which to budget fixed costs.[14]

The home health PPS relies on a 153-category case-mix adjuster (80 previous to 2008) to set payment rates based on patient characteristics including clinical severity, functional status, and the need for rehabilitative therapy services. The case-mix adjusted payment rate is similar to the Medicare SNF and inpatient hospital prospective payment systems. Like its counterparts, the home health PPS also includes payments that partially reimburse for unexpectedly high outliers, and adjusts payments for geographically through an area wage index. However, a major difference among the systems is the unit of payment. SNFs are paid by the day while the home health PPS pays by the 60-day episode.

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[5] Centers for Medicare & Medicaid Services (CMS) online data, published March 2010.

[6] Sisko, Andrea, C. Truffer, S. Smith, S. Keehan, et al. "Health Spending Projections Through 2018: Recession Effects Add Uncertainty To The Outlook," Health Affairs (Web Exclusive): February 24, 2009.

[7] The Lewin Group, "An Impact Analysis for Home Health Agencies of the Medicare Home Health Interim Payment System of the 1997 Balanced Budget Act." Washington, DC: National Association for Home Care (August 11, 1999).

[8] Smith, B.M., K.A. Maloy, and D.J. Hawkins, "An Examination of Medicare Home Health Services: A Descriptive Study of the Effects of the Balanced Budget Act Interim Payment System on Access to and Quality of Care," Washington, DC: George Washington University Center for Health Services Research & Policy. (September 1999)

[9] Smith, B.M., Maloy, K.A., and Hawkins, D.J., "An Examination of Medicare Home Health Services: A Descriptive Study of the Effects of The Balanced Budget Act Interim Payment System on Hospital Discharge Planning," Washington, DC: George Washington University Center for Health Services Research & Policy. (January 2000).

[10] Abt Associates, Inc. *Survey of Home Health Agencies*, No. 99-2. Cambridge (MA): Author. Report to the Medicare Payment Advisory Commission under contract. (September 1999), and General Accounting Office. *Medicare Home Health Agencies: Closures Continue, With Little Evidence Beneficiary Access Is Impaired.* No. HEHS-99-120. Washington: Author. (May 1999).

[11] Medicare Payment Advisory Commission, *Report to the Congress: Variation and Innovation in Medicare* (June 2003).

[12] Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information. (March 2010)

[13] "Medicare Program; Prospective Payment System for Home Health Agencies; Final Rule," *Federal Register*, vol. 65, no. 128, July 3, 2000. Pp. 41128-41214.

[14] Cheh V., "The Final Evaluation Report on the National Home Health Prospective Payment Demonstration: Agencies Reduce Visits While Preserving Quality," Princeton, NJ: Mathematica Policy Research, Inc. (April 30, 2001).

Medicaid Home Care

Medicaid payments for home care are divided into three main categories: the mandatory traditional home health benefit, and two optional programs, the personal care option and home and community-based waivers. Together, these three home care service categories represent a relatively small but growing portion of total Medicaid payments.

Figure 4 shows that approximately 34 percent ($94 billion) of the $276 billion in Medicaid benefit payments in fiscal year 2007 (FY2007) were for hospital care and institutional services. Home care services comprised 20.2 percent of the payments. Hospice is an optional Medicaid service that is currently offered by 48 states; payments for hospice services in FY2006 were estimated at $1.6 billion.

Table 3 shows the growth in Medicaid home care outlays since FY1995. Expenditures increased to $24.3 million in FY2000, decreased to $16.7 million (a loss of 31.5 percent) in FY2001, and rebounded to $55.9 million in FY2007. Changes in the reporting of Medicaid expenditures make it difficult to pinpoint the source of the decrease and why there appears to be a dramatic increase, although states have recently begun to place a greater emphasis on providing care at home in lieu of institutions.

Managed Care

Health care services in the United States are increasingly financed through managed care organizations. Managed care organizations, including health maintenance organizations (HMOs), typically finance health care services through a negotiated, prepaid rate to health care providers. A fully capitated contract specifies a lump sum payment per enrollee to cover all care provided through the plan, but there are many variations of capitation. In contrast, traditional health insurance, commonly termed fee-for-service, pays providers based on the number of services delivered generally with fewer limitations on which providers would be paid.
Managed care is most prevalent in the employer-based health insurance market. Ninety-one percent of workers with health insurance received health insurance through a managed care plan in 2009.[15] Managed care enrollment has increased among Medicaid enrollees as states seek federal waivers to convert their Medicaid programs to managed care programs. By December 31, 2008, 69.82 percent of all Medicaid beneficiaries were enrolled in managed care.[16] While Medicare managed care enrollment has only slowly increased, financial incentives created by the Medicare Modernization Act (MMA) has led to an increasing number of beneficiaries enrolling in Medicare Advantage (MA) plans. As of February 2010, 25.2 percent of Medicare beneficiaries were enrolled in MA.[17]

The increasingly competitive health care market has created incentives for home care agencies to enter managed care provider networks. However, little is known about the extent to which home care agencies have entered into managed care arrangements. A preliminary (and somewhat dated) study conducted for HCFA (now CMS). The authors found that managed care clients utilized less home health resources, compared to fee-for-service clients, but also had less favorable outcomes on average. This suggests the need for further research on the relationship

[15] Claxton, G., et al. "Job-Based Health Insurance: Costs Climb At a Moderate Pace," *Health Affairs*: (Web Exclusive), w1002, 15 September, 2009.
[16] Centers for Medicare & Medicaid Services, "Medicaid Managed Care Enrollment as of December 31, 2008," http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/downloads/08Dec31f.pdf (January 2010).
[17] Centers for Medicare & Medicaid Services online, http://www.cms.hhs.gov/MCRAdvPartDEnrolData/. (March 2010)..

between managed care and home care patient outcomes.[18]

HOME CARE RECIPIENTS

The *2000 Home and Hospice Care Survey* findings indicate that 7.2 million individuals received formal home care services in 2000, a decrease of 5.8 percent from 1998.[19] (Table 4) This figure represents roughly 2.5 percent of the US population. Of these recipients, 69 percent were over age 65 and approximately 64 percent were women. Much of this reduction can be attributed to a reduction in patients receiving home health benefits under Medicare.

Table 5 shows that 25.5 percent of 2008 Medicare home health patients had conditions related to diseases of the circulatory system as their principal diagnosis. People with heart disease, including congestive heart failure, made up approximately half of this group. Endocrine, nutritional, and metabolic diseases and immunity disorders (predominantly diabetes mellitus), diseases of the musculoskeletal system and connective tissue, and symptoms, signs, and ill-defined conditions were also frequent principal diagnoses for Medicare home health patients.

Many hospital patients are discharged to home care services for continued rehabilitative care. As hospital stays shortened beginning in the early 1980s, the percentage of Medicare patients discharged to home health care increased from 9.1 percent in 1981 to 17.9 percent in 1985. MedPAC estimated that an average of 16.0 percent of Medicare hospital patients used home health care following discharge in 2006.[20] In a June 2008 Data Report, MedPAC estimated that 16.0 percent of Medicare patients discharged from acute care hospitals used home health care.[21] In the June 2008 report, home health was also estimated as the "most common second post acute care setting used," following SNF (29.3 percent), inpatient rehabilitation (56.8 percent), and hospice (2.4 percent).

Table 6 shows the percentage of Medicare beneficiaries discharged from an acute care hospital to home health care by selected DRGs. Medicare's hospital inpatient PPS pays hospitals a predetermined amount per hospital discharge. The DRG classification system assigns patients to over 500 groups, distinguishing cases with similar clinical problems that are expected to require similar amounts of hospital resources. The DRG-based payment for each discharge includes separately determined amounts for operating and capital costs.[22]
A study performed by the Department of Health and Human Services, Office of Inspector General found that 38 percent of Medicare beneficiaries who began use of home health care in the year 2000 came directly from the community. These patients had no prior hospitalizations (48 percent) or nursing home stays (14 percent) within 15 days of receiving home health care.[23] Table 7 shows the top five diagnoses for Medicare community home health beneficiaries. Diagnosis is indicated by International Classification of Diseases coding system (ICD-9).

CAREGIVERS

[18] Shaughnessy P.W., R.E. Schlenker, D.F. Hittle, et al., *A Study of Home Health Care Quality and Cost Under Capitated and Fee-For-Service Payment Systems, Vol. 1: Summary* (Denver: Center for Health Policy Research 1994).
[19] US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, *2000 National Home and Hospice Care Survey*, CD-ROM Series 13, No. 31. July 2002.
[20] Medicare Payment Advisory Commission, *A Data Book: Healthcare Spending and the Medicare program* (June 2008).
[21] Medicare Payment Advisory Commission, *A Data Book: Healthcare Spending and the Medicare program* (June 2008).
[22] Medicare Payment Advisory Commission, *Report to the Congress: New Approaches in Medicare* (June 2004).
[23] Department of Health and Human Services, Office of Inspector General, *Home Health Community Beneficiaries 2001*, October 2001, #OEI-02-01-00070.

The *2009 Caregiving in the U.S.* survey, sponsored by the National Alliance for Caregiving and AARP, documented the prevalence of caregiving in the US. The study found that more than one in three US households (an estimated 48.9 million caregivers over age 18) are informal caregivers for a person older than age 18, with an additional 16.8 million caring for children or both children and adults, for a total of 65.7 million individual caregivers. This report also showed that 63 percent of caregivers are married and/or living with a partner, and two-thirds (66 percent) are women. One third (34 percent) care for two or more people, with 86 percent providing care to a relative—more than one-third caring for a parent and one in seven (14 percent) caring for their own child. Twenty-five percent have completed some college education, with an additional 43 percent having graduated from college. The typical caregiver is a 48 year old woman who provides more than 20 hours of care each week.[24]

Formal Caregivers

Formal caregivers include professionals and paraprofessionals who are compensated to provide in-home health care and personal care services. BLS and CMS provide data on these employees; however, agency definitions and methods of counting formal caregivers differ. BLS provides an occupational classification for "home health care services," which excludes hospital-based and public agency workers. Its method of counting is "number of employees." CMS limits its statistics to employees of certified home health agencies. Furthermore, its survey presents data on aggregated full-time equivalents (FTEs).

As shown in Table 8, BLS estimated that 958,000 persons were employed in home health care agencies in 2008, with the exclusions described above. For both BLS and CMS, the largest numbers of employees/FTEs are home care aides and RNs. CMS recorded 290,439 FTEs employed in Medicare-certified agencies as of December 2008.

Figure 5 shows calendar year home care services employment for 1996 to 2009 based on BLS annual statistics. From 1993 to 2008, home care employment grew an average 5.4 percent annually (510,000 to 961,400). Between 1997 and 1999, total home care employment declined by more than 10 percent. By the end of 2009, it had regained approximately 63 percent from the low point in 1999.

Productivity

Since 1996, NAHC has worked with the Hospital and Healthcare Compensation Service (HCS) to conduct an annual survey of compensation in the home care and hospice industry. Employee productivity data are now collected in this survey. Productivity in home care is typically based on the average number of visits provided per day. Table 9 shows data from the *Homecare Salary & Benefits Report 2009-2010.*

Compensation

Summary home care and hospice compensation results for the above-mentioned 2009 to 2010 HCS survey are shown in Tables 10 and 11. To reduce the likelihood that outliers skew results, compensation is reported for the median salary, rather than mean salary. The survey includes data from agencies with revenues up to $15 million. HCS publishes a separate report for agencies and chain organizations with revenues in excess of $15 million (The Multi-Facility Corporate Compensation Report; for more information, visit www.hhcsinc.com).

[24] National Alliance for Caregiving and AARP. " Caregiving in the U.S.," November 2009 (www.aarp.org).

COST EFFECTIVENESS

Home care is a cost-effective service for individuals recuperating from a hospital stay and for those who, because of a functional or cognitive disability, are unable to take care of themselves. Table 12 compares the average Medicare charges on a per day basis for hospital and SNF to the average Medicare charge for a home health visit.

The following section lists some examples of the cost-effectiveness of home care. However, it should be noted that cost-effectiveness is not the only rationale for home care. Home care reinforces and supplements care provided by family members and friends and maintains the recipient's dignity and independence, qualities that can be lost even in the best institutions. Home care also allows patients to take an active role in their care.[25]

Home Health Care vs. SNF and Inpatient Rehabilitation Facility Care

One study by the RAND Corporation for MedPAC found that home health benefit ranks highest regarding outcomes and cost-effectiveness for patients who have undergone hip or knee replacement. The study compares care delivered in the home health setting with SNFs and inpatient rehabilitation facility (IRF) care. RAND determined that 35 percent of the knee and hip replacement patients studied were discharged from an acute care hospital to home for either home health rehabilitation, outpatient therapy, or no formal continuing care. The remainder of the patients was split evenly in discharge to IRF or SNF care. To measure health outcomes, RAND examined mortality rates and whether patients were institutionalized 120 days after being discharged from acute care. The study found that patients who received SNF or IRF care were more likely to be institutionalized than patients discharged to home. RAND considered post-acute care payments and total episode payments, including the cost of the initial hospitalization for joint replacement provided to patients discharged to home. The costs studied did not include Medicare Part B payments to physicians.

Several studies have compared inpatient care to home care costs for a specific group of patients. An analysis of studies that investigated the use of home care as a cost-effective substitute for acute care services found a statistically significant relationship between home health use and reduced use of inpatient hospital care.[26] The cost savings data for six studies of home care cost-effectiveness are summarized in Table 13. The information has been aggregated at a monthly level for purposes of comparison.

Psychiatric Care

An in-home crisis intervention program developed for psychiatric patients in Connecticut was effective in reducing hospital admissions, lengths of stay, and readmissions. A two-year analysis of more than 600 patients showed that 80.7 percent of patients referred for hospital care could be treated at home instead. When inpatient admissions were necessary, the average length of stay was reduced from 11.97 days to 7.48 days by adding elements of the in-home care program. Patients who received home care services were also less likely to be readmitted for hospital care (11.8 percent of home care

[25] Sheldon P. and M. Bender. "High-Technology in Home Care." *Community Health Nursing and Home Health Nursing*, no. 3 (1994): 507-519.

[26] Hughes S.L., A. Ulasevich, F.M. Weaver, et al. "Impact of Home Care on Hospital Days: A Meta Analysis," *Health Services Research* no. 4 (1997): 415-532.

patients were readmitted compared to 45.9 percent of patients who did not receive home care services).[27]

Patients with COPD

An innovative home care program for patients with chronic obstructive pulmonary disease (COPD) that was tested in Connecticut found significant cost savings by providing more comprehensive home care services to COPD patients who previously required frequent hospitalizations. Monthly costs for hospitalizations, emergency room visits and home care fell from $2,836 per patient before the intervention to $2,508 per patient--a net savings of $328 per patient per month.[28]

Terminally Ill Veterans

A home care program for terminally ill veterans reduced hospital per capita costs by $971. In the six-month study, patients receiving home care used 5.9 fewer hospital days than those in the control group. No differences were found in patient survival, activities of daily living, cognitive functioning, or morale. However, patient and caregiver satisfaction with care was significantly better among the patients receiving home care.[29]

Patients with Congestive Heart Failure

The impact of intensive home care monitoring on the morbidity rates of elderly patients with congestive heart failure was the focus of another study. The study found that with intensive home care surveillance, the total hospitalization rate dropped from 3.2 admissions per year to 1.2 admissions per year and the length of stay decreased from 26 days per year to six days per year. Cardiovascular admissions declined from 2.9 admissions per year to 0.8 admissions per year and length of stay decreased from 23 days per year to four days per year. An in-home program also resulted in significant functional status improvement in elderly patients with congestive heart failure.[30]

[27] Pigott H.E. and L. Trott. "Translating Research into Practice: The Implementation of an In-home Crisis Intervention Triage and Treatment Service in the Private Sector," *American Journal of Health Quality* no. 3 (1993): 138-144.
[28] Haggerty M.C., R. Stockdale-Woolley, and S. Nair. "Respi-Care: An Innovative Home Care Program for the Patient with Chronic Obstructive Pulmonary Disease," *Chest* no. 3 (1991): 607-612.
[29] Hughes S.L., J. Cummings, F. Weaver, L. Manheim, B. Braun, and K. Conrad. "A Randomized Trial of the Cost Effectiveness of VA Hospital-based Home Care for the Terminally Ill," *Health Services Research* no. 6 (1992): 801-817.
[30] Komowski R., D. Zeeli, M. Averbuch, and A. Finkelstein, et al. (Tel Aviv, Israel). "Intensive Homecare Surveillance Prevents Hospitalization and Improved Morbidity Rates Among Elderly Patients with Severe Congestive Heart Failure," *American Heart Journal* no. 4 (1995): 762-766.

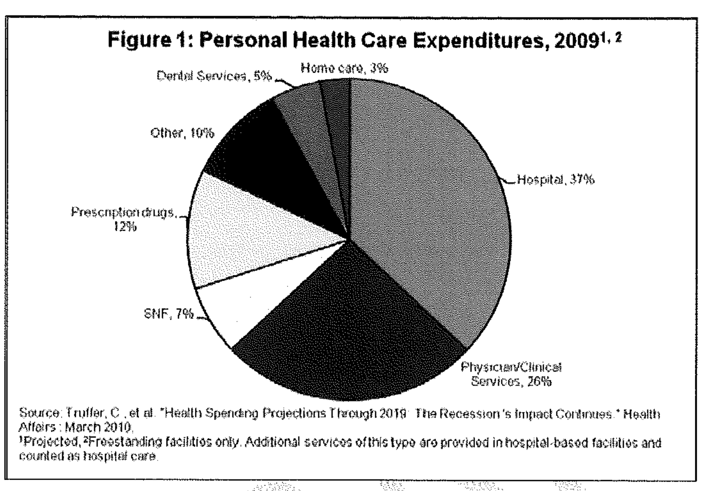
APPENDIX A: Tables and Figures

Table 1: Number of Medicare-certified Home Care Agencies, by Auspice, for Selected Years, 1967-2009

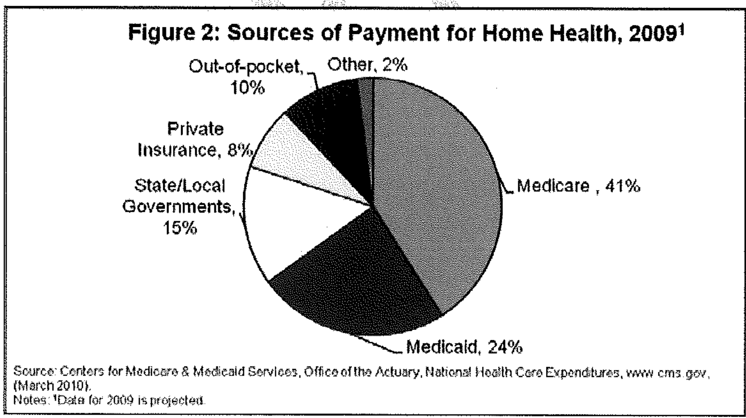
	FREESTANDING AGENCIES						FACILITY-BASED AGENCIES			
Year	VNA	COMB	PUB	PROP	PNP	OTH	HOSP	REHAB	SNF	TOTAL
1967	549	93	939	0	0	39	133	0	0	1,753
1980	515	63	1,260	186	484	40	359	8	9	2,924
1990	474	47	985	1,884	710	0	1,486	8	101	5,695
1996	576	34	1,177	4,658	695	58	2,634	4	191	10,027
1997	553	33	1,149	5,024	715	65	2.698	3	204	10,444
1998	460	35	968	3,414	610	69	2,356	2	166	8,080
1999	452	35	918	3,192	621	65	2,300	1	163	7,747
2000	436	31	909	2,863	560	56	2,151	1	150	7,152
2001	425	23	867	2,835	543	68	1,976	1	123	6,861
2002	430	27	850	3,027	563	79	1,907	1	119	7,007
2003	439	27	888	3,402	546	74	1,776	0	113	7,265
2004	446	36	932	3,832	558	69	1,695	1	110	7,679
2005	461	36	1,043	4,321	566	74	1,618	2	103	8,224
2006	459	29	1,132	4,919	562	85	1,547	2	103	8,838
2007	475	31	NA	NA	NA	NA	1,503	2	99	9,284
2008	489	37	1,273	5,849	559	92	1,425	1	99	9,824
2009	516	36	1,392	6,585	598	98	1,311	1	97	10,581

Source: Centers for Medicare & Medicaid Services (CMS), Center for Information Systems, Health Standards and Quality Bureau, (2009 data obtained in January 2010).

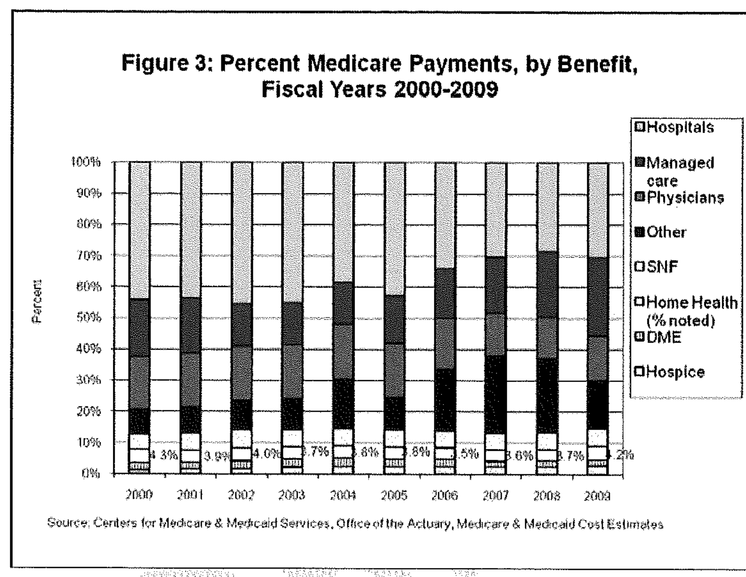
VNA: Visiting Nurse Associations are freestanding, voluntary, nonprofit organizations governed by a board of directors and usually financed by tax-deductible contributions as well as by earnings.
COMB: Combination agencies are combined government and voluntary agencies. These agencies are sometimes included with counts for VNAs.
PUB: Public agencies are government agencies operated by a state, county, city, or other unit of local government having a major responsibility for preventing disease and for community health education.
PROP: Proprietary agencies are freestanding, for-profit home care agencies.
PNP: Private not-for-profit agencies are freestanding and privately developed, governed, and owned nonprofit home care agencies. These agencies were not counted separately prior to 1980.
OTH: Other freestanding agencies that do not fit one of the categories for freestanding agencies listed above.
HOSP: Hospital-based agencies are operating units or departments of a hospital. Agencies that have working arrangements with a hospital, or perhaps are even owned by a hospital but operated as separate entities, are classified as freestanding agencies under one of the categories listed above.
REHAB: refers to agencies based in rehabilitation facilities.
SNF: Refers to agencies based in skilled nursing facilities.



Source: Truffer, C., et al. "Health Spending Projections Through 2019: The Recession's Impact Continues." Health Affairs: March 2010.
[1]Projected, [2]Freestanding facilities only. Additional services of this type are provided in hospital-based facilities and counted as hospital care.



Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Care Expenditures, www.cms.gov, (March 2010).
Notes: [1]Data for 2009 is projected.



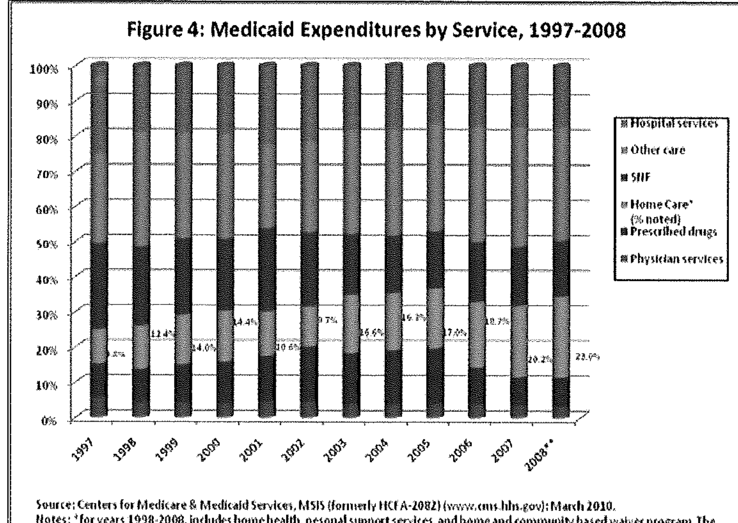
Source: Centers for Medicare & Medicaid Services, Office of the Actuary, Medicare & Medicaid Cost Estimates

Table 2: Medicare Fee-for-Service Home Health Outlays, Visits, Clients, Payment/Client, and Visits/Client, 1996-2008

Year	Outlays ($million)	Visits (1000s)	Clients (1000s)	Payment/ Client	Visits/ Client
1996	16,789	264,553	3,598	4,666	74
1997	16,723	257,751	3,554	4,705	73
1998	10,446	154,992	3,062	3,412	51
1999	7,908	112,748	2,735	2,892	41
2000	7,352	90,730	2,497	2,945	36
2001	8,637	73,698	2,439	3,541	30
2002	9,635	78,055	2,724	3,538	29
2003	10,149	82,517	2,888	3,524	29
2004	11,500	88,872	2,840	4,050	31
2005	12,885	95,534	3,228	3,991	30
2006	14,050	103,981	3,302	4,254	32
2007	15,677	114,199	3,383	4,635	34
2008	17,115	121,026	3,466	4,938	35

Sources: Centers for Medicare & Medicaid Services. HCIS home health data, 1994-1998 (December 2000). HCIS home health data, 1999 & 2000 (September 2001). HCIS home health data, 2001 (December 2002). HCIS home health data, 2002 (October 2003). HCIS home health data, 2003 (October 2004). HCIS home health data, 2004 (October 2005). HCIS home health data, 2005 (October 2006). HCIS home health data, 2006 (October 2007). HCIS home health data, 2007 (March 2009). HCIS home health data, 2008 (June 2010).

Figure 4: Medicaid Expenditures by Service, 1997-2008



Source: Centers for Medicare & Medicaid Services, MSIS (formerly HCFA-2082) (www.cms.hhs.gov); March 2010.
Notes: *for years 1998-2008, includes home health, pesonal support services, and home and community based waiver program. The 1997 figure represents home health only. All numbers represent combined federal and state spending.
**Only 31 states are represented in the 2008 data.

Table 3: Medicaid Home Care Expenditures and Recipients, 1995-2008

Fiscal Year	Vendor Payments ($millions)	Recipients (1000s)
1995	9,406	1,639
1996	10,583	1,633
1997	12,237	1,861
1998	17,600	4,800
1999	21,500	4,882
2000[1]	24,300	5,544
2001	16,655	6,776
2002	19,288	7,775
2003	38,715	8,125
2004	37,241	8,377
2005	46,618	9,076
2006	50,310	9,112
2007	55,882	8,890
2008[2]	44,915	6,039

Source: Centers for Medicare & Medicaid Services, MSIS (formerly HCFA-2082). (www.cms.gov). (2001 & 2002 data obtained February 2005). (2003 & 2004 data obtained July 2007). (2005-2008 data obtained March 2010).
Notes: [1]Hawaii did not report for FY 2000. Their FY 1999 data are used in this table.
[2]Data for 2008 is incomplete, only 31 states reported.
Figures include expenditures for home health and personal support services. Figures for 1999 through 2008 also include home and community-based waiver program.

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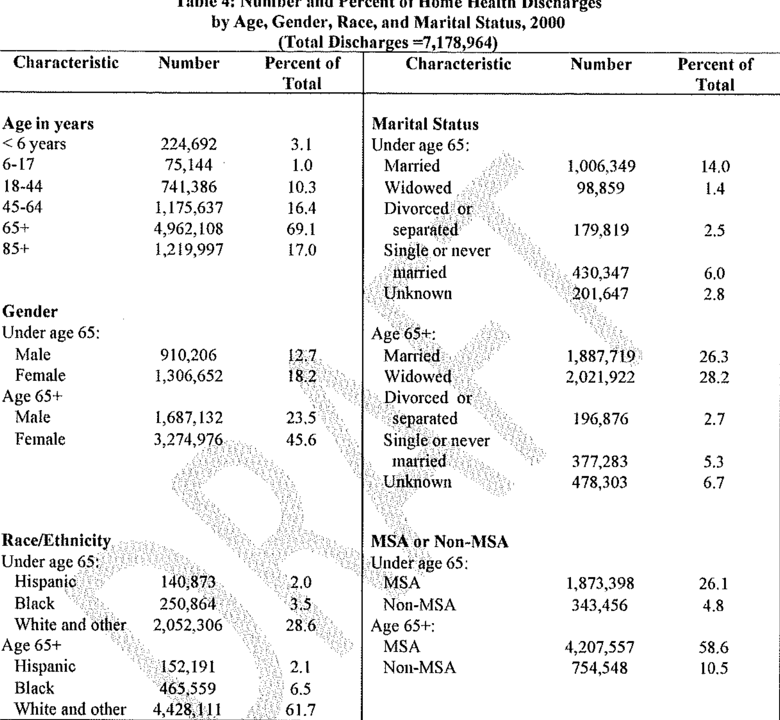

Table 4: Number and Percent of Home Health Discharges by Age, Gender, Race, and Marital Status, 2000 (Total Discharges =7,178,964)

Characteristic	Number	Percent of Total
Age in years		
< 6 years	224,692	3.1
6-17	75,144	1.0
18-44	741,386	10.3
45-64	1,175,637	16.4
65+	4,962,108	69.1
85+	1,219,997	17.0
Gender		
Under age 65:		
Male	910,206	12.7
Female	1,306,652	18.2
Age 65+		
Male	1,687,132	23.5
Female	3,274,976	45.6
Race/Ethnicity		
Under age 65:		
Hispanic	140,873	2.0
Black	250,864	3.5
White and other	2,052,306	28.6
Age 65+		
Hispanic	152,191	2.1
Black	465,559	6.5
White and other	4,428,111	61.7

Characteristic	Number	Percent of Total
Marital Status		
Under age 65:		
Married	1,006,349	14.0
Widowed	98,859	1.4
Divorced or separated	179,819	2.5
Single or never married	430,347	6.0
Unknown	201,647	2.8
Age 65+:		
Married	1,887,719	26.3
Widowed	2,021,922	28.2
Divorced or separated	196,876	2.7
Single or never married	377,283	5.3
Unknown	478,303	6.7
MSA or Non-MSA		
Under age 65:		
MSA	1,873,398	26.1
Non-MSA	343,456	4.8
Age 65+:		
MSA	4,207,557	58.6
Non-MSA	754,548	10.5

Source: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, *2000 National Home and Hospice Care Survey*, CD-ROM Series 13, No. 31 (July 2002).
Note: Percentages may not add to totals due to rounding.

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Table 5: Medicare Home Health Utilization by Principal Diagnosis, Calendar Year 2008			
Principal ICD-9-CM Diagnosis[1]	**Principal ICD-9-CM Codes**	**Patients (1,000's)**	**Percent**
Infectious and Parasitic Diseases	001-139	20	0.6
Neoplasms	140-239	110	3.5
Malignant Neoplasm of Trachea, Bronchus, and Lung	162	22	0.7
Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders	240-279	372	11.7
Diabetes Mellitus	250	341	10.8
Diseases of the Blood and Blood Forming Organs	280-289	60	1.9
Mental Disorders	290-319	68	2.1
Diseases of the Nervous System and Sense Organs	320-389	152	4.8
Diseases of the Circulatory System	390-459	809	25.5
Essential Hypertension	401	223	7.0
Heart Disease	402, 410-411, 413-414, 427-428	398	12.6
Diseases of the Respiratory System	460-519	271	8.6
Pneumonia, Organism Unspecified	486	59	1.9
Diseases of the Digestive System	520-579	74	2.3
Diseases of the Genitourinary System	580-629	82	2.6
Diseases of the Skin and Subcutaneous Tissue	680-709	196	6.2
Diseases of the Musculoskeletal System and Connective Tissue	710-739	399	12.6
Osteoarthritis and Allied Disorders	715	93	2.9
Symptoms, Signs, and Ill-Defined Conditions	780-799	262	8.3
Injury and Poisoning	800-999	208	6.6
Supplementary Classification	V01-V82	1,088	34.3
Total, All Diagnoses[2]	---	**3,172**	**100.0**
Total Leading Diagnoses[3]	---	**1,813**	**57.2**

[1]ICD-9-CM is International Classification of Diseases, 9th Revision, Clinical Modification (Volume 1). Only the first-listed or principal diagnosis has been used.
[2]Includes invalid codes not listed separately.
[3]Specific leading diagnostic categories were selected for presentation because of frequency of occurrences or because of special interest.
Source: Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information. *Health Care Financing Review: Medicare and Medicaid Statistical Supplement.* 2009.

Table 6: Proportion of Medicare Beneficiaries Discharged to Home Health Care for the 10 Most Common Diagnosis Related Groups (DRGs), 2000-2004						
Initial Hospital DRG	**2000**	**2001**	**2002**	**2003**	**2004**	**% Change 2000-2004**
DRG 462- Rehabilitation	7.4%	7.9%	8.1%	8.6%	8.7%	17.6
DRG 209- Major Joint and Limb Reattachment Procedures of Lower Extremity	7.0	7.3	7.6	7.9	8.2	17.1
DRG 127- Heart Failure and Shock	6.1	6.0	5.7	5.6	5.6	-8.2
DRG 089- Simple Pneumonia and Pleurisy	4.3	3.7	4.1	3.8	4.2	-2.3
DRG 088- Chronic Obstructive Pulmonary Disease	3.4	3.1	3.1	2.9	3.1	-8.8
DRG 148- Major Small and Large Bowel Procedures	2.1	2.0	2.0	2.0	1.9	-9.5
DRG 014- Intracranial Hemorrhage or Cerebral Infarction	3.1	3.1	3.0	2.4	1.9	-38.7
DRG 296- Nutrition/Miscellaneous Metabolic Disorders	1.7	1.7	1.9	1.9	1.7	0
DRG 107- Coronary Bypass With Cardiac Catheterization	2.0	2.0	1.8	1.8	1.5	-25.0
DRG 121- Circulatory Disorders with Acute Myocardial Infarction and Major Complication	1.6	1.6	1.5	1.4	1.4	-12.5

Source: Department of Health and Human Services, Office of Inspector General. *Medicare Beneficiary Access to Home Health Agencies: 2004.* #OEI-02-04-00260. July 2006. OIG analysis of CMS's National Claims History File, 2005
Note that the year starts with April 1 of the prior year and ends with March 31 of that year.

Table 7: Ranking of Highest Volume Diagnoses for "Community Beneficiaries" by Year, 1997-2000				
	Percent (rank)			
Primary ICD9 Diagnosis	**1997**	**1998**	**1999**	**2000**
250- Diabetes	8.6 (1)	7.6 (1)	6.9 (1)	6.2 (1)
401- Essential hypertension	7.7 (2)	6.2 (2)	5.5 (3)	5.3 (3)
428- Heart failure	5.3 (3)	5.0 (3)	4.7 (4)	4.6 (4)
707- Chronic ulcer of the skin	3.6 (4)	4.6 (4)	5.7 (2)	5.6 (2)
715- Osteoarthritis	3.2 (5)	3.3 (5)	3.2 (5)	3.6 (5)

Source: Department of Health and Human Services, Office of Inspector General. *Medicare Home Health Care Community Beneficiaries 2001*, #OEI-02-01-00070. October 2001.

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Table 8: Number of Home Health Care Workers, (2008) and Medicare-certified Agency FTEs (2009)		
Type of Employee	Total Number of Home Health Employees[1]	Number of Medicare Home Health FTEs[2]
RNs	132,400	92,113
LPNs	62,100	44,646
Physical Therapy Staff	22,700	26,823
Home Care Aides	324,400	65,146
Occupational Therapists	6,500	8,215
Social Workers	16,200	5,077
Other	393,700	78,420
Totals	**958,000**	**290,439**

Sources: [1] U.S. Department of Labor, Bureau of Labor Statistics, National Industry-Occupational Employment Matrix, data for 2008. Excludes hospital-based and public agencies. Home Health Aides, Personal and Home Care Aides, and Personal Care and Service Workers are included in the Home Care Aides category of the BLS data. (February 2010)
[2] Unpublished data on FTEs in Medicare-certified home health agencies for calendar year (CY) 2009 from the Centers for Medicare & Medicaid Services HCFA Center for Information Systems, Health Standards and Quality Bureau. (February 2010).

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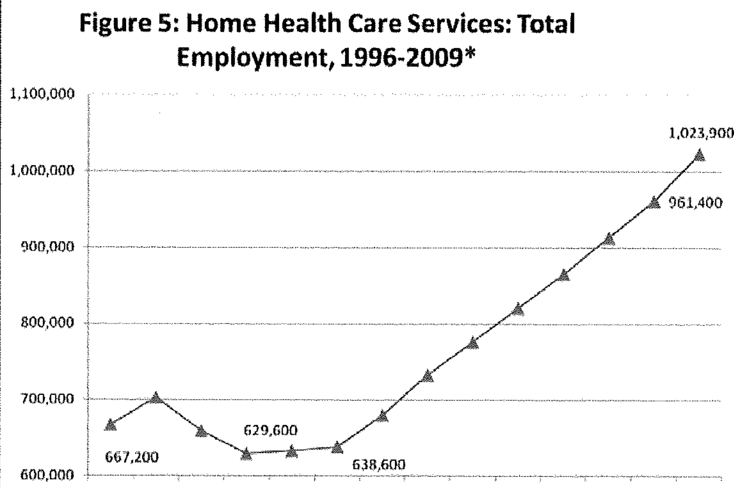


Source: U.S. Department of Labor, Bureau of Labor Statistics: Employment, Hours, and Earnings from the Current Employment Statistics Survey (National), www.bls.gov (March 2010).
Notes: *Annual number for 2009 is projected.
Excludes hospital-based and public home care agency employees. Annual data for 1996-2009 is based on the North American Industry Classifications System (NAICS).

Table 9: Home Health Care Visit Staff Productivity (Actual Visits Performed)

Staff Type	Productivity (per 8 Hours)
RN	4.96
LPN/LVN	5.90
Home Care Aide	5.17
Physical Therapist	5.39
Occupational Therapist	5.30
Social Worker	3.48

Source: National Association for Home Care & Hospice, Hospital & Healthcare Compensation Service. *Homecare Salary & Benefits Report 2009-2010*. October 2009.

Table 10: Average Compensation of Home Health Agency Executives, October 2009

	Salary Range by Percentile Median (25th, 75th)
Executive Director/CEO	$125,080 (98,640, 179,900)
Chief Operating Officer/ Program Director	83,000 (74,187, 100,000)
Top Level Financial Executive	99,951 (81,500, 124,000)
Director of Clinical Services	75,000 (67,777, 84,534)
Director of Social Work and Counseling	62,600 (55,200, 70,224)
Quality Improvement/ Utilization Review Manager	66,895 (57,047, 78,000)

Source: National Association for Home Care & Hospice, Hospital & Healthcare Compensation Service. *Homecare Salary & Benefits Report 2009-2010*. October 2009.

Table 11: Average Compensation of Home Health Agency Caregivers, October 2009

	Per-Hour Rates by Percentile			Per-Visit Rates by Percentile		
	25th	Median	75th	25th	Median	75th
Registered Nurse	$25.64	$27.79	$31.09	$31.75	$35.13	$40.00
LPN/LVN	17.97	19.81	22.47	20.74	23.38	26.55
Occupational Therapist	31.00	34.13	36.52	53.88	58.50	62.00
Physical Therapist	34.49	37.22	40.37	56.05	60.00	65.00
Respiratory Therapist	21.88	23.44	24.96	55.00	75.00	82.50
Speech/Language Pathologist	30.41	33.65	38.57	55.00	59.92	65.00
Medical Social Worker	20.78	23.48	26.56	45.00	51.50	60.00
Home Care Aide III	10.98	12.11	13.38	12.25	13.75	15.50

Source: National Association for Home Care & Hospice, Hospital & Healthcare Compensation Service. *Homecare Salary & Benefits Report 2009-2010*. October 2009.

Table 12: Comparison of Hospital, SNF, and Home Health Medicare Charges, 2005-2009[1]

	2005	2006	2007	2008	2009
Hospital (per day)	$4,999	$5,475	$5,895	$6,196	$6,200
SNF (per day)	504	519	558	590	622
Home health (per visit)	125	129	130	134	135

Sources: The hospital Medicare charge data for 2005-2007 are from the *Annual Statistical Supplement*, 2008, to *the Social Security Bulletin*, Social Security Administration online (www.ssa.gov). SNF data for 2005 are from the *Annual Statistical Supplement*, 2007, to *the Social Security Bulletin*, Social Security Administration online (www.ssa.gov). Home health information 2005 data are from the Health Care Financing Review, Statistical Supplement, Centers for Medicare & Medicaid Services, 2006. Home health information 2006 data are from the Health Care Financing Review, Statistical Supplement, Centers for Medicare & Medicaid Services, 2007. Home health information 2007 data are from the Health Care Financing Review, Statistical Supplement, Centers for Medicare & Medicaid Services, 2008.Home health information 2008 data are from the Health Care Financing Review, Statistical Supplement, Centers for Medicare & Medicaid Services, 2009.

Note: [1]Hospital data for 2008 and 2009 were updated using the Bureau of Labor Statistics' (BLS) Producer Price Index (PPI) for General medical and surgical hospitals by payor types, Medicare patients. Skilled nursing facility data for 2006, 2007, 2008 and 2009 were updated using BLS' PPI for Nursing care facilities, Public payors. Home health data for 2009 were updated using the BLS' PPI for Home health care services, Medicare payors. (www.bls.gov).

Table 13: Cost of Inpatient Care (Per Patient per Month) Compared to Home Care, Selected Conditions

Conditions	Hospital Costs	Home Care Costs	Dollar Savings
Low birth weight[1]	$26,190	$330	$25,860
Ventilator-dependent adults[2]	21,570	7,050	14,520
Oxygen-dependent children[3]	12,090	5,250	6,840
Chemotherapy for children with cancer[4]	68,870	55,950	13,920
Congestive heart failure in the elderly[5]	1,758	1,605	153
Intravenous antibiotic therapy for cellulitis, Osteomyelitis, others[6]	12,510	4,650	7,860

Sources: [1]Casiro, O.G., McKenzie, M.E., McFayden, L., Shapiro, C., Seshia M.M.K., MacDonald, N., Moffat, M., and Cheang, M.S. "Earlier Discharge with Community-based Intervention for Low Birth Weight Infants: A Randomized Trial." *Pediatrics* 92, no. 1 (1993): 128-134.
[2]Bach, J.R., Intinola, P., Alba, A.S., and Holland, I.E. "The Ventilator-assisted Individual: Cost Analysis of Institutionalization vs. Rehabilitation and In-home Management." *Chest* 101, no. 1 (1992): 26-30.
[3]Field, A.I., Rosenblatt, A., Pollack, M.M., and Kaufman, J. "Home Care Cost-Effectiveness for Respiratory Technology-dependent Children." *American Journal of Diseases of Children* 145 (1991): 729-733.
[4]Close, P., Burkey, E., Kazak, A., Danz, P., and Lange, B. "A Prospective Controlled Evaluation of Home Chemotherapy for Children with Cancer." *Pediatrics* 95, no. 6 (1995): 896-900. (**Note**: The study found that the daily charges for chemotherapy were $2,329±$627 in the hospital and $1,865±$833 at home. These charges were multiplied by 30 days reflecting the above per-patient per-month costs.)
[5]Rich, M.W., Beckham, V., Wittenberg, C., Leven, C., Freedland, K., and Carney, R.M. "A Multidisciplinary Intervention to Prevent the Readmission of Elderly Patients with Congestive Heart Failure." *The New England Journal of Medicine* 333, no. 18 (1995): 1190-1195.
[6]William, D.N., et al. "Safety, Efficacy, and Cost Savings in an Outpatient Intravenous Antibiotic Program." *Clinical Therapy* 15 (1993): 169-179, cited in Williams, D., "Reducing Costs and Hospital Stay for Pneumonia with Home Intravenous Cefotaxime Treatment: Results with a Computerized Ambulatory Drug Delivery System." *The American Journal of Medicine* 97, no. 2A (1994): 50-55. (**Note**: The estimated hospital cost/day/patient is $417 and the estimated savings/day/patient is $262. These costs were multiplied by 30 days, reflecting the above per-patient per-month costs.)

Attachment G

Maxim Deferred Prosecution Agreement and Other Federal Settlement Documents

CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
MAXIM HEALTHCARE SERVICES, INC.

I. PREAMBLE

Maxim Healthcare Services, Inc. (Maxim) hereby enters into this Corporate Integrity Agreement (CIA) with the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) to promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, and all other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) (Federal health care program requirements). Contemporaneously with this CIA, Maxim is entering into a Settlement Agreement with the United States.

II. TERM AND SCOPE OF THE CIA

A. The period of the compliance obligations assumed by Maxim under this CIA shall be (1) five years from the Effective Date of this CIA, or (2) beginning on the CIA Effective Date through the anniversary of the CIA Effective Date following the final payment under the Settlement Agreement between the United States and Maxim, whichever is later, unless otherwise specified. The "Effective Date" shall be the date on which the final signatory of this CIA executes this CIA. Each one-year period, beginning with the one-year period following the Effective Date, shall be referred to as a "Reporting Period."

B. The requirements set forth in Section III.A through Section III.E will be suspended during the first 24 months of the CIA unless (a) the Deferred Prosecution Agreement with the United States Attorney's Office for the District of New Jersey (DPA) is no longer in effect; or (b) the OIG lifts the suspension. The date on which the CIA suspension is terminated shall be referred to as the "Suspension Termination Date." The determination whether or not to lift the suspension of Section III.A through Section III.E shall be made at the sole discretion of the OIG. In the event that any requirements of

Section III.A through Section III.E are no longer suspended, Maxim shall within 90 days implement the requirements of Section III.A through Section III.E. Within 30 days of Maxim's engagement of an IRO, Maxim shall provide the information described in Appendix A regarding the IRO. Within 30 days of Maxim's engagement of a Consultant, Maxim shall provide the information described in Appendix C regarding the Consultant.

C. Sections VII, X, and XI shall expire no later than 120 days after OIG's receipt of: (1) Maxim's final Annual Report; or (2) any additional materials submitted by Maxim pursuant to OIG's request, whichever is later.

D. The scope of this CIA shall be governed by the following definitions:

1. "Owner" means any person or entity (including any trustee of a trust that holds Maxim securities) with the power to vote or control the voting power of five percent or more of a class of equity security of Maxim, whether directly or by proxy. Any person or entity that has transferred such power by proxy shall not be deemed to be an Owner.

2. "Covered Persons" includes:

a. all owners, officers, directors, and employees of Maxim;

b. all contractors, subcontractors, agents, and other persons who provide patient care items or services or who perform billing or coding functions on behalf of Maxim (other than its Maxim Staffing Solutions division (MSS)), excluding vendors whose sole connection with Maxim is selling or otherwise providing medical supplies or equipment to Maxim and who do not bill the Federal health care programs for such medical supplies or equipment; and

c. all physicians and other non-physician practitioners who are members of Maxim's active medical staff.

Notwithstanding the above, this term does not include part-time or per diem employees, contractors, subcontractors, agents, and other persons who are not reasonably expected to work more than 160 hours per year, except that any such individuals shall

become "Covered Persons" at the point when they work more than 160 hours during the calendar year.

3. "Billing, Coding, and Reimbursement Covered Persons" includes all Covered Persons involved directly, or in a supervisory role, in the preparation or submission of claims for reimbursement from any Federal health care program. Billing, Coding, and Reimbursement Covered Persons also includes those individuals who determine the proper codes and applicable rates.

4. "Clinical Services Covered Persons" includes all Covered Persons who are involved directly or indirectly in the delivery of patient care.

5. "Certifying Employee" includes all Maxim officers, presidents, vice presidents, national and regional directors (other than board directors), and national and regional accounts managers.

6. "Management Covered Persons" means

a. all Certifying Employees;

b. all Covered Persons who work for or on behalf of Maxim's compliance department; and

c. all employees who provide legal advice to Maxim.

7. "Relevant Covered Persons" means all Billing, Coding, and Reimbursement Covered Persons, Clinical Services Covered Persons, and Management Covered Persons.

8. "MSS Contractors" means all contractors, subcontractors, agents, and other persons who provide patient care items or services or who perform billing or coding functions on behalf of MSS.

9. "Monitor" means the outside independent individual retained by Maxim under the DPA.

10. "Consultant" or "Compliance Consultant" means the outside independent entity retained by Maxim, such as a healthcare or consulting firm, to perform the functions identified in Appendix C.

III. Corporate Integrity Obligations

Maxim shall establish and maintain a Compliance Program that includes the following elements.

A. Compliance Officer and Committee

1. *Compliance Officer.* Maxim has appointed, and shall maintain during the term of the CIA, an individual to serve as its Compliance Officer. The Compliance Officer shall be responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements set forth in this CIA and with Federal health care program requirements. The Compliance Officer shall be a member of senior management of Maxim, shall report directly to the Board of Directors and indirectly to the Chief Executive Officer of Maxim, and shall make periodic (at least quarterly) reports regarding compliance matters directly to the Board of Directors and shall be authorized to report on such matters to the Board of Directors at any time. The Compliance Officer shall not be or be subordinate to the General Counsel, Chief Financial Officer, or any sales or clinical officers. The Compliance Officer shall be responsible for monitoring the day-to-day compliance activities engaged in by Maxim as well as for any reporting obligations created under this CIA. Any noncompliance job responsibilities of the Compliance Officer shall be limited and must not interfere with the Compliance Officer's ability to perform the duties outlined in this CIA.

Maxim shall not assert a privilege to the OIG with respect to legal advice or counsel Maxim obtains after the Effective Date and during the term of the CIA from the Compliance Officer or any employee reporting to the Compliance Officer regarding (a) Federal health care programs, statutes, and regulations, or (b) compliance with the terms of this CIA. The Compliance Officer or any employee reporting to the Compliance Officer may seek legal advice from internal or external attorneys outside the Compliance Department without waiving any applicable privilege.

Maxim shall report to OIG, in writing, any change in the identity of the Compliance Officer, or any actions or changes that would affect the Compliance Officer's

ability to perform the duties necessary to meet the obligations in this CIA, within five days after the change.

2. *Corporate Compliance Committee.* Maxim has appointed and shall maintain during the term of this CIA a Corporate Compliance Committee. The Corporate Compliance Committee shall, at a minimum, include the Compliance Officer and other members of senior management necessary to meet the requirements of this CIA (e.g., senior executives of relevant departments, such as billing, clinical, human resources, audit, and operations). The Compliance Officer shall chair the Corporate Compliance Committee and the Committee shall support the Compliance Officer in fulfilling his/her responsibilities (e.g., shall assist in the analysis of the Maxim's risk areas and shall oversee monitoring of internal and external audits and investigations). The Corporate Compliance Committee shall meet at least monthly.

Maxim shall report to OIG, in writing, any changes in the composition of the Corporate Compliance Committee, or any actions or changes that would affect the Corporate Compliance Committee's ability to perform the duties necessary to meet the obligations in this CIA, within 15 days after such a change.

3. *Board of Directors Compliance Obligations.* Maxim has appointed and shall maintain a Compliance Committee of the Board of Directors (the "Board Compliance Committee"). The Board Compliance Committee shall include at least three directors, the majority of whom shall be outside members of the Board. The Board Compliance Committee shall be responsible for the review and oversight of matters related to compliance with Federal health care program requirements and the obligations of this CIA.

The Board Compliance Committee shall, at a minimum, be responsible for the following:

a. meeting at least quarterly to review and oversee Maxim's Compliance Program, including but not limited to the performance of the Compliance Officer and Corporate Compliance Committee;

b. ensuring, through consultation with the Consultant and other means, that Maxim adopts and implements policies,

procedures, and practices designed to ensure compliance with the requirements set forth in this CIA and Federal health care program requirements;

c. reviewing the Compliance Review Reports; and

d. for each Reporting Period of the CIA, adopting a resolution, signed by each member of the Board Compliance Committee, summarizing its review and oversight of Maxim's compliance with Federal health care program requirements and the obligations of this CIA.

At minimum, the resolution shall include the following language:

"The Board Compliance Committee has made a reasonable inquiry into the operations of Maxim's Compliance Program including the performance of the Compliance Officer and the Compliance Committee. The Board Compliance Committee has also arranged for the Compliance Review, as set forth in Appendix C, of the Company's compliance operations by the Consultant. Based on the Compliance Review, and its own inquiry and review, the Board Compliance Committee has concluded that, to the best of its knowledge, Maxim has implemented an effective compliance program to meet the requirements of the CIA and Federal health care program requirements."

If the Board Compliance Committee is unable to provide such a conclusion in the resolution, the Board Compliance Committee shall include in the resolution a written explanation of the reasons why it is unable to provide the conclusion and the steps it is taking to implement an effective Compliance Program at Maxim.

Maxim shall report to OIG, in writing, any changes in the composition of the Board Compliance Committee, or any actions or changes that would affect the Board Compliance Committee's ability to perform the duties necessary to meet the obligations in this CIA, within 15 days after such a change.

4. *Management Accountability and Certifications.* Within 60 days after the Suspension Termination Date, Maxim shall make compliance a component of each employee's performance evaluation. In addition to the responsibilities set forth in this CIA for all Covered Persons, all Certifying Employees are specifically expected to

monitor and oversee activities within their areas of authority and shall annually certify in writing or electronically that, to the best of their knowledge, their department or functional area is in material compliance with applicable Federal health care program requirements and the obligations of this CIA.

For each Reporting Period, each Certifying Employee shall certify in writing or electronically that:

"I have been trained on and understand the compliance requirements and responsibilities as they relate to [department or functional area], an area under my supervision. My job responsibilities include ensuring compliance with regard to the [department or functional area]. To the best of my knowledge, except as otherwise described herein, the [department or functional area] of Maxim is in material compliance with applicable Federal health care program requirements and the obligations of the CIA."

If any Certifying Employee is unable to provide such a conclusion in the certification, the Certifying Employee shall include in the certification a written explanation of the reasons why he or she is unable to provide the conclusion and the steps being taken to address the issue(s) identified in the certification.

B. <u>Written Standards</u>

1. *Code of Conduct.* Within 90 days after the Suspension Termination Date, Maxim shall modify its existing written Code of Conduct and distribute and implement this revised Code of Conduct to all Covered Persons, if Maxim has not already done so after the Effective Date or within one month prior to the Effective Date. Maxim shall make the promotion of, and adherence to, the Code of Conduct an element in evaluating the performance of all employees. The Code of Conduct shall, at a minimum, set forth:

a. Maxim's commitment to full compliance with all Federal health care program requirements, including its commitment to prepare and submit accurate claims consistent with Federal health care program requirements;

b. Maxim's requirement that all of its Covered Persons shall be expected to comply with all Federal health care program requirements and with Maxim's own Policies and Procedures;

c. the requirement that all of Maxim's Covered Persons shall be expected to report to the Compliance Officer, or other appropriate individual designated by Maxim, suspected violations of any Federal health care program requirements or of Maxim's own Policies and Procedures; and

d. the right of all individuals to use the Disclosure Program described in Section III.F, and Maxim's commitment to non-retaliation and to maintaining, as appropriate, confidentiality and anonymity with respect to such disclosures.

Within 90 days after the Suspension Termination Date, each Covered Person shall certify, in writing, that he or she has received, read, understood, and shall abide by Maxim's Code of Conduct, if each Covered Person has not already done so after the Effective Date or within one month prior to the Effective Date. New Covered Persons shall receive the Code of Conduct and shall complete the required certification within 30 days after becoming a Covered Person or within 90 days after the Suspension Termination Date, whichever is later.

Maxim shall periodically review the Code of Conduct to determine if revisions are appropriate and shall make any necessary revisions based on such review. Any revised Code of Conduct shall be distributed within 30 days after any revisions are finalized. Each Covered Person shall certify, in writing, that he or she has received, read, understood, and shall abide by the revised Code of Conduct within 30 days after the distribution of the revised Code of Conduct.

2. *Policies and Procedures.* Within 90 days after the Suspension Termination Date, Maxim shall implement written Policies and Procedures regarding the operation of its compliance program, including the compliance program requirements outlined in this CIA, and Maxim's compliance with Federal health care program requirements, if Maxim has not already done so after the Effective Date or within one month prior to the Effective Date. At a minimum, the Policies and Procedures shall address:

a. ensuring claims are coded correctly, consistent with Federal health care program requirements;

b. ensuring the preparation and submission of accurate claims consistent with Federal health care program requirements;

c. ensuring that services are provided in accordance with physician orders, by appropriate staff, and that staff have appropriate licenses, credentials, and certifications;

d. ensuring that services are appropriately documented in the medical record; and

e. conducting periodic billing, coding, and clinical systems reviews and audits.

Within 90 days after the Suspension Termination Date, Maxim shall distribute the Policies and Procedures to all Covered Persons, if Maxim has not already done so after the Effective Date or within one month prior to the Effective Date. Appropriate and knowledgeable staff shall be available to explain the Policies and Procedures. New Covered Persons shall receive the Policies and Procedures within 30 days after becoming a Covered Person or within 90 days after the Suspension Termination Date, whichever is later.

At least annually (and more frequently, if appropriate), Maxim shall assess and update, as necessary, the Policies and Procedures. Within 30 days after the effective date of any revisions, any such revised Policies and Procedures shall be distributed to all Covered Persons.

C. Training and Education

1. *General Training.* Within 90 days after the Suspension Termination Date, Maxim shall provide at least two hours of General Training to each Covered Person, if Maxim has not already done so within the preceding six months. This training, at a minimum, shall explain Maxim's:

a. CIA requirements; and

b. Compliance Program, including the Code of Conduct.

New Covered Persons shall receive the General Training described above within 30 days after becoming a Covered Person or within 90 days after the Suspension Termination Date, whichever is later. After receiving the initial General Training described above, each Covered Person shall receive at least one hour of General Training in each subsequent Reporting Period.

2. *Billing, Coding, and Reimbursement Covered Persons Specific Training.* Within 90 days after the Suspension Termination Date, each Billing, Coding, and Reimbursement Covered Person shall receive at least four hours of Specific Training in addition to the General Training required above, if each Billing, Coding, and Reimbursement Covered Person has not already received such Specific Training within the preceding six months. The Specific Training shall include a discussion of:

a. the Federal health care program requirements regarding the accurate coding, preparation, and submission of claims;

b. policies, procedures, and other requirements applicable to the documentation of medical records, including the Federal health care programs' requirement that medical records be maintained in their original state and not be fabricated or improperly altered;

c. the personal obligation of each individual involved in the claims submission process to ensure that such claims are accurate;

d. applicable reimbursement statutes, regulations, and program requirements and directives;

e. the legal sanctions for violations of the Federal health care program requirements;

f. examples of proper and improper claims submission practices; and

g. examples of proper and improper coding practices.

After receiving the initial Specific Training described in this section, Billing, Coding, and Reimbursement Covered Persons shall receive at least two hours of Specific Training in each subsequent Reporting Period.

3. *Clinical Services Covered Persons Specific Training.* Within 90 days after the Suspension Termination Date, each Clinical Services Covered Person shall receive at least two hours of Specific Training in addition to the General Training required above, if each Clinical Services Covered Person has not already received such Specific Training in the preceding six months. The Specific Training shall include a discussion of:

a. policies, procedures, and other requirements applicable to the documentation of medical records, including the Federal health care programs requirement that medical records be maintained in their original state and not be fabricated or improperly altered;

b. the personal obligation of each individual involved in patient care to ensure that care is appropriate, delivered in accordance with the physician's order and plan of care, and meets professionally recognized standards of care;

c. applicable reimbursement statutes, regulations, and program requirements and directives;

d. the legal sanctions for violations of the Federal health care program requirements; and

e. examples of proper and improper medical record documentation practices.

After receiving the initial Specific Training described in this section, Clinical Services Covered Persons shall receive at least two hours of Specific Training in each subsequent Reporting Period.

4. *Management Covered Persons Specific Training.* Within 90 days after the Suspension Termination Date, each Management Covered Person shall receive at least two hours of Specific Training in addition to the General Training required above, if each Management Covered Person has not already received such Specific Training in the preceding six months. In the first post-suspension Reporting Period, this training shall include a discussion of:

a. the role and responsibilities of Management Covered Persons in implementing and effectuating Maxim's Compliance Program; and

b. findings and recommendations of the Monitor in the prior Reporting Periods or, if no such findings and recommendations exist, the facts that gave rise to this CIA as a case study, focusing on the role of Management Covered Persons in (1) communicating the importance of complying with Federal health care program requirements, (2) providing structures that promote and enhance compliance in day-to-day operations across the company, and (3) identifying and resolving compliance issues.

In subsequent Reporting Periods, Maxim shall develop and provide at least one hour of Management Covered Persons Specific Training based on the findings of the most recent Compliance Review.

5. *New Relevant Covered Persons.* New Relevant Covered Persons shall receive the applicable Specific Training within 30 days after the beginning of their

work at Maxim or becoming Relevant Covered Persons, or within 90 days after the Suspension Termination Date, whichever is later.

6. *Board Member Training.* Within 90 days after the Suspension Termination Date, Maxim shall provide at least one hour of training to each member of the Board of Directors, in addition to the General Training, if Maxim has not already done so within the preceding six months. This training shall address the responsibilities of board members and corporate governance.

New members of the Board of Directors shall receive the Board Member Training described above within 30 days after becoming a member or within 90 days after the Suspension Date, whichever is later.

7. *MSS Contractor Training.* To the extent that any MSS Contractor is reasonably expected to work more than 160 hours per year on behalf of MSS only, the MSS Contractor shall receive compliance training either from (a) Maxim, in accordance with the General Training and, if the MSS Contractor would qualify as a Relevant Covered Person if employed by Maxim, the Specific Training, (b) the MSS Contractor's employer, or (c) the health care facility or other entity at which the MSS Contractor provides patient care items or services or billing or coding functions through Maxim. For all MSS Contractors who receive training under subsection 7(b) or 7(c) above, Maxim shall certify in each Annual Report that during that Reporting Period it has reviewed the Compliance Training of the employer, health care facility, or other entity providing the training to ensure that such training satisfies the requirements of this Agreement with respect to the General Training and, if the MSS Contractor would qualify as a Relevant Covered Person if employed by Maxim, the appropriate Specific Training. Maxim also shall provide each MSS Contractor with a current copy of the Code of Conduct and each subsequent revision to the Code of Conduct and shall ensure that all MSS Contractors are informed of the CIA, Maxim's hotline, and their ability to use Maxim's hotline.

8. *Certification.* Each individual who is required to attend training shall certify, in writing, or in electronic form, if applicable, that he or she has received the required training. The certification shall specify the type of training received and the date received. The Compliance Officer (or designee) shall retain the certifications, along with all course materials. The certifications and training materials shall be made available to OIG, upon request.

9. *Qualifications of Trainer.* Persons providing the training shall be knowledgeable about the subject area.

10. *Update of Training.* Maxim shall review the training annually, and, where appropriate, update the training to reflect changes in Federal health care program requirements, any issues discovered during internal audits or the Claims Review, and any other relevant information.

11. *Computer-based Training.* Maxim may provide the training required under this CIA through appropriate computer-based training approaches. If Maxim chooses to provide computer-based training, it shall make available appropriately qualified and knowledgeable staff or trainers either in person or electronically, at reasonable times, to answer questions or provide additional information to the individuals receiving such training.

D. Claims and Unallowable Cost Review Procedures

1. *General Description*

a. *Engagement of Independent Review Organization.* Within 90 days after the Suspension Termination Date, Maxim shall engage an entity (or entities), such as an accounting, auditing, or consulting firm (hereinafter "Independent Review Organization" or "IRO"), to perform reviews to assist Maxim in assessing and evaluating its billing and coding practices and certain other obligations pursuant to this CIA and the Settlement Agreement. The applicable requirements relating to the IRO are outlined in Appendix A to this CIA, which is incorporated by reference.

b. *IRO Reviews.* The IRO shall perform the Claims Review and Unallowable Cost Review, and shall prepare reports, as described in this Section III.D and in Appendix B to this CIA.

c. *Retention of Records.* The IRO and Maxim shall retain and make available to OIG, upon request, all work papers, supporting documentation, correspondence, and draft reports

(those exchanged between the IRO and Maxim) related to the reviews.

2. *Repayment of Identified Overpayments.* Maxim shall repay within 30 days any Overpayment(s) identified in the Discovery Sample or the Full Sample (if applicable), regardless of the Error Rate, to the appropriate payor and in accordance with payor refund policies. Maxim shall make available to OIG all documentation that reflects the refund of the Overpayment(s) to the payor.

3. *Unallowable Cost Review.* For the first Reporting Period of the CIA, the IRO shall conduct a review of Maxim's compliance with the unallowable cost provisions of the Settlement Agreement. The IRO shall determine whether Maxim has complied with its obligations not to charge to, or otherwise seek payment from, federal or state payors for unallowable costs (as defined in the Settlement Agreement) and its obligation to identify to applicable federal or state payors any unallowable costs included in payments previously sought from the United States, or any state Medicaid program. This unallowable costs analysis shall include, but not be limited to, payments sought in any cost reports, cost statements, information reports, or payment requests already submitted by Maxim or any affiliates. To the extent that such cost reports, cost statements, information reports, or payment requests, even if already settled, have been adjusted to account for the effect of the inclusion of the unallowable costs, the IRO shall determine if such adjustments were proper. In making this determination, the IRO may need to review cost reports and/or financial statements from the year in which the Settlement Agreement was executed, as well as from previous years.

4. *Unallowable Cost Review Report.* The IRO shall prepare a report based upon the Unallowable Cost Review performed (Unallowable Cost Review Report). The Unallowable Cost Review Report shall include the IRO's findings and supporting rationale regarding the Unallowable Cost Review and whether Maxim has complied with its obligation not to charge to, or otherwise seek payment from, federal or state payors for unallowable costs (as defined in the Settlement Agreement) and its obligation to identify to applicable federal or state payors any unallowable costs included in payments previously sought from such payor.

5. *Request to Implement Verification Review.* After submitting the first post-suspension Annual Report containing the IRO's Claims Review Report, or after the submission of any subsequent Annual Report, Maxim may submit to the OIG in writing a

request to implement the Verification Review provision of the Claims Review set forth at Section A.4 of Appendix B (Verification Review). Maxim's request shall contain (a) a description of its compliance auditing program, (b) a summary of its audit findings from the Effective Date to the date of the request, and (c) a certification by its Compliance Officer that Maxim is able to perform the Verification Review without diminishing the quality or quantity of Maxim's claims reviews that would have been performed under its compliance program absent the Verification Review. OIG will consider Maxim's request and decide whether to implement the Verification Review. The decision to implement the Verification Review shall be at the sole discretion of the OIG.

6. *Validation Review*. In the event OIG has reason to believe that: (a) Maxim's Claims Review or Unallowable Cost Review fails to conform to the requirements of this CIA; or (b) the IRO's findings or Claims Review or Unallowable Cost Review results are inaccurate, or (c) Maxim's Verification Review findings are inaccurate, OIG may, at its sole discretion, conduct its own review to determine whether the Claims Review or Unallowable Cost Review complied with the requirements of the CIA, the IRO's findings or Claims Review or Unallowable Cost Review results are inaccurate, and/or Maxim's Verification Review findings or results are inaccurate (Validation Review). Maxim shall pay for the reasonable cost of any such review performed by OIG or any of its designated agents. Any Validation Review of Reports submitted as part of Maxim's final Annual Report shall be initiated no later than one year after Maxim's final submission (as described in Section II) is received by OIG.

Prior to initiating a Validation Review, OIG shall notify Maxim of its intent to do so and provide a written explanation of why OIG believes such a review is necessary. To resolve any concerns raised by OIG, Maxim may request a meeting with OIG to: (a) discuss the results of any Claims Review or Unallowable Cost Review submissions or findings, or of any Verification Review findings; (b) present any additional information to clarify the results of the Claims Review, Unallowable Cost Review, or Verification Review or to correct the inaccuracy of the Claims Review, Unallowable Cost Review, or Verification Review; and/or (c) propose alternatives to the proposed Validation Review. Maxim agrees to provide any additional information as may be requested by OIG under this Section III.D.6 in an expedited manner. OIG will attempt in good faith to resolve any Claims Review, Unallowable Cost Review, or Verification Review issues with Maxim prior to conducting a Validation Review. However, the final determination as to whether or not to proceed with a Validation Review shall be made at the sole discretion of OIG.

7. *Independence and Objectivity Certification.* The IRO shall include in its report(s) to Maxim a certification or sworn affidavit that it has evaluated its professional independence and objectivity, as appropriate to the nature of the engagement, with regard to the Claims Review and Unallowable Cost Review and that it has concluded that it is, in fact, independent and objective.

E. Compliance Review

1. *General Description*

a. *Engagement of Consultant.* Within 60 days after the Suspension Termination Date, Maxim shall engage a Consultant to perform reviews to assist Maxim in assessing and evaluating its compliance and clinical systems. The applicable requirements relating to the Consultant are outlined in Appendix C to this CIA, which is incorporated by reference.

b. *Compliance Review.* The Consultant shall evaluate and analyze Maxim's compliance program generally and specifically with regard to the provision of clinical services in accordance with the requirements set forth in Appendix C.

c. *Frequency of Compliance Review.* The Compliance Review shall be performed annually and shall cover each of the Reporting Periods. The Consultant shall perform all components of each annual Compliance Review.

d. *Retention of Records.* The Consultant and Maxim shall retain and make available to OIG, upon request, all work papers, supporting documentation, correspondence, and draft reports (those exchanged between the Consultant and Maxim) related to the reviews.

2. *Compliance Review Report.* The Consultant shall prepare a report based upon the Compliance Review. Information to be included in the Compliance Review

Report is described in Appendix C. The Consultant shall deliver each Compliance Review Report simultaneously to Maxim's Chief Compliance Officer, the Chair of the Board of Directors, and OIG.

3. *Independence and Objectivity Certification.* The Consultant shall include in its report(s) to Maxim a certification or sworn affidavit that it has evaluated its professional independence and objectivity, as appropriate to the nature of the engagement, with regard to the Compliance Review Report and that it has concluded that it is, in fact, independent and objective.

F. Disclosure Program

Maxim has established and shall maintain a Disclosure Program that includes a mechanism (e.g., a toll-free compliance telephone line) to enable individuals to disclose, to the Compliance Officer or some other person who is not in the disclosing individual's chain of command, any identified issues or questions associated with Maxim's policies, conduct, practices, or procedures with respect to a Federal health care program believed by the individual to be a potential violation of criminal, civil, or administrative law. Maxim shall appropriately publicize the existence of the disclosure mechanism (e.g., via periodic e-mails to employees or by posting the information in prominent common areas).

The Disclosure Program shall emphasize a non-retribution, non-retaliation policy, and shall include a reporting mechanism for anonymous communications for which appropriate confidentiality shall be maintained. Upon receipt of a disclosure, the Compliance Officer (or designee) shall gather all relevant information from the disclosing individual. The Compliance Officer (or designee) shall make a preliminary, good faith inquiry into the allegations set forth in every disclosure to ensure that he or she has obtained all of the information necessary to determine whether a further review should be conducted. For any disclosure that is sufficiently specific so that it reasonably: (1) permits a determination of the appropriateness of the alleged improper practice; and (2) provides an opportunity for taking corrective action, Maxim shall conduct an internal review of the allegations set forth in the disclosure and ensure that proper follow-up is conducted.

The Compliance Officer (or designee) shall maintain a disclosure log, which shall include a record and summary of each disclosure received (whether anonymous or not),

the status of the respective internal reviews, and any corrective action taken in response to the internal reviews. The disclosure log shall be made available to OIG upon request.

G. Ineligible Persons

1. *Definitions*. For purposes of this CIA:

a. an "Ineligible Person" shall include an individual or entity who:

i. is currently excluded, debarred, suspended, or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or nonprocurement programs; or

ii. has been convicted of a criminal offense that falls within the scope of 42 U.S.C. § 1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

b. "Exclusion Lists" include:

i. the HHS/OIG List of Excluded Individuals/Entities (available through the Internet at http://www.oig.hhs.gov); and

ii. the General Services Administration's List of Parties Excluded from Federal Programs (available through the Internet at http://www.epls.gov).

2. *Screening Requirements.* Maxim shall ensure that all prospective and current Covered Persons are not Ineligible Persons, by implementing the following screening requirements.

a. Maxim shall screen all prospective Covered Persons against the Exclusion Lists prior to engaging their services and, as part of the hiring or contracting process, shall require such

Covered Persons to disclose whether they are Ineligible Persons. With respect to Covered Contractors, Maxim can comply with this provision by including in its contracts a requirement that each Covered Contractor screen its employees against the Exclusions Lists prior to allowing any employee to provide services to Maxim and on an annual basis thereafter.

b. Maxim shall screen all Covered Persons against the Exclusion Lists within 90 days after the Effective Date and on an annual basis thereafter.

c. Maxim shall implement a policy requiring all Covered Persons to disclose immediately any debarment, exclusion, suspension, or other event that makes that person an Ineligible Person.

Nothing in Section III.G affects Maxim's responsibility to refrain from (and liability for) billing Federal health care programs for items or services furnished, ordered, or prescribed by excluded persons. Maxim understands that items or services furnished by excluded persons are not payable by Federal health care programs and that Maxim may be liable for overpayments and/or criminal, civil, and administrative sanctions for employing or contracting with an excluded person regardless of whether Maxim meets the requirements of Section III.G.

3. *Removal Requirement.* If Maxim has actual notice that a Covered Person has become an Ineligible Person, Maxim shall remove such Covered Person from responsibility for, or involvement with, Maxim's business operations related to the Federal health care programs and shall remove such Covered Person from any position for which the Covered Person's compensation or the items or services furnished, ordered, or prescribed by the Covered Person are paid in whole or part, directly or indirectly, by Federal health care programs or otherwise with Federal funds at least until such time as the Covered Person is reinstated into participation in the Federal health care programs.

4. *Pending Charges and Proposed Exclusions.* If Maxim has actual notice that a Covered Person is charged with a criminal offense that falls within the scope of 42 U.S.C. §§ 1320a-7(a), 1320a-7(b)(1)-(3), or is proposed for exclusion during the

Covered Person's employment or contract term or during the term of a physician's or other practitioner's medical staff privileges, Maxim shall take all appropriate actions to ensure that the responsibilities of that Covered Person have not and shall not adversely affect the quality of care rendered to any beneficiary, patient, or resident, or any claims submitted to any Federal health care program.

H. Notification of Government Investigation or Legal Proceedings

Within 30 days after discovery, Maxim shall notify OIG, in writing, of any ongoing investigation or legal proceeding known to Maxim conducted or brought by a governmental entity or its agents involving an allegation that Maxim has committed a crime or has engaged in fraudulent activities. This notification shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding. Maxim shall also provide written notice to OIG within 30 days after the resolution of the matter, and shall provide OIG with a description of the findings and/or results of the investigation or proceedings, if any.

I. Repayment of Overpayments

1. *Definition of Overpayments.* For purposes of this CIA, an "Overpayment" shall mean the amount of money Maxim has received in excess of the amount due and payable under any Federal health care program requirements.

2. *Repayment of Overpayments*

a. If, at any time, Maxim identifies any Overpayment, Maxim shall repay the Overpayment to the appropriate payor (e.g., Medicare fiscal intermediary or carrier) within 30 days after identification of the Overpayment and take remedial steps within 60 days after identification (or such additional time as may be agreed to by the payor) to correct the problem, including preventing the underlying problem and the Overpayment from recurring. If not yet quantified, within 30 days after identification, Maxim shall notify the payor of its efforts to quantify the Overpayment amount along with a schedule of when such work is expected to be completed.

Notification and repayment to the payor shall be done in accordance with the payor's policies.

b. Notwithstanding the above, notification and repayment of any Overpayment amount that routinely is reconciled or adjusted pursuant to policies and procedures established by the payor should be handled in accordance with such policies and procedures.

J. Reportable Events

1. *Definition of Reportable Event.* For purposes of this CIA, a "Reportable Event" means anything that involves:

a. a substantial Overpayment;

b. a matter that a reasonable person would consider a probable violation of criminal, civil, or administrative laws applicable to any Federal health care program for which penalties or exclusion may be authorized;

c. the employment of or contracting with a Covered Person who is an Ineligible Person as defined by Section III.G.1.a; or

d. the filing of a bankruptcy petition by Maxim.

A Reportable Event may be the result of an isolated event or a series of occurrences.

2. *Reporting of Reportable Events.* If Maxim determines (after a reasonable opportunity to conduct an appropriate review or investigation of the allegations) through any means that there is a Reportable Event, Maxim shall notify OIG, in writing, within 30 days after making the determination that the Reportable Event exists.

3. *Reportable Events under Section III.J.1.a.* For Reportable Events under Section III.J.1.a, the report to OIG shall be made at the same time as the repayment to the payor required in Section III.I, and shall include:

a. a copy of the notification and repayment to the payor required in Section III.I.2;

b. a description of the steps taken by Maxim to identify and quantify the Overpayment;

c. a complete description of the Reportable Event, including the relevant facts, persons involved, and legal and Federal health care program authorities implicated;

d. a description of Maxim's actions taken to correct the Reportable Event; and

e. any further steps Maxim plans to take to address the Reportable Event and prevent it from recurring.

4. *Reportable Events under Section III.J.1.b and c.* For Reportable Events under Section III.J.1.b and c, the report to OIG shall include:

a. a complete description of the Reportable Event, including the relevant facts, persons involved, and legal and Federal health care program authorities implicated;

b. a description of Maxim's actions taken to correct the Reportable Event;

c. any further steps Maxim plans to take to address the Reportable Event and prevent it from recurring; and

d. if the Reportable Event has resulted in an Overpayment, a description of the steps taken by Maxim to identify and quantify the Overpayment.

5. *Reportable Events under Section III.J.1.d.* For Reportable Events under Section III.J.1.d, the report to the OIG shall include documentation of the bankruptcy filing and a description of any Federal health care program authorities implicated.

6. *Reportable Events Involving the Stark Law.* Notwithstanding the reporting requirements outlined above, any Reportable Event that involves only a probable violation of section 1877 of the Social Security Act, 42 U.S.C. §1395nn (the Stark Law) should be submitted by Maxim to the Centers for Medicare & Medicaid Services (CMS) through the self-referral disclosure protocol (SRDP), with a copy to the OIG. The requirements of Section III.I.2 that require repayment to the payor of any identified Overpayment within 30 days shall not apply to any Overpayment that may result from a probable violation of only the Stark Law that is disclosed to CMS pursuant to the SRDP.

IV. CHANGES TO BUSINESS UNITS OR LOCATIONS

A. Change or Closure of Unit or Location. In the event that, after the Effective Date, Maxim changes locations or closes a business unit or location related to the furnishing of items or services that may be reimbursed by Federal health care programs, Maxim shall notify OIG of this fact as soon as possible, but no later than within 30 days after the date of change or closure of the location.

B. Purchase or Establishment of New Unit or Location. In the event that, after the Effective Date, Maxim purchases or establishes a new business unit or location related to the furnishing of items or services that may be reimbursed by Federal health care programs, Maxim shall notify OIG at least 30 days prior to such purchase or the operation of the new business unit or location. This notification shall include the address of the new business unit or location, phone number, fax number, the location's Medicare and state Medicaid program provider number and/or supplier number(s); and the name and address of each Medicare and state Medicaid program contractor to which Maxim currently submits claims. Each new business unit or location and all Covered Persons at each new business unit or location shall be subject to the applicable requirements of this CIA.

C. Sale of Unit or Location. In the event that, after the Effective Date, Maxim proposes to sell any or all of its business units or locations that are subject to this CIA,

Maxim shall notify OIG of the proposed sale at least 30 days prior to the sale of such business unit or location. This notification shall include a description of the business unit or location to be sold, a brief description of the terms of the sale, and the name and contact information of the prospective purchaser. This CIA shall be binding on the purchaser of such business unit or location, unless otherwise determined and agreed to in writing by the OIG.

V. Monitor, Implementation, and Annual Reports

A. Monitor Reports.

1. Maxim shall submit to OIG any report or written recommendations produced by the Monitor pursuant to the DPA within five days of Maxim receiving any report or written recommendations from the Monitor.

2. Maxim shall submit to OIG any report Maxim provides to the Monitor pursuant to the DPA at the same time Maxim provides the report to the Monitor.

3. Any written documentation Maxim provides to the Monitor pursuant to the DPA shall be made available to the OIG upon request.

B. Implementation Report. Within 120 days after the Suspension Termination Date Maxim shall submit a written report to OIG summarizing the status of its implementation of the requirements of this CIA (Implementation Report). The Implementation Report shall, at a minimum, include:

1. the name, address, phone number, and position description of the Compliance Officer required by Section III.A, and a summary of other noncompliance job responsibilities the Compliance Officer may have;

2. the names and positions of the members of the Corporate Compliance Committee required by Section III.A;

3. a copy of Maxim's Code of Conduct required by Section III.B.1;

4. a summary of all Policies and Procedures required by Section III.B.2;

5. the number of individuals required to complete the Code of Conduct certification required by Section III.B.1, the percentage of individuals who have completed such certification, and an explanation of any exceptions;

6. the following information regarding each type of training required by Section III.C:

a. a description of such training, including a summary of the topics covered, the length of sessions, and a schedule of training sessions;

b. the number of individuals required to be trained, percentage of individuals actually trained, and an explanation of any exceptions;

7. The certification regarding MSS Contractors' training required by Section III.C.7, if applicable;

8. the following information regarding the IRO(s): (a) identity, address, and phone number; (b) a copy of the engagement letter; (c) information to demonstrate that the IRO has the qualifications outlined in Appendix A to this CIA; (d) a summary and description of any and all current and prior engagements and agreements between Maxim and the IRO; and (e) a certification from the IRO regarding its professional independence and objectivity with respect to Maxim;

9. the following information regarding the Consultant(s): (a) identity, address, and phone number; (b) a copy of the engagement letter; (c) information to demonstrate that the Consultant has the qualifications outlined in Appendix C to this CIA; (d) a summary and description of any and all current and prior engagements and agreements between Maxim and the Consultant; and (e) a certification from the Consultant regarding its professional independence and objectivity with respect to Maxim;

10. a description of the process by which Maxim fulfills the requirements of Section III.G regarding Ineligible Persons;

11. a list of all of Maxim's locations (including locations and mailing addresses); the corresponding name under which each location is doing business; the corresponding phone numbers and fax numbers; each location's Medicare and state Medicaid program provider number and/or supplier number(s); and the name and address of each Medicare and state Medicaid program contractor to which Maxim currently submits claims;

12. a description of Maxim's corporate structure, including identification of any parent and sister companies, subsidiaries, and their respective lines of business; and

13. the certifications required by Section V.E.

C. Implementation Information Not Subject to Suspension: In the Implementation Report or the Annual Report for the first Reporting Period, whichever is submitted earlier, Maxim shall submit the following information:

1. a description of the Disclosure Program required by Section III.F;
2. a description of the process by which Maxim fulfills the requirements of Section III.G regarding Ineligible Persons;
3. a list of all of Maxim's locations (including locations and mailing addresses); the corresponding name under which each location is doing business; the corresponding phone numbers and fax numbers; each location's Medicare and state Medicaid program provider number and/or supplier number(s); and the name and address of each Medicare and state Medicaid program contractor to which Maxim currently submits claims; and
4. a description of Maxim's corporate structure, including identification of any parent companies, brother and sister companies underneath such parents, subsidiaries, and their respective lines of business.

D. Annual Reports. Maxim shall submit to OIG annually a report with respect to the status of, and findings regarding, Maxim's compliance activities for each of the Reporting Periods (Annual Report).

Each Annual Report shall include (except that Maxim need not include information on any suspended obligations for the time period in which the suspension is in effect), at a minimum:

1. any change in the identity, position description, or other noncompliance job responsibilities of the Compliance Officer and any change in the membership of the Corporate Compliance Committee described in Section III.A;

2. the Board resolution required by Section III.A;

3. the Certifying Employee certifications required by Section III.A;

4. a summary of any significant changes or amendments to the Policies and Procedures required by Section III.B and the reasons for such changes (e.g., change in contractor policy);

5. the number of individuals required to complete the Code of Conduct certification required by Section III.B.1., the percentage of individuals who have completed such certification, and an explanation of any exceptions;

6. the following information regarding each type of training required by Section III.C:

a. a description of the initial and annual training, including a summary of the topics covered, the length of sessions, and a schedule of training sessions; and

b. the number of individuals required to complete the initial and annual training, the percentage of individuals who actually completed the initial and annual training, and an explanation of any exceptions;

7. The certification regarding MSS Contractors' training required by Section III.C.7, if applicable;

8. a complete copy of all reports prepared pursuant to Section III.D, and Appendix B along with a copy of the IRO's engagement letter;

9. Maxim's response to the reports prepared pursuant to Section III.D and Appendix B, along with corrective action plan(s) related to any issues raised by the reports;

10. a summary and description of any and all current and prior engagements and agreements between Maxim and the IRO (if different from what was submitted as part of the Implementation Report);

11. a certification from the IRO regarding its professional independence and objectivity with respect to Maxim;

12. a complete copy of the report prepared pursuant to Section III.E and Appendix C, along with a copy of the Consultant's engagement letter;

13. Maxim's response to the report prepared pursuant to Section III.E and Appendix C, along with corrective action plan(s) related to any issues raised by the reports;

14. a summary and description of any and all current and prior engagements and agreements between Maxim and the Consultant (if different from what was submitted as part of the Implementation Report);

15. a certification from the Consultant regarding its professional independence and objectivity with respect to Maxim;

16. a summary of Reportable Events (as defined in Section III.J) identified during the Reporting Period and the status of any corrective and preventative action relating to all such Reportable Events;

17. a report of the aggregate Overpayments that have been returned to the Federal health care programs. Overpayment amounts shall be broken down into the

following categories: Medicare, Medicaid (report each applicable state separately, if applicable), and other Federal health care programs. Overpayment amounts that are routinely reconciled or adjusted pursuant to policies and procedures established by the payor do not need to be included in this aggregate Overpayment report;

18. a summary of the disclosures in the disclosure log required by Section III.F that relate to Federal health care programs;

19. any changes to the process by which Maxim fulfills the requirements of Section III.G regarding Ineligible Persons;

20. a summary describing any ongoing investigation or legal proceeding required to have been reported pursuant to Section III.H. The summary shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding;

21. a description of all changes to the most recently provided list of Maxim's locations (including addresses) as required by Section V.B.11; the corresponding name under which each location is doing business; the corresponding phone numbers and fax numbers; each location's Medicare and state Medicaid program provider number(s) and/or supplier number(s); and the name and address of each Medicare and state Medicaid program contractor to which Maxim currently submits claims; and

22. the certifications required by Section V.E.

The first Annual Report shall be received by OIG no later than 120 days after the end of the first Reporting Period. Subsequent Annual Reports shall be received by OIG no later than the anniversary date of the due date of the first Annual Report.

E. Certifications. The Implementation Report and each Annual Report shall include a certification by the Compliance Officer that:

1. to the best of his or her knowledge, except as otherwise described in the report, Maxim is in compliance with all of the requirements of this CIA;

2. he or she has reviewed the report and has made reasonable inquiry regarding its content and believes that the information in the report is accurate and truthful; and

3. to the best of his or her knowledge, Maxim has complied with its obligations under the Settlement Agreement: (a) not to resubmit to any Federal health care program payors any previously denied claims related to the Covered Conduct addressed in the Settlement Agreement, and not to appeal any such denials of claims; (b) not to charge to or otherwise seek payment from federal or state payors for unallowable costs (as defined in the Settlement Agreement); and (c) to identify and adjust any past charges or claims for unallowable costs.

F. Designation of Information. Maxim shall clearly identify any portions of its submissions that it believes are trade secrets, or information that is commercial or financial and privileged or confidential, and therefore potentially exempt from disclosure under the Freedom of Information Act (FOIA), 5 U.S.C. § 552. Maxim shall refrain from identifying any information as exempt from disclosure if that information does not meet the criteria for exemption from disclosure under FOIA.

VI. NOTIFICATIONS AND SUBMISSION OF REPORTS

Unless otherwise stated in writing after the Effective Date, all notifications and reports required under this CIA shall be submitted to the following entities:

OIG:
Administrative and Civil Remedies Branch
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services
Cohen Building, Room 5527
330 Independence Avenue, S.W.
Washington, DC 20201
Telephone: 202.619.2078
Facsimile: 202.205.0604

Maxim:
Jacqueline C. Baratian
Vice President & Chief Compliance Officer
Maxim Healthcare Services, Inc.
7227 Lee Deforest Drive
Columbia, MD 21046
Telephone: 410.910.6225
Facsimile: 410.872.9417

Unless otherwise specified, all notifications and reports required by this CIA may be made by certified mail, overnight mail, hand delivery, or other means, provided that there is proof that such notification was received. For purposes of this requirement, internal facsimile confirmation sheets do not constitute proof of receipt. Upon request by OIG, Maxim may be required to provide OIG with an electronic copy of each notification or report required by this CIA in searchable portable document format (.pdf), either instead of or in addition to a paper copy.

VII. OIG Inspection, Audit, and Review Rights

In addition to any other rights OIG may have by statute, regulation, or contract, OIG or its duly authorized representative(s) may examine or request copies of Maxim's books, records, and other documents and supporting materials and/or conduct on-site reviews of any of Maxim's locations for the purpose of verifying and evaluating: (a) Maxim's compliance with the terms of this CIA; and (b) Maxim's compliance with the requirements of the Federal health care programs in which it participates. The documentation described above shall be made available by Maxim to OIG or its duly authorized representative(s) at all reasonable times for inspection, audit, or reproduction. Furthermore, for purposes of this provision, OIG or its duly authorized representative(s) may interview any of Maxim's employees, contractors, or agents who consent to be interviewed at the individual's place of business during normal business hours or at such other place and time as may be mutually agreed upon between the individual and OIG. Maxim shall assist OIG or its duly authorized representative(s) in contacting and arranging interviews with such individuals upon OIG's request. Maxim's employees may elect to be interviewed with or without a representative of Maxim present.

VIII. DOCUMENT AND RECORD RETENTION

Maxim shall maintain for inspection all documents and records relating to reimbursement from the Federal health care programs and to compliance with this CIA for one year after the end of the last Reporting Period (or longer if otherwise required by law).

IX. DISCLOSURES

Consistent with HHS's FOIA procedures, set forth in 45 C.F.R. Part 5, OIG shall make a reasonable effort to notify Maxim prior to any release by OIG of information submitted by Maxim pursuant to its obligations under this CIA and identified upon submission by Maxim as trade secrets, or information that is commercial or financial and privileged or confidential, under the FOIA rules. With respect to such releases, Maxim shall have the rights set forth at 45 C.F.R. § 5.65(d).

X. BREACH AND DEFAULT PROVISIONS

Maxim is expected to fully and timely comply with all of its CIA obligations.

A. Stipulated Penalties for Failure to Comply with Certain Obligations. As a contractual remedy, Maxim and OIG hereby agree that failure to comply with certain obligations as set forth in this CIA may lead to the imposition of the following monetary penalties (hereinafter referred to as "Stipulated Penalties") in accordance with the following provisions.

1. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day Maxim fails to establish and implement any of the following obligations as described in Section III:

a. a Compliance Officer;

b. a Corporate Compliance Committee;

c. the Board resolution;

d. the Certifying Employee certifications;

e. a written Code of Conduct;

f. written Policies and Procedures;

g. the training of Covered Persons, Relevant Covered Persons, Board Members, and MSS Contractors;

h. a Disclosure Program;

i. Ineligible Persons screening and removal requirements;

j. notification of Government investigations or legal proceedings; and

k. reporting of Reportable Events.

2. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day Maxim fails to engage and use an IRO, as required in Section III.D, Appendix A, and Appendix B or fails to engage and use a Consultant, as required in Section III.E and Appendix C.

3. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day Maxim fails to submit any Monitor Reports, the Implementation Report, or any Annual Reports to OIG in accordance with the requirements of Section V by the deadlines for submission.

4. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day Maxim fails to submit any Claims Review Report, Unallowable Cost Review Report, or Compliance Review Report in accordance with the requirements of Sections III.D and III.E and Appendices B and C.

5. A Stipulated Penalty of $1,500 for each day Maxim fails to grant access as required in Section VII. (This Stipulated Penalty shall begin to accrue on the date Maxim fails to grant access.)

6. A Stipulated Penalty of $5,000 for each false certification submitted by or on behalf of Maxim as part of its Implementation Report, Annual Report, additional documentation to a report (as requested by the OIG), or otherwise required by this CIA.

7. A Stipulated Penalty of $1,000 for each day Maxim fails to comply fully and adequately with any obligation of this CIA. OIG shall provide notice to Maxim stating the specific grounds for its determination that Maxim has failed to comply fully and adequately with the CIA obligation(s) at issue and steps Maxim shall take to comply with the CIA. (This Stipulated Penalty shall begin to accrue 10 days after Maxim receives this notice from OIG of the failure to comply.) A Stipulated Penalty as described in this Subsection shall not be demanded for any violation for which OIG has sought a Stipulated Penalty under Subsections 1- 6 of this Section.

B. Timely Written Requests for Extensions. Maxim may, in advance of the due date, submit a timely written request for an extension of time to perform any act or file any notification or report required by this CIA. Notwithstanding any other provision in this Section, if OIG grants the timely written request with respect to an act, notification, or report, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until one day after Maxim fails to meet the revised deadline set by OIG. Notwithstanding any other provision in this Section, if OIG denies such a timely written request, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until three business days after Maxim receives OIG's written denial of such request or the original due date, whichever is later. A "timely written request" is defined as a request in writing received by OIG at least five business days prior to the date by which any act is due to be performed or any notification or report is due to be filed.

C. Payment of Stipulated Penalties

1. *Demand Letter*. Upon a finding that Maxim has failed to comply with any of the obligations described in Section X.A and after determining that Stipulated Penalties are appropriate, OIG shall notify Maxim of: (a) Maxim's failure to comply; and (b) OIG's exercise of its contractual right to demand payment of the Stipulated Penalties. (This notification shall be referred to as the "Demand Letter.")

2. *Response to Demand Letter*. Within 10 days after the receipt of the Demand Letter, Maxim shall either: (a) cure the breach to OIG's satisfaction and pay the

applicable Stipulated Penalties or (b) request a hearing before an HHS administrative law judge (ALJ) to dispute OIG's determination of noncompliance, pursuant to the agreed upon provisions set forth below in Section X.E. In the event Maxim elects to request an ALJ hearing, the Stipulated Penalties shall continue to accrue until Maxim cures, to OIG's satisfaction, the alleged breach in dispute. Failure to respond to the Demand Letter in one of these two manners within the allowed time period shall be considered a material breach of this CIA and shall be grounds for exclusion under Section X.D.

3. *Form of Payment.* Payment of the Stipulated Penalties shall be made by electronic funds transfer to an account specified by OIG in the Demand Letter.

4. *Independence from Material Breach Determination.* Except as set forth in Section X.D.1.d, these provisions for payment of Stipulated Penalties shall not affect or otherwise set a standard for OIG's decision that Maxim has materially breached this CIA, which decision shall be made at OIG's discretion and shall be governed by the provisions in Section X.D, below.

D. Exclusion for Material Breach of this CIA.

1. *Definition of Material Breach.* A material breach of this CIA means:

a. a repeated or flagrant violation of the obligations under this CIA, including, but not limited to, the obligations addressed in Section X.A;

b. a failure by Maxim to report a Reportable Event, take corrective action, and make the appropriate refunds, as required in Section III.J;

c. a failure to engage and use an IRO in accordance with Section III.D, Appendix A, and Appendix B, or to engage and use a Consultant in accordance with Section III.E and Appendix C; or

d. a failure to respond to a Demand Letter concerning the payment of Stipulated Penalties in accordance with Section X.C.

2. *Notice of Material Breach and Intent to Exclude.* The parties agree that a material breach of this CIA by Maxim constitutes an independent basis for Maxim's exclusion from participation in the Federal health care programs. Upon a determination by OIG that Maxim has materially breached this CIA and that exclusion is the appropriate remedy, OIG shall notify Maxim of: (a) Maxim's material breach; and (b) OIG's intent to exercise its contractual right to impose exclusion. (This notification shall be referred to as the "Notice of Material Breach and Intent to Exclude.")

3. *Opportunity to Cure.* Maxim shall have 30 days from the date of receipt of the Notice of Material Breach and Intent to Exclude to demonstrate to OIG's satisfaction that:

a. Maxim is in compliance with the obligations of the CIA cited by OIG as being the basis for the material breach;

b. the alleged material breach has been cured; or

c. the alleged material breach cannot be cured within the 30-day period, but that: (i) Maxim has begun to take action to cure the material breach; (ii) Maxim is pursuing such action with due diligence; and (iii) Maxim has provided to OIG a reasonable timetable for curing the material breach.

4. *Exclusion Letter.* If, at the conclusion of the 30-day period, Maxim fails to satisfy the requirements of Section X.D.3, OIG may exclude Maxim from participation in the Federal health care programs. OIG shall notify Maxim in writing of its determination to exclude Maxim. (This letter shall be referred to as the "Exclusion Letter.") Subject to the Dispute Resolution provisions in Section X.E, below, the exclusion shall go into effect 30 days after the date of Maxim's receipt of the Exclusion Letter. The exclusion shall have national effect and shall also apply to all other Federal procurement and nonprocurement programs. Reinstatement to program participation is not automatic. After the end of the period of exclusion, Maxim may apply for reinstatement by submitting a written request for reinstatement in accordance with the provisions at 42 C.F.R. §§ 1001.3001-.3004.

E. Dispute Resolution

1. *Review Rights.* Upon OIG's delivery to Maxim of its Demand Letter or of its Exclusion Letter, and as an agreed-upon contractual remedy for the resolution of disputes arising under this CIA, Maxim shall be afforded certain review rights comparable to the ones that are provided in 42 U.S.C. § 1320a-7(f) and 42 C.F.R. Part 1005 as if they applied to the Stipulated Penalties or exclusion sought pursuant to this CIA. Specifically, OIG's determination to demand payment of Stipulated Penalties or to seek exclusion shall be subject to review by an HHS ALJ and, in the event of an appeal, the HHS Departmental Appeals Board (DAB), in a manner consistent with the provisions in 42 C.F.R. § 1005.2-1005.21. Notwithstanding the language in 42 C.F.R. § 1005.2(c), the request for a hearing involving Stipulated Penalties shall be made within 10 days after receipt of the Demand Letter and the request for a hearing involving exclusion shall be made within 25 days after receipt of the Exclusion Letter.

2. *Stipulated Penalties Review.* Notwithstanding any provision of Title 42 of the United States Code or Title 42 of the Code of Federal Regulations, the only issues in a proceeding for Stipulated Penalties under this CIA shall be: (a) whether Maxim was in full and timely compliance with the obligations of this CIA for which OIG demands payment; and (b) the period of noncompliance. Maxim shall have the burden of proving its full and timely compliance and the steps taken to cure the noncompliance, if any. OIG shall not have the right to appeal to the DAB an adverse ALJ decision related to Stipulated Penalties. If the ALJ agrees with OIG with regard to a finding of a breach of this CIA and orders Maxim to pay Stipulated Penalties, such Stipulated Penalties shall become due and payable 20 days after the ALJ issues such a decision unless Maxim requests review of the ALJ decision by the DAB. If the ALJ decision is properly appealed to the DAB and the DAB upholds the determination of OIG, the Stipulated Penalties shall become due and payable 20 days after the DAB issues its decision.

3. *Exclusion Review.* Notwithstanding any provision of Title 42 of the United States Code or Title 42 of the Code of Federal Regulations, the only issues in a proceeding for exclusion based on a material breach of this CIA shall be:

a. whether Maxim was in material breach of this CIA;

b. whether such breach was continuing on the date of the Exclusion Letter; and

c. whether the alleged material breach could not have been cured within the 30-day period, but that: (i) Maxim had begun to take action to cure the material breach within that period; (ii) Maxim has pursued and is pursuing such action with due diligence; and (iii) Maxim provided to OIG within that period a reasonable timetable for curing the material breach and Maxim has followed the timetable.

For purposes of the exclusion herein, exclusion shall take effect only after an ALJ decision favorable to OIG, or, if the ALJ rules for Maxim, only after a DAB decision in favor of OIG. Maxim's election of its contractual right to appeal to the DAB shall not abrogate OIG's authority to exclude Maxim upon the issuance of an ALJ's decision in favor of OIG. If the ALJ sustains the determination of OIG and determines that exclusion is authorized, such exclusion shall take effect 20 days after the ALJ issues such a decision, notwithstanding that Maxim may request review of the ALJ decision by the DAB. If the DAB finds in favor of OIG after an ALJ decision adverse to OIG, the exclusion shall take effect 20 days after the DAB decision. Maxim shall waive its right to any notice of such an exclusion if a decision upholding the exclusion is rendered by the ALJ or DAB. If the DAB finds in favor of Maxim, Maxim shall be reinstated effective on the date of the original exclusion.

4. *Finality of Decision.* The review by an ALJ or DAB provided for above shall not be considered to be an appeal right arising under any statutes or regulations. Consequently, the parties to this CIA agree that the DAB's decision (or the ALJ's decision if not appealed) shall be considered final for all purposes under this CIA.

XI. EFFECTIVE AND BINDING AGREEMENT

Maxim and OIG agree as follows:

A. This CIA shall be binding on the successors, assigns, and transferees of Maxim.

B. This CIA shall become final and binding on the date the final signature is obtained on the CIA.

C. This CIA constitutes the complete agreement between the parties and may not be amended except by written consent of the parties to this CIA.

D. OIG may agree to a suspension of Maxim's obligations under this CIA based on a certification by Maxim that it is no longer providing health care items or services that will be billed to any Federal health care program and that it does not have any ownership or control interest, as defined in 42 U.S.C. §1320a-3, in any entity that bills any Federal health care program. If Maxim is relieved of its CIA obligations, Maxim will be required to notify OIG in writing at least 30 days in advance if Maxim plans to resume providing health care items or services that are billed to any Federal health care program or to obtain an ownership or control interest in any entity that bills any Federal health care program. At such time, OIG shall evaluate whether the CIA will be reactivated or modified.

E. The undersigned Maxim signatories represent and warrant that they are authorized to execute this CIA. The undersigned OIG signatories represent that they are signing this CIA in their official capacities and that they are authorized to execute this CIA.

F. This CIA may be executed in counterparts, each of which constitutes an original and all of which constitute one and the same CIA. Facsimiles of signatures shall constitute acceptable, binding signatures for purposes of this CIA.

ON BEHALF OF MAXIM HEALTHCARE SERVICES, INC.

W. BRADLEY BENNETT
Chief Executive Officer

DATE

LAURA LAEMMLE-WEIDENFELD
Patton Boggs LLP
Counsel for Maxim Healthcare Services, Inc.

DATE

ON BEHALF OF MAXIM HEALTHCARE SERVICES, INC.

W. BRADLEY BENNETT
Chief Executive Officer

DATE

9/6/2011

LAURA LAEMMLE-WEIDENFELD
Patton Boggs LLP
Counsel for Maxim Healthcare Services, Inc.

DATE

ON BEHALF OF THE OFFICE OF INSPECTOR GENERAL
OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

9/9/11

GREGORY E. DEMSKE
Assistant Inspector General for Legal Affairs
Office of Inspector General
U. S. Department of Health and Human Services

DATE

9-7-11

LAURA E. ELLIS
Senior Counsel
Office of Inspector General
U. S. Department of Health and Human Services

DATE

APPENDIX A

INDEPENDENT REVIEW ORGANIZATION

This Appendix contains the requirements relating to the Independent Review Organization (IRO) required by Section III.D of the CIA.

A. IRO Engagement

1. Maxim shall engage an IRO that possesses the qualifications set forth in Paragraph B, below, to perform the responsibilities in Paragraph C, below. The IRO shall conduct the review in a professionally independent and objective fashion, as set forth in Paragraph D. Within 30 days after OIG receives the information identified in Section V.B.8 of the CIA or any additional information submitted by Maxim in response to a request by OIG, whichever is later, OIG will notify Maxim if the IRO is unacceptable. Absent notification from OIG that the IRO is unacceptable, Maxim may continue to engage the IRO.

2. If Maxim engages a new IRO during the term of the CIA, this IRO shall also meet the requirements of this Appendix. If a new IRO is engaged, Maxim shall submit the information identified in Section V.B.8 of the CIA to OIG within 30 days of engagement of the IRO. Within 30 days after OIG receives this information or any additional information submitted by Maxim at the request of OIG, whichever is later, OIG will notify Maxim if the IRO is unacceptable. Absent notification from OIG that the IRO is unacceptable, Maxim may continue to engage the IRO.

B. IRO Qualifications

The IRO shall:

1. assign individuals to conduct the Claims Review and Unallowable Cost Review engagements who have expertise in the billing, coding, reporting, and other requirements of home health and other areas of care provided by Maxim, and in the general requirements of the Federal health care program(s) from which Maxim seeks reimbursement;

2. assign individuals to design and select the Claims Review sample who are knowledgeable about the appropriate statistical sampling techniques;

3. assign individuals to conduct the coding review portions of the Claims Review who have a nationally recognized coding certification and who have maintained this certification (e.g., completed applicable continuing education requirements); and

4. have sufficient staff and resources to conduct the reviews required by the CIA on a timely basis.

C. IRO Responsibilities

The IRO shall:

1. perform each Claims Review and the Unallowable Cost review in accordance with the specific requirements of the CIA;

2. follow all applicable Medicare, Medicaid, or VA rules and reimbursement guidelines in making assessments in the Claims Review;

3. if in doubt of the application of a particular Medicare, Medicaid, or VA policy or regulation, request clarification from the appropriate authority (e.g., fiscal intermediary or carrier);

4. respond to all OIG inquires in a prompt, objective, and factual manner; and

5. prepare timely, clear, well-written reports that include all the information required by Appendix B to the CIA.

D. IRO Independence and Objectivity

The IRO must perform the Claims Review in a professionally independent and objective fashion, as appropriate to the nature of the engagement, taking into account any other business relationships or engagements that may exist between the IRO and Maxim.

E. IRO Removal/Termination

1. *Maxim and IRO.* If Maxim terminates its IRO or if the IRO withdraws from the engagement during the term of the CIA, Maxim must submit a notice explaining its reasons for termination or the reason for withdrawal to OIG no later than 30 days after termination or withdrawal. Maxim must engage a new IRO in accordance with Paragraph A of this Appendix and within 60 days of termination or withdrawal of the prior IRO or at least 60 days prior to the end of the current Reporting Period, whichever is earlier.

2. *OIG Removal of IRO.* In the event OIG has reason to believe that the IRO does not possess the qualifications described in Paragraph B, is not independent and/or objective as set forth in Paragraph D, or has failed to carry out its responsibilities

as described in Paragraph C, OIG may, at its sole discretion, require Maxim to engage a new IRO in accordance with Paragraph A of this Appendix. Maxim must engage a new IRO within 60 days of termination of the prior IRO or at least 60 days prior to the end of the current Reporting Period, whichever is earlier.

Prior to requiring Maxim to engage a new IRO, OIG shall notify Maxim of its intent to do so and provide a written explanation of why OIG believes such a step is necessary. To resolve any concerns raised by OIG, Maxim may present additional information regarding the IRO's qualifications, independence or performance of its responsibilities. OIG will attempt in good faith to resolve any differences regarding the IRO with Maxim prior to requiring Maxim to terminate the IRO. However, the final determination as to whether or not to require Maxim to engage a new IRO shall be made at the sole discretion of OIG.

APPENDIX B

CLAIMS REVIEW

A. Claims Review

The IRO shall perform the Claims Review annually to cover each of the five Reporting Periods. The IRO shall perform all components of each Claims Review.

1. *Definitions*. For the purposes of the Claims Review, the following definitions shall be used:

a. Overpayment: The amount of money Maxim has received in excess of the amount due and payable under any Federal health care program requirements.

b. Paid Claim: A claim submitted by Maxim and for which Maxim has received reimbursement from the Medicare or Medicaid programs.

c. Population: The Population shall be defined as all Paid Claims during the 12-month period covered by the Claims Review.

d. Error Rate: The Error Rate shall be the percentage of net Overpayments identified in the sample. The net Overpayments shall be calculated by subtracting all underpayments identified in the sample from all gross Overpayments identified in the sample. (Note: Any potential cost settlements or other supplemental payments should not be included in the net Overpayment calculation. Rather, only underpayments identified as part of the Discovery Sample shall be included as part of the net Overpayment calculation.)

The Error Rate is calculated by dividing the net Overpayment identified in the sample by the total dollar amount associated with the Paid Claims in the sample.

2. *Selection of Offices for Review.* The IRO shall utilize RAT-STATS to select a random sample of 12 percent of Maxim homecare offices. In selecting these facilities, the IRO shall randomly select an equal number of the offices from each region. In the event that Maxim reorganizes its structure to add or subtract regions, the sample of

offices selected shall be distributed evenly across the regions. The sample of offices from a region shall comprise an Office Set.

3. *Discovery Samples.* For each Office Set, the IRO shall randomly select and review a sample of 60 Paid Claims selected from the aggregate population of Paid Claims for that Office Set's Discovery Sample. The Paid Claims shall be reviewed based on the supporting documentation available at Maxim's office or under Maxim's control and applicable billing and coding regulations and guidance to determine whether the claim was correctly coded, submitted, and reimbursed.

If the Error Rate (as defined above) for a Discovery Sample is less than 5%, no additional sampling is required, nor is a Systems Review required. (Note: The guidelines listed above do not imply that this is an acceptable error rate. Accordingly, Maxim should, as appropriate, further analyze any errors identified in any Discovery Sample. Maxim recognizes that OIG or other HHS component, in its discretion and as authorized by statute, regulation, or other appropriate authority may also analyze or review Paid Claims included, or errors identified, in any Discovery Sample or any other segment of the universe.)

4. *Verification Review.* In lieu of performing each entire Discovery Sample, for the first Claims Review performed under this provision the IRO shall randomly select 20% of the Paid Claims in each Discovery Sample for review by Maxim's compliance audit program (Maxim's Review Set). For each subsequent Claims Review, the IRO shall increase by an incremental 20% the number of Paid Claims in Maxim's Review Set (i.e., 20% of each discovery Sample in the first Verification Review's Claims Review, 40% in the second, etc.). Maxim shall perform its review in accordance with the requirements of this Appendix. After Maxim has completed its review, the IRO shall randomly select half of Maxim's Review Set and verify Maxim's review. The IRO shall independently review all Paid Claims in the Discovery Samples that are not part of Maxim's Review Set. For all Paid Claims that the IRO reviews, whether initially or as a verification of Maxim's review, the IRO's determination shall serve as the basis for determining the Error Rate for each Discovery Sample.

5. *Full Sample.* If a Discovery Sample indicates that the Error Rate is 5% or greater, the IRO shall select an additional sample of Paid Claims (Full Sample) from the same Office Set using commonly accepted sampling methods. The Full Sample shall be designed to: (1) estimate the actual Overpayment in the population with a 90% confidence level and with a maximum relative precision of 25% of the point estimate; and (2) conform to the Centers for Medicare and Medicaid Services' statistical sampling for overpayment estimation guidelines. The Paid Claims selected for the Full Sample shall be reviewed based on supporting documentation available at Maxim or under Maxim's control and applicable billing and coding regulations and guidance to determine whether the claim was correctly coded, submitted, and reimbursed. For purposes of

calculating the size of the Full Sample, a Discovery Sample may serve as the probe sample, if statistically appropriate. Additionally, the IRO may use the Paid Claims sampled as part of a Discovery Sample, and the corresponding findings for those Paid Claims, as part of its Full Sample, if: (1) statistically appropriate and (2) the IRO selects the Full Sample Paid Claims using the seed number generated by the Discovery Sample. OIG, in its sole discretion, may refer the findings of the Full Sample (and any related workpapers) received from Maxim to the appropriate Federal health care program payor, including the Medicare contractor (e.g., carrier, fiscal intermediary, or DMERC), for appropriate follow-up by that payor.

6. *Systems Review.* If a Discovery Sample identifies an Error Rate of 5% or greater, Maxim's IRO shall also conduct a Systems Review for that region. The Systems Review shall consist of the following:

a. a review of Maxim's billing and coding systems and processes relating to claims submitted to Federal health care programs (including, but not limited to, the operation of the billing system, the process by which claims are coded, safeguards to ensure proper coding, claims submission and billing; and procedures to identify and correct inaccurate coding and billing);

b. for each claim in the Discovery Sample and Full Sample that resulted in an Overpayment, the IRO shall review the system(s) and process(es) that generated the claim and identify any problems or weaknesses that may have resulted in the identified Overpayments. The IRO shall provide its observations and recommendations on suggested improvements to the system(s) and the process(es) that generated the claim.

7. *Other Requirements*

a. Supporting Documentation. The IRO shall request all documentation and materials required for its review of the Paid Claims selected as part of the Discovery Samples or Full Samples (if applicable), and Maxim shall furnish such documentation and materials to the IRO, prior to the IRO initiating its review of the Discovery Samples or Full Samples (if applicable). If the IRO accepts any supplemental documentation or materials from Maxim after the IRO has completed its initial review of the Discovery Samples or Full Samples (if applicable) (Supplemental Documentation), the

IRO shall identify in the Claims Review Report the Supplemental Documentation, the date the Supplemental Documentation was accepted, and the relative weight the IRO gave to the Supplemental Documentation in its review. In addition, the IRO shall include a narrative in the Claims Review Report describing the process by which the Supplemental Documentation was accepted and the IRO's reasons for accepting the Supplemental Documentation.

b. Paid Claims without Supporting Documentation. Any Paid Claim for which Maxim cannot produce documentation sufficient to support the Paid Claim shall be considered an error and the total reimbursement received by Maxim for such Paid Claim shall be deemed an Overpayment. Replacement sampling for Paid Claims with missing documentation is not permitted.

c. Use of First Samples Drawn. For the purposes of all samples (Discovery Sample(s) and Full Sample(s)) discussed in this Appendix, the Paid Claims selected in each first sample shall be used (i.e., it is not permissible to generate more than one list of random samples and then select one for use with the Discovery Sample or Full Sample).

B. Claims Review Report. The IRO shall complete a Claims Review Report as described in this Appendix for each Claims Review performed. If the Discovery Samples portion of the Claims Review is performed under the Verification Review provision at Section A.4 above, Maxim shall contribute the information pertaining to its review. The following information shall be included in the Claims Review Report for each Discovery Sample and Full Sample (if applicable).

1. *Claims Review Methodology*

a. Claims Review Population. A description of the Population subject to the Claims Review.

b. Claims Review Objective. A clear statement of the objective intended to be achieved by the Claims Review.

c. Source of Data. A description of the specific documentation relied upon by the IRO when performing the Claims Review (e.g., medical records, physician orders, certificates of medical necessity, requisition forms, local medical review

policies (including title and policy number), program memoranda (including title and issuance number), carrier or intermediary manual or bulletins (including issue and date), other policies, regulations, or directives).

d. Review Protocol. A narrative description of how the Claims Review was conducted and what was evaluated.

e. Supplemental Documentation. A description of any Supplemental Documentation as required by A.7.a., above.

2. *Statistical Sampling Documentation*

a. A copy of the printout of the random numbers generated by the "Random Numbers" function of the statistical sampling software used by the IRO.

b. A copy of the statistical software printout(s) estimating how many Paid Claims are to be included in the Full Sample, if applicable.

c. A description or identification of the statistical sampling software package used to select the sample and determine the Full Sample size, if applicable.

3. *Claims Review Findings*

a. Narrative Results

i. A description of Maxim's billing and coding system(s), including the identification, by position description, of the personnel involved in coding and billing.

ii. A narrative explanation of the IRO's findings and supporting rationale (including reasons for errors, patterns noted, etc.) regarding the Claims Review, including the results of the Discovery Samples, and the results of the Full Samples (if any).

b. Quantitative Results

i. Total number and percentage of instances in which the IRO determined that the Paid Claims submitted by Maxim

(Claim Submitted) differed from what should have been the correct claim (Correct Claim), regardless of the effect on the payment.

ii. Total number and percentage of instances in which the Claim Submitted differed from the Correct Claim and in which such difference resulted in an Overpayment to Maxim.

iii. Total dollar amount of all Overpayments in the sample.

iv. Total dollar amount of Paid Claims included in the sample and the net Overpayment associated with the sample.

v. Error Rate in the sample.

vi. A spreadsheet of the Claims Review results that includes the following information for each Paid Claim: Federal health care program billed, beneficiary health insurance claim number, date of service, code submitted (e.g., DRG, CPT code, etc.), code reimbursed, allowed amount reimbursed by payor, correct code (as determined by the IRO), correct allowed amount (as determined by the IRO), dollar difference between allowed amount reimbursed by payor and the correct allowed amount.

c. Recommendations. The IRO's report shall include any recommendations for improvements to Maxim's billing and coding system based on the findings of the Claims Review

4. *Systems Review.* The IRO shall prepare a report based on any Systems Review (Systems Review Report) that shall include the IRO's observations, findings, and recommendations regarding:

a. the strengths and weaknesses in Maxim's billing systems and processes;

b. the strengths and weaknesses in Maxim's coding systems and processes; and

c. possible improvements to Maxim's billing and coding systems and processes to address the specific problems or weaknesses that resulted in the identified Overpayments.

5. *Credentials*. The names and credentials of the individuals who: (1) designed the statistical sampling procedures and the review methodology utilized for the Claims Review and (2) performed the Claims Review.

APPENDIX C

COMPLIANCE REVIEW

A. Consultant Engagement

1. Maxim shall engage a Consultant that possesses the qualifications set forth in Paragraph B, below, to perform the Compliance Review described in Paragraph C, below, and issue the Compliance Review Report described in Paragraph D, below. The Consultant shall conduct the review in a professionally independent and objective fashion, as set forth in Paragraph E. Within 30 days after OIG receives the information identified in Section V.B.9 of the CIA or any additional information submitted by Maxim in response to a request by OIG, whichever is later, OIG will notify Maxim if the Consultant is unacceptable. Absent notification from OIG that the Consultant is unacceptable, Maxim may continue to engage the Consultant.

2. If Maxim engages a new Consultant during the term of the CIA, this Consultant shall also meet the requirements of this Appendix. If a new Consultant is engaged, Maxim shall submit the information identified in Section V.B.9 of the CIA to OIG within 30 days of engagement of the Consultant. Within 30 days after OIG receives this information or any additional information submitted by Maxim at the request of OIG, whichever is later, OIG will notify Maxim if the Consultant is unacceptable. Absent notification from OIG that the Consultant is unacceptable, Maxim may continue to engage the Consultant. Maxim must make available to the new Consultant the prior Consultant's reports and the Monitor's reports.

B. Consultant Qualifications

The Consultant shall have expertise in health care compliance systems and in evaluating compliance and clinical systems in the areas of care provided by Maxim.

C. Compliance Review

The Consultant shall perform the Compliance Review annually to cover each Reporting Period. The Consultant shall perform all components of each Compliance Review. The Consultant shall assess the effectiveness, reliability, and thoroughness of Maxim's compliance program generally and specifically with regard to the provision of clinical services. To assist the Consultant's review, Maxim shall make available to the Consultant all the Monitor's reports, as described in Section V.A. The Compliance Review shall be undertaken at all relevant levels of the organization, including but not limited to corporate offices and local offices (*i.e.*, local branch offices within each region). The Compliance Review shall be performed as follows:

1. *Work plan Review.* Within 60 days after the start of each Reporting Period, the Consultant shall provide the OIG with a draft copy of its work plan, including offices to be reviewed. Within 30 days after OIG receives the Consultant's draft work plan or any additional information submitted by the Consultant in response to a request by OIG, whichever is later, OIG will notify the Consultant if the work plan is unacceptable. Absent notification from the OIG that the work plan is unacceptable, the Consultant may proceed with the Compliance Review.

2. *Compliance Review.* As part of the Compliance Review, the Consultant shall conduct site visits to Maxim's corporate headquarters and local offices within each region. The Consultant shall review, at a minimum:

a. Maxim's internal compliance systems, including, but not limited to:

i. whether the systems in place to promote compliance and quality of care, and to respond to issues, are operating in a timely and effective manner;

ii. whether Maxim has an effective medical record review within its compliance audit program;

iii. whether the communication system is effective, allowing for accurate information, decisions, and results of decisions to be transmitted to the proper individuals in a timely fashion; and

iv. whether the clinical training programs are effective, thorough, competency-based, and provided timely.

b. Maxim's response to compliance issues, which shall include an assessment of:

i. Maxim's ability to identify the problem;

ii. Maxim's ability to determine the scope of the problem, including, but not limited to, whether the problem is isolated or systemic;

iii. Maxim's ability to conduct a root-cause analysis;

iv. Maxim's ability to create an action plan to respond to the problem;

v. Maxim's ability to execute the action plan; and

vi. Maxim's ability to monitor and evaluate whether the assessment, action plan, and execution of that plan was effective, reliable, and thorough.

c. Maxim's ability to identify new, emerging, and potential compliance risks and take steps to address such risks proactively.

d. Maxim's actions to address findings and recommendations made by the Monitor and the Consultant.

D. Compliance Review Report

The Compliance Report for each Compliance Review shall contain the following information:

1. the work plan for the Compliance Review;

2. the Consultant's findings and recommendations;

3. the Consultant's evaluation of the actions Maxim has taken to implement the Monitor's recommendations and, as applicable, the Consultant's previous recommendations; and

4. the names, credentials, expertise, and Compliance Review responsibilities of the individuals who are involved in the Compliance Review.

E. Consultant Independence and Objectivity

The Consultant must perform the Compliance Review in a professionally independent and objective fashion, as appropriate to the nature of the engagement, taking into account any other business relationships or engagements that may exist between the Consultant and Maxim. Maxim shall not assert a privilege to the OIG with respect to any advice, counsel, or work product provided by the Consultant after the Effective Date and during the term of the CIA.

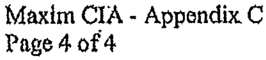
F. Consultant Removal/Termination

1. *Maxim and Consultant.* If Maxim terminates its Consultant or if the Consultant withdraws from the engagement during the term of the CIA, Maxim must

submit a notice explaining its reasons for termination or the reason for withdrawal to OIG no later than 30 days after termination or withdrawal. Maxim must engage a new Consultant in accordance with Paragraph A of this Appendix within 60 days of termination or withdrawal of the prior Consultant or at least 60 days prior to the end of the current Reporting Period, whichever is earlier. Maxim must make available to the new Consultant the prior Consultant's reports and the Monitor's reports.

2. *OIG Removal of Consultant.* In the event OIG has reason to believe that the Consultant does not possess the qualifications described in Paragraph B, is not independent and/or objective as set forth in Paragraph E, or has failed to carry out its responsibilities as described in Paragraphs C and D, OIG may, at its sole discretion, require Maxim to engage a new Consultant in accordance with Paragraph A of this Appendix. Maxim must engage a new Consultant within 60 days of termination of the prior Consultant or at least 60 days prior to the end of the current Reporting Period, whichever is earlier.

Prior to requiring Maxim to engage a new Consultant, OIG shall notify Maxim of its intent to do so and provide a written explanation of why OIG believes such a step is necessary. To resolve any concerns raised by OIG, Maxim may present additional information regarding the Consultant's qualifications, independence, or performance of its responsibilities. OIG will attempt in good faith to resolve any differences regarding the Consultant with Maxim prior to requiring Maxim to terminate the Consultant. However, the final determination as to whether or not to require Maxim to engage a new Consultant shall be made at the sole discretion of OIG.



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AT 8:30 ....M
CHAMBERS OF THE
HON. MICHAEL A. SHIPP,
U.S.M.J.

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA : Magistrate No. 11-6107 (MAS)

v.

MAXIM HEALTHCARE SERVICES, INC. : **CRIMINAL COMPLAINT**

I, Eugene H. Fayer, the undersigned complainant, being duly sworn, state that the following is true and correct to the best of my knowledge and belief:

From in or about 2003 to in or about 2009, in the District of New Jersey, and elsewhere, defendant

MAXIM HEALTHCARE SERVICES, INC.

did knowingly and willfully conspire and agree with others to devise a scheme and artifice (1) to defraud health care benefit programs, and (2) to obtain, by means of false and fraudulent pretenses, representations, and promises, money and property owned by, and under the custody and control of, a health care benefit program, in connection with the delivery of and payment for health care benefits, items, and services, contrary to Title 18, United States Code, Section 1347. In violation of Title 18, United States Code, Section 1349.

I further state that I am a Special Agent with the United States Department of Health and Human Services, Office of the Inspector General, and that this complaint is based upon the following facts:

SEE ATTACHMENT A

continued on the attached page and made a part hereof.

Eugene H. Fayer, Special Agent
United States Department of
Health and Human Services
Office of the Inspector General

Sworn to before me and subscribed in my presence,

September 12th, 2011, at Newark, New Jersey

Honorable Michael A. Shipp
United States Magistrate Judge

Signature of Judicial Officer

ATTACHMENT A

I, Eugene H. Fayer, state that I am a Special Agent with the United States Department of Health and Human Services, Office of the Inspector General. I have personally participated in this investigation and am aware of the facts contained herein, based upon my own investigation, as well as information provided to me by other law enforcement officers. Because this Attachment A is submitted for the limited purpose of establishing probable cause, I have not included herein the details of every aspect of the investigation.

Summary

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 health care 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.

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.	J. Gilmore Childers Attorney for the United States Acting Under Authority Conferred by 28 U.S.C. § 515 District of New Jersey
9/6/11 Date	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

Date 9/6/11

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.

A MEDICAID FRAUD VICTIM SPEAKS OUT: WHAT'S NOT WORKING AND WHY

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON GOVERNMENT ORGANIZATION, EFFICIENCY AND FINANCIAL MANAGEMENT

AND THE

SUBCOMMITTEE ON HEALTHCARE, DISTRICT OF COLUMBIA, CENSUS AND THE NATIONAL ARCHIVES

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

DECEMBER 7, 2011

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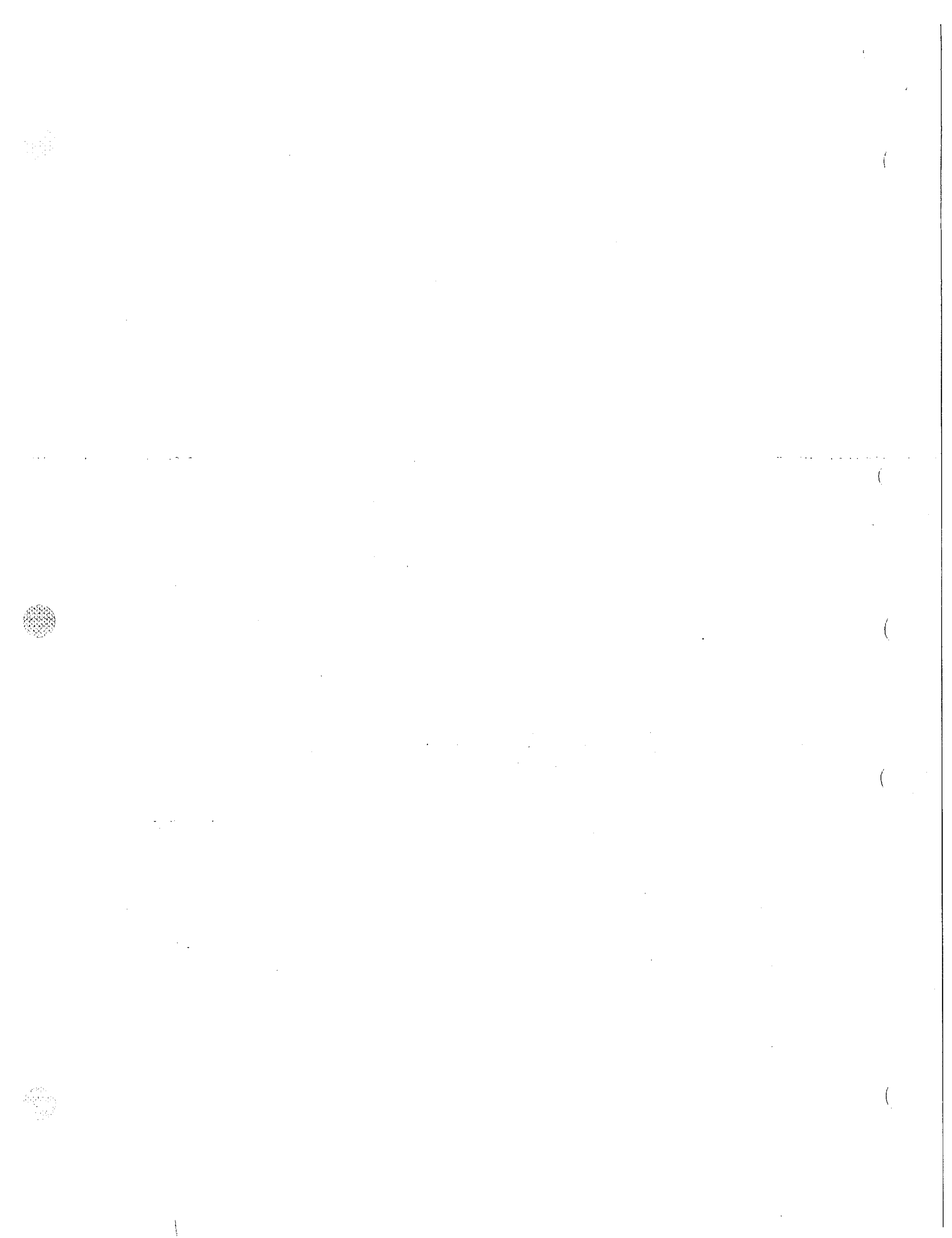

A MEDICAID FRAUD VICTIM SPEAKS OUT: WHAT'S NOT WORKING AND WHY

WEDNESDAY, DECEMBER 7, 2011

HOUSE OF REPRESENTATIVES, SUBCOMMITTEE ON GOVERNMENT ORGANIZATION, EFFICIENCY AND FINANCIAL MANAGEMENT, JOINT WITH THE SUBCOMMITTEE ON HEALTHCARE, DISTRICT OF COLUMBIA, CENSUS AND THE NATIONAL ARCHIVES, COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,

Washington, DC.

The subcommittees met, pursuant to notice, at 10:07 a.m., in room 2154, Rayburn House Office Building, Hon. Todd Russell Platts (chairman of the Subcommittee on Government Organization, Efficiency and Financial Management) presiding.

Present: Representatives Platts, Issa, Lankford, Gosar, DesJarlais, Gowdy, Cummings, Towns, Norton, Connolly, and Davis.

Staff present: John Cuaderes, deputy staff director; Sery E. Kim, counsel; Mark D. Marin, director of oversight; Brian Blase, professional staff member; Will L. Boyington, staff assistant; Molly Boyl, parliamentarian; Tegan Millspaw, research analyst; Linda Good, chief clerk; Laura Rush, deputy chief clerk; Gwen D'Luzansky, assistant clerk; Suzanne Sachsman Grooms, minority chief counsel; Yvette Cravins, minority counsel; Devon Hill, minority staff assistant; Lucinda Lessley, minority policy director; Ashley Ettienne, minority director of communications; Jennifer Hoffman, minority press secretary; Jaron Bourke, minority director of administration; and Carla Hultberg, minority chief clerk.

Mr. PLATTS. This hearing will come to order. I appreciate everyone's attendance and welcome everybody here in this joint subcommittee hearing, the Subcommittee on Government Organization, Efficiency and Financial Management along with the Subcommittee on Health Care, District of Columbia, Census and the National Archives.

Today's hearing will examine the serious problem of fraud, waste and abuse in Medicaid. In fiscal year 2011, the Medicaid program issued $21.9 billion in improper payments, higher than any program in government except Medicare. It is unknown how much of these improper payments are fraudulent or how much fraud goes undetected. The integrity program is responsible for identifying improper payments, educating providers about fraud and providing assistance to States in order to combat fraud, waste and abuse. The Patient Protection and Affordable Care Act of 2010 expanded funding for Medicaid program integrity. However, it also expands the

size of the Medicaid program and will increase Medicaid spending by over $600 billion between 2014 and 2021.

Given this dramatic expansion, fraud detection and prevention will be all the more important.

Better data quality is essential in reducing waste, fraud and abuse. In 2006, CMS initiated two new data systems in an attempt to improve quality and access. GAO issued a report finding that both the new systems were inadequate and underutilized. GAO also could not find any evidence of financial benefits in implementing the new systems despite the fact that CMS has been using them for over 5 years. There are also problems with State-reported data.

Many States are not reporting all required data and there are often lag times for up to 1 year between when States report data and when CMS gets it and verifies it. This makes it extremely difficult and often impossible to prevent data fraud before payments are issued. And as I know, we will hear in the testimony here today from one of our witnesses some of the information is as old as 12 years, which is just unthinkable as far as usefulness of it.

As a result of poor data systems, CMS relies on contractors to identify fraud through audit work. CMS spent $42 million on Medicaid integrity contractors in 2010. However, GAO has noted pervasive deficiencies in CMS's oversight of its contractors and has issued numerous recommendations to CMS.

Most of these recommendations have not been implemented. The Office of Inspector General has been on the front lines of investigating fraud through its work with the State Medicaid fraud control units, MFCUs.

In 2010, these units conducted 9,710 fraud investigations and recovered $1.8 billion. This work is essential and would become even more crucial as Medicaid expands. But States have limited resources to combat the rising problem of Medicaid fraud, and there is also a question of the incentive of States to do so because of much of the money is coming back to Federal Government, not to their own treasury.

Health care fraud is sometimes called a faceless or victimless crime, and we also talk about it in terms of money lost. As a result, it can be easy to overlook what a devastating impact it can have on victims, beneficiaries who do not get the care that they need and deserve.

Today we are joined by one such individual, Mr. Richard West, a Vietnam war veteran and a victim of Medicaid fraud.

He and his lawyer, along with his son, will testify here today about their personal experiences and their efforts to uncover fraud within the Medicaid program.

And their case is going to show that this isn't just about money, this is about ensuring that we do right by every American citizen who is in need of medical assistance and is a part of the Medicaid program. As Mr. West will share, it wasn't just the millions of dollars that was being stolen from American taxpayers, it was because of that fraud that he was being denied care through the Medicaid program. It is not just about money, it is about people. We will also hear testimony from CMS, OIG and GAO on systemic problems

within Medicaid and what must be done to provide effective oversight and reduce fraud, waste and abuse in the Medicaid program.

And now I am honored to recognize the ranking member of our subcommittee, the gentleman from New York, Mr. Towns, for an opening statement.

Mr. TOWNS. Thank you very much, Mr. Chairman.

Let me thank the ranking member, Mr. Davis, as well for convening today's hearing on fraud in the Medicaid system. Weeding out fraud is a bipartisan goal that all stewards of taxpayers' dollars should share, so I truly appreciate this opportunity to explore this subject fully.

I thank the witnesses on both panels for joining us today to discuss their views. I especially would like to thank Mr. West for sharing his story and for his service to this country, the Vietnam War. Mr. West, I salute you.

There is no question that Medicaid is an essential program. It provides a vital safety net for many children, seniors, and the disabled who truly need it. It is unfortunate, however, that it has become a target for bad actors seeking to game the system. There is some positive news to note, even in this era of budget cuts. CMS, in its efforts to undercover fraud, are actually making money for the government and for taxpayers. For every $1 invested in fraud prevention and detection, over $16 is actually recovered. Much of this recovery came from cases like the very successful case brought by Mr. West.

We need to be certain that we are encouraging whistleblowers who become aware of these cases in the Medicaid program to bring them forward. This administration has done an admirable job of stepping up fraud detection in the Medicare and Medicaid programs. However, I understand that there have been a number of recommendations made by GAO that intends to address this issue but have not yet been adopted.

I look forward to exploring the limitations that CMS and HHS has so that we can work together to further prevent undercover and recover payments in the Medicaid system.

Thank you, Mr. Chairman, of course, and for this hearing and I look forward to working with you and I yield back the balance of my time.

Mr. PLATTS. Thank you, Mr. Towns. I am now honored to yield to the chairman of the subcommittee on Health Care, District of Columbia, Census and National Archives, the distinguished gentleman from South Carolina, Chairman Gowdy.

Mr. GOWDY. Thank you, Mr. Chairman. Today the committee will hear from Richard West, a man with firsthand knowledge of how easily government programs are defrauded and how the government all too often just doesn't seem to care. Mr. West acted responsibly and alerted the State of New Jersey Medicaid and his social worker to the fraudulent behavior of his health care provider, but none of the government agencies did anything. This is wholly unacceptable. And this is why people have lost trust in the institutions of government, and this is why our fellow citizens have so little trust that we are spending their money as carefully as we would spend our own.

Mr. West kept track of the nursing care received and was able to compare his records to the provider's records. He found discrepancies and because Medicaid capped the monthly services provided to Mr. West, he was not receiving the care he was entitled to. In other words, due to the fraudulent activities of the company providing Mr. West's care, he reached the cap and Medicaid told him his services were suspended. So not only was the provider ripping off taxpayers, but the provider was also not providing the obligated services to Mr. West.

It is impossible to believe that Mr. West's story is isolated. Medicaid is designated a high-risk program and is, therefore, highly susceptible to waste, fraud and abuse. Many experts believe the loss rates for Medicaid and Medicare due to fraud equals about 20 percent of the total program funding. So perhaps as much as one-fifth of the money spent is wasted, and ignoring legitimate calls for investigations into fraud when witnessed firsthand, has a chilling effect on other like-minded people who might be willing to alert authorities to abuse.

Most of the fraud occurs when providers bill for services never delivered to Medicaid patients. According to Malcolm Sparrow, a Harvard University expert on health care fraud, the rule for criminals is simple. If you want to steal from Medicare or Medicaid, or any other health care insurance program, learn to bill your lies correctly. Then for the most part, your claims will be paid in full and on time without a hiccup by a computer with no human involvement at all.

One reason for high rates of abuse might be that States do not appear to have an adequate incentive to root out waste and fraud. This is, in large part, due to the fact that a large part of what is recovered must be sent back to Washington. Another reason may be the Centers for Medicaid & Medicare Services doesn't typically analyze claims data for over a year after the date the claim was filed.

This lag time indicates CMS needs to update the tracking system used to root waste, fraud and abuse of the Medicaid system out.

Although every tax dollar inappropriately spent is a concern, the magnitude of waste, fraud and abuse in Medicaid elevates this problem.

Our country now spends $430 billion on Medicaid a year. And CMS projects the total spending on Medicaid will double by the end of this decade. States are struggling to deal with Medicaid's growth and Medicaid is crowding out State priorities like education, transportation and public safety.

I look forward to today's hearing and hearing from our witnesses and hopefully flushing out ideas for eliminating the amount of tax dollars that are being wasted through the Medicaid program. When folks like Mr. West are being hurt and neglected due to fraud, it is time to find solutions and our fellow citizens, the ones who trust us enough to let us be their voice in this town are increasingly losing confidence that we are not serious about tackling waste, fraud and abuse. We must reclaim their confidence. We do that one episode at a time, and we might as well start with Mr. West. With that, I would yield back to the chairman.

[The prepared statement of Hon. Trey Gowdy follows:]

Opening Statement

Chairman Trey Gowdy

Subcommittee on Health Care, D.C., Census and Natl. Archives

December 7, 2011

Today the Committee will hear from Richard West, a man with first-hand knowledge of how easily government programs are defrauded and how the government too often does not seem to care. Mr. West acted responsibly and alerted the state of New Jersey, Medicaid, and his social worker to the fraudulent behavior of his health care provider. But none of the government agencies did anything. This is unacceptable. This is why people have lost trust in the institutions of government. This is why our fellow citizens have so little trust that we are spending their money as carefully as we would spend our own.

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It is impossible to believe that Mr. West's story is isolated. Medicaid is designated a high risk program and is therefore highly susceptible to waste, fraud and abuse. Many experts believe that loss rates from Medicare and Medicaid due to fraud equals about 20 percent of total program spending. So, perhaps as much as 1/5 of the money spent is wasted and ignoring legitimate calls for investigations into fraud – when witnessed firsthand – has a chilling effect on other likeminded people who might be willing to alert authorities to abuse.

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Centers for Medicare and Medicaid Services (CMS) doesn't typically analyze claims data for over a year after the date the claim was filed. This lag time indicates CMS needs to update the tracking system used to root out fraud and abuse of the Medicaid system

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Mr. PLATTS. I thank the gentleman. I am now pleased and honored and yield to the ranking member of the Subcommittee on Health Care, District of Columbia, Census and National Archives, the gentleman from Illinois, Mr. Davis.

Mr. DAVIS. Thank you very much, Chairman Platts, Chairman Gowdy, Ranking Member Towns, I thank all of you for holding today's hearing. Reducing waste, fraud and abuse in health care is a rare and desirable policy shared by Republicans and Democrats alike.

It is disturbing that some entrusted with caring for our most vulnerable populations would seek to defraud the government by falsely billing for services. It is the height of corporate greed. In this era of budget shortfalls and cuts, we can no longer stumble upon these bad actors. We must be vigilant in locating and weeding out fraud. The proper resources must be dedicated to root out waste and abuse. Our taxpayer dollars are too precious. The more funds expended on phantom services delay or extinguish the authentic and necessary health care programs and services that people depend upon daily.

As Medicaid is determined to be a high-risk program, I want to further encourage CMS to fully utilize and implement all of the tools available in this fight, including the Integrated Data Repository and the One Program Integrity. These technological programs are invaluable in consolidating the data necessary in fraud detection. The Patient Protection and Affordable Care Act further provides tools to fight Medicaid fraud. The licensure and background checks on providers and suppliers are a productive first step for program integrity.

In the enforcement arena, the new civil penalties created for falsifying information is evidence that the Federal Government takes fraud seriously. To that end, the Affordable Care Act adds $10 million annually for fiscal years 2011 through 2020.

Simply put, fighting health care fraud is good fiscal policy.

And I might add that I am totally opposed to fraudulent practices in medicine, especially involving the most vulnerable, the most unsuspecting, and, in many instances, the most gullible members of our society. I have seen firsthand low-income communities deal with Medicaid meals where people are lined up to be taken advantage of. These are practices we should not, cannot and must not tolerate.

Therefore, I applaud the tireless efforts of Mr. Richard West. He serves as an example to others. He saw a wrong and tried to right it. And so we all thank you, Mr. West. I look forward to your testimony and the testimony of all the witnesses. And I thank you, Mr. Chairman, and yield back.

Mr. PLATTS. I thank the gentleman. We have also been joined by the distinguished ranking member of the full Committee on Oversight and Government Reform, the gentleman from Maryland, Mr. Cummings. And I recognize him for an opening statement.

Mr. CUMMINGS. Thank you very much, Mr. Chairman. I would also like to thank Mr. West for taking the time to come to Capitol Hill today to share his experience so we might apply the lessons learned from his case to future policy and law enforcement decisions. Last year, Medicaid provided critical health care services to

an estimated 56 million Americans in need, the vast majority of whom are seniors, individuals with disabilities, and children. Since so many Americans rely on this program, it is imperative that we root out fraud because every dollar squandered is a dollar that does not go to critical health care services for these vulnerable Americans.

Today's hearing focuses on a case that was brought to light by Richard West, a Medicaid beneficiary who asserted his rights under the False Claims Act to prosecute fraud against the Medicaid system by Maxim Healthcare Service. Mr. West's lawsuit retrieved nearly $150 million for the U.S. taxpayers. We need support efforts by people like Mr. West to ensure that American citizens are empowered to take on corporate wrongdoing. The written testimony of our witnesses on the second panel also makes clear that we need better coordination between State and Medicaid programs and the Centers for Medicare & Medicaid Services to reduce duplicative efforts and better align resources.

Fortunately, the Affordable Care Act provides additional funding to fight waste, fraud and abuse in Medicaid. It also contains a number of provisions designed to improve data quality and promote data sharing between Federal agencies, the States and health care providers.

The fight against unscrupulous companies like Maxim Healthcare Services requires more resources, not less. When we invest in fraud prevention, government spending more than pays for itself. That is one reason why repealing the Affordable Care Act and cutting Medicaid's enforcement budget would be very shortsighted, and indeed, counterproductive.

I look forward to the testimony of our witnesses today, and I hope their recommendations will help reduce fraud, waste, and abuse and create a stronger Medicaid program for those who rely on it.

And with that, Mr. Chairman, I yield back.

[The prepared statement of Hon. Elijah E. Cummings follows:]

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Opening Statement
Rep. Elijah E. Cummings, Ranking Member
Committee on Oversight and Government Reform

Subcommittee on Government Organization, Efficiency and Financial Management and the Subcommittee on Health Care, District of Columbia, Census and the National Archives Joint Hearing on "A Medicaid Fraud Victim Speaks Out: What's Not Working and Why?"

December 7, 2011

Thank you, Mr. Chairman. I would also like to thank Mr. West for taking the time to come to Capitol Hill to share his experience so we might apply the lessons learned from his case to future policy and law enforcement decisions.

Last year, Medicaid provided critical health care services to an estimated 56 million Americans in need, the vast majority of whom are seniors, individuals with disabilities, and children. Since so many Americans rely on this program, it is imperative that we root out fraud, because every dollar squandered is a dollar that does not go to critical health care services for these vulnerable Americans.

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The fight against unscrupulous companies like Maxim Healthcare Services requires more resources, not less. When we invest in fraud prevention, government spending more than pays for itself. That is one reason why repealing the Affordable Care Act and cutting Medicaid's enforcement budget would be shortsighted and counterproductive.

I look forward to the testimony of our witnesses today and hope their recommendations will help reduce fraud, waste, and abuse and create a stronger Medicaid program for those who rely on it.

Contact: Ashley Etienne, Communications Director, (202) 226-5181.

Mr. PLATTS. I thank the gentleman, and yield to the distinguished gentleman from Virginia, Mr. Connolly, for his opening statement.

Mr. CONNOLLY. Thank you Mr. Chairman and thank you for your leadership on this important subject.

Reducing Medicaid improper payments contributes directly to the long-term health of these essential health care programs. I appreciate our two subcommittees holding a hearing on the different anti-fraud programs within HHS and Centers for Medicare & Medicaid Services. While HHS and CMS are devoting unprecedented attention to reducing Medicaid fraud, it is clear we must do more to reduce improper payments and protect the economic security of individuals such as Richard West who have lost benefits temporarily as a result of attacking Medicaid and Medicare fraud.

As the written testimony of this hearing makes clear, Congress and the administration have devoted a great deal of effort to reducing improper payments within the last decade. In 2005, Congress passed the Deficit Reduction Act which established the Medicaid integrity program. The MIP provides States with technical assistance to identify and prevent fraud which is appropriate since States administer Medicaid.

The Deficit Reduction Act also requires CMS to work with Medicaid integrity contractors to ferret out overpayments, conduct audits and educate program participants about fraud prevention.

CMS uses this and other data for its Medicaid statistical information system which includes eligibility and claims information across the country. By maintaining a central data base, CMS can conduct analyses which identify possible fraud or areas where fraud is likely to occur. It also works with agencies to duplicate best practices and has identified 52 of them that could be replicated all across the country. Despite these laudable efforts, it is clear more can and must be done to reduce fraudulent Medicaid payments.

As the testimony of Mr. West today and Robin Page West demonstrates, CMS has not always been responsive to reports of fraud. I look forward to learning more from Ms. Brice-Smith and Mr. Cantrell about what CMS is doing to prevent such negligences from occurring in the future.

Continuing robust implementation of existing policies is essential because CMS also must implement important reforms enacted under the Affordable Care Act.

As Ms. Brice-Smith notes in her testimony, the Affordable Care Act sometimes referred to as ObamaCare significantly strengthens anti-fraud programs. These include elementary reforms such as requiring service providers and suppliers to document orders and referrals. The Affordable Care Act also established the Medicaid Recovery Auditor Contract [RAC] program to create incentives for contractors to reduce fraudulent payments and in conjunction with Secretary Sebelius' Center For Program Integrity, the Affordable Care Act is designed to identify improper fraud payments before they are issued by CMS.

I hope today's testimony illuminates the progress we have already made and additional administrative improvements which would reduce Medicaid fraud. Perhaps we should consider more

stringent punishments for companies and individuals who systematically defraud Medicaid. As Mr. West suggests in his testimony, consider harsher punishment for the management of such companies.

Again, I thank you Mr. Chairman for holding this very important hearing, part of a series of getting at so called improper payments from the Federal Government which total $125 billion a year. So there is plenty of work to be done. Thank you.

Mr. PLATTS. I thank the gentleman. I thank all of our witnesses and guests, your patience while we gave our opening statements, but now we are going to move to why we are really here, and that is to hear from our witnesses, and we are honored in our first panel to have a true patriot, Mr. Richard West, who served our Nation not just in uniform during the Vietnam War, which we are all eternally grateful and indebted to you for that service, but also Mr. West's service as a private citizen who saw a wrong and sought to correct it, and when the government didn't take action to correct it, he did.

And so, Mr. West, we are honored to have you here along with your attorney, Attorney Page West and your son, Adam.

As is consistent with the rules of the committee, we need to swear all three of you in before we have your testimony. Ms. West and Adam, if you would stand and raise your right hands and we will swear all three of you in.

[Witnesses sworn.]

Mr. PLATTS. Let the record reflect all three witnesses have affirmed the oath.

And you may be seated.

And on behalf of Mr. Richard West, who I will save his voice for questions, we are going to have his son Adam read his opening statement. Adam, if you are ready, please begin.

STATEMENTS OF RICHARD WEST, VICTIM OF MEDICAID FRAUD; AND ROBIN PAGE WEST, ATTORNEY, COHAN, WEST, & KARPOOK, P.C.

STATEMENT OF RICHARD WEST

Mr. ADAM WEST. Thank you, Chairman Platts, Chairman Gowdy, Ranking Member Towns, Ranking Member Davis, and distinguished members of the subcommittees for inviting me to discuss Medicaid fraud. I received home health care and other services through the Community Resources For People With Disabilities Medicaid Waiver program. As a ventilator wheelchair and oxygen-dependent person, I qualified for the government-funded program that provides Medicaid benefits up to 16 hours per day of in-home nursing care. There's a limit on the services under this program each month, and benefits may be suspended or reduced if the monthly cap is exceeded.

Beginning in March 2003, I received home health care through Maxim Health Care Services under this program. Maxim billed the home health care services to Medicaid which paid for them with both State and Federal funds. In September 2004, I received a letter from the New Jersey Department of Human Services Division of Disability Services Home and Community Services telling me

that I had exceeded my monthly cap and that my Medicaid services were being temporarily reduced or suspended as a result. This prevented me from obtaining needed dental care.

I complained to the State of New Jersey, I complained to Medicaid, and I complained to a social worker who was assigned to me telling them that Medicaid had been billed for nursing care I had not received. None of them did anything about it. Since none of the government agencies I had contacted about this did anything, I hired a private attorney, Robin Page West, no relation, of Baltimore, Maryland, who filed on my behalf a whistleblower lawsuit under the False Claims Act that triggered an investigation of Maxim.

Somebody decided to make a profit on my disability and rip off the government. That was wrong and the right thing for me to do was to expose it. But because the case was under seal while the government investigated, I couldn't talk about it. Sometimes I had trouble getting nurses and I suspected word had gotten out that I was a troublemaker. Over the course of the government's investigation, viruses made me severely ill. Each day when I sat alone in my home and no nurse came, I got sicker and sicker. I was afraid of dying and leaving my son with a big legal mess. I feared that if I were no longer alive, the case might be dismissed. Meanwhile, the government investigation carried on, and investigators kept discovering more and more billing improprieties.

Finally after 7 years, the government reached a settlement with Maxim and the case went public with Maxim paying a civil settlement of approximately $130 million and a criminal fine of approximately $30 million. This was the largest home health care fraud settlement in history. Yet Maxim is still permitted to do business with the government and none of the executives went to jail. Details of the settlement are available at www.homehealthcarefraudsettlement.com.

Maxim was overbilling and under delivering basic services to America's oldest, sickest and poorest. The goal was not to provide better services and products at lower prices, but rather to see if they could take advantage of weak Medicare and Medicaid oversight, to see if Uncle Sam could be ripped off and no one noticed, to see if patients who complained would not be taken seriously or would give up after a few calls to Medicaid. And guess what? They were right. Maxim's game went on for years and America's taxpayers were systematically ripped off.

But not only were taxpayers ripped off, when corporations rip off Medicare and Medicaid there are other victims besides taxpayers.

Maxim took services from people like me.

Despite the big monetary settlement, Maxim executives did not go to jail and the company was not excluded from doing future business with Medicare and Medicaid. The settlement received a lot of these covers that many folks asking why this was. How is it that a company that takes millions of government dollars is not entitled to continue along in business, while a shoplifter of a few $100 worth of merchandise will be sent to jail. It is commendable that the government did take on Maxim, but until corporate executives receive harsher penalties, I do not think we will see the fraud stop.

Having the corporation pay some settlement money is just a cost of doing business for the fraudsters.

The settlement money does not even come out of their own pockets. Changing that and sending some executives to jail may actually make the fraud stop.

How many other companies got away with this same fraud for the last 7 years? How many other people saw this and did nothing? How many were afraid of losing their health care for being a troublemaker? That is what happened to me. At this time, I am being told my Medicaid will end because of this settlement. My whistleblower recovery is being paid over 8 years with half of it coming at the end of that period. In the intervening years, there will not be enough to pay for my in-home care. I will go broke or die.

This is the price of doing the right thing. Do I know of other companies doing fraud? Yes. Four. Can I tell anyone? No. I can't afford to lose any more services. I thought if you do the right thing that maybe things would work out in the end, but maybe not. I am a Vietnam veteran and never took or asked for any services I didn't need. I lived a productive life and raised my son, Adam West. This program allowed me to live in my own home, to see him graduate high school and college, and now he is living on his own. If someone is willing to steal from and old sick vet, I would think my government would help. If I had an HMO, who would help? Should I call their CEO? It took 7 years, but I had the full weight of the U.S. Government behind me. Many folks are not as fortunate.

I came to this hearing hoping to help Congress help other people who need help through no fault of their own. Thank you again for inviting me to testify. I look forward to answering your questions.

Mr. PLATTS. Thank you, Mr. West.

[The prepared statement of Mr. West follows:]

Testimony of Richard W. West
before the
House Committee on Oversight and Government Reform
Subcommittee on Government Organization, Efficiency and Financial Management
and the
Subcommittee on Healthcare, District of Columbia, Census and the National Archives

December 7, 2011

Thank you Chairman Platts, Chairman Gowdy, Ranking Member Towns, Ranking Member Davis and distinguished members of the Subcommittees, for inviting me to discuss Medicaid fraud.

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I had been keeping track of the number of hours of nursing care I had been receiving and I knew that I had not exceeded my cap. After examining my own records and the records Medicaid shared with me, it looked like Maxim had billed Medicaid for approximately 735 hours of nursing care at $28.00

per hour that I never received during the period April 2003 to July 2004.

Based on conversations that I had had with my nurses, I did not believe that these were bookkeeping errors or accidental mistakes. I thought Maxim was deliberately billing for nursing care that it did not provide so that it could make more money.

I complained to the State of New Jersey, I complained to Medicaid, and I complained to a social worker who was assigned to me, telling them that Medicaid had been billed for nursing care that I had not received. None of them did anything about it.

Since none of the government agencies I had contacted about this did anything, I hired a private attorney, Robin Page West, (no relation), of Baltimore, Maryland, who filed on my behalf a whistleblower lawsuit under the False Claims Act that triggered an investigation of Maxim.

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poorest. The goal was not to provide better services and products at lower prices, but rather to see if they could take advantage of weak Medicare and Medicaid oversight--to see if Uncle Sam could be ripped off and no one would notice. To see if patients who complained would not be taken seriously or would give up after a few calls to Medicaid. And guess what? They were right. Maxim's game went on for years, and America's taxpayers were systematically ripped off. But not only were taxpayers ripped off. When corporations rip off Medicare and Medicaid, there are other victims besides taxpayers. Maxim took services from people like me.

It's hard to get the the government's attention without filing a False Claims Act case. I doubt I was the first person to call Medicaid about the billing fraud going on at Maxim. For all I know 20 or 30 other people called the Medicaid tip line before me, and they were simply ignored. My distinction is not that I called a tip line. My distinction is that I was the first person to assemble the physical, visible evidence of Maxim's fraud, and I was the first person to hire a good lawyer and file a False Claims Act case about that fraud. The government cannot simply ignore a False Claims Act as if it was just an email or a voice message left on the Medicaid tip line. The way you get the government's attention if you suspect fraud is *not* to call them on the telephone; it's to get a good False Claims Act lawyer and file a case. Then the government has to investigate. They simply cannot press the "delete" key and make it disappear.

Despite the big monetary settlement, Maxim executives did not go to jail, and the company was not excluded from doing future business with Medicare and Medicaid. The settlement received a lot of news coverage that had many folks asking why that was. How is it that a company that takes millions of government dollars it's not entitled to can continue on in business, while a shoplifter of a few hundred dollars worth of merchandise will be sent to jail? It is commendable that the government did take on Maxim, but until corporate executives receive harsher penalties, I do not think we will see the fraud stop. Having their corporation pay some settlement money is just a cost of doing business for the

fraudsters. The settlement money doesn't even come out of their own pockets. Changing that, and sending some executives to jail, might actually make the fraud stop.

How many other companies got away with this same fraud for the last seven years? How many other people saw this and did nothing? How many were afraid of losing their healthcare, for being a trouble maker? That is what happened to me, at this time I'm being told my Medicaid will end because of this settlement.

My whistleblower recovery is being paid over over eight years with half of it coming at the end of that period. In the intervening years, it will not be enough to pay for my in home care. I will go broke or die. This is the price of doing the right thing. Do I know of other companies doing fraud? Yes, four. Can I tell anyone? No, I can't afford to lose any more services! I thought if you do the right thing that things would work out in the end; maybe not.

I am a Vietnam veteran, and never took or asked for any services I didn't need. I have lived a productive life, and raised my son Adam R, West. This program allowed me live in my own home, to see him graduate high school and college, and now he is living on his own. If someone is willing to steal from a sick old vet I would like to think my government would help!

If I had an HMO who would help? Should I call their CEO ? It took seven years but I had the full weight of the United States of America, my government behind me. Many folks are not as fortunate.

I came to this hearing hoping to help Congress help the other people who need help through no fault of their own.

Thank you again for inviting me to testify. I look forward to answering your questions.

Mr. PLATTS. Ms. West, if you would like to share your testimony.

STATEMENT OF ROBIN PAGE WEST

Ms. PAGE WEST. Thank you, Chairman Platts, Chairman Gowdy, Ranking Member Towns, Ranking Member Davis and distinguished members of the subcommittees for inviting us to discuss Medicaid fraud. I represented Richard West in the Medicaid fraud lawsuit that resulted in the $150 million settlement with Maxim. For the past 20 years, I have focused on bringing cases such as Mr. West's to recover money the government has lost to fraud. I am also the author of a book on this subject published by the American Bar Association entitled Advising the Qui Tam Whistleblower.

In examining ways to improve oversight and accountability of Medicaid, it is helpful to look at the process we followed in bringing Mr. West's Medicaid fraud lawsuit. As he testified, after Mr. West attempted to bring this matter to the government's attention by contacting the State, the Medicaid program and his social worker, all to no avail, he turned to a private lawyer. We then brought a lawsuit under the False Claims Act [FCA], which empowers an ordinary person to step into the shoes of the government and sue fraudsters to recover the amounts stolen plus civil penalties and trouble damages.

The person who sues on behalf of the government, the whistleblower, is known as a qui tam relater, based on a Latin phrase that translates as he who sues on behalf of the king as well as for himself.

The act provides for a whistleblower reward that in a successful intervened case can range from 15 to 25 percent of the government's recovery. In our case, using records Mr. West had kept, we showed how the number of hours Maxim had billed Medicaid exceeded significantly the number of hours Mr. West received. In addition, we gave the government information Mr. West had learned through discussions with various of his nurses that led him to believe Maxim was doing this on purpose.

The FCA provides 60 days for the government to decide whether to intervene in a case, and if it needs more time, it must request it from the court. This is quite different from hotlines that are not accountable for acting on callers' tips within a certain period of time, if at all. The FCA is also different from oversight programs and contractors that exist to identify improper payments and fraud. These cost the government money, sometimes more than they recover. For example, CMS's senior Medicare patrol program teaches seniors and others how to review Medicare notices and Medicaid claims for fraud and what to do about it.

Over 14 years, from 1997 to 2010, it saved $106 million. But its current annual budget of $9.3 million leads to the question whether it is even saving what it costs.

The incentive of earning a False Claims Act whistleblower reward, on the other hand, mobilizes private individuals and their attorneys to do the work without the need for any government programs. The FCA model also outperforms the Medicare Recovery Audit Contractor, RAC, program which although it pays contractors a percentage of the improper payments they recoup stills dips into the recouped fund to pay those contingencies.

Not so with FCA recoveries. Not one dime comes from taxpayers to pay for these recoveries because the statute allows recovery of triple damages from the fraudster so that the government can be made whole for the cost not only of the whistleblower rewards, but also the investigation, prosecution and lost interest over time, not to mention the savings caused by deterrence.

There is no doubt that the cases whistleblowers are bringing to the government are of high quality. As shown on this graph, which is based on Department of Justice statistics, recoveries from whistleblower-initiated cases by far outpace those in government-initiated cases. More than 80 percent of the False Claims Act cases now being pursued by the U.S. Department of Justice were initiated by whistleblowers, and the amounts of the recoveries are in the billions each year.

In closing, one aspect of Mr. West's case that I would like to highlight is that the waiver program capped his benefits at a monthly amount that if exceeded, triggered a denial of further Medicaid benefits. So when Mr. West went to the dentist, he was informed that he could not get treatment because he had supposedly exceeded his cap.

In most Medicare, Medicaid and other Federal and State health programs, that would not happen because there is no cap that stops benefits from being paid, so even if Medicaid beneficiaries noticed suspicious billing, they have no incentive to spend time questioning them because their future Medicaid benefits are not at stake. And this is one reason I believe we have not seen more health care fraud cases initiated by Medicare and Medicaid beneficiaries.

Thank you again for inviting us to testify. I look forward to answering your questions.

[The prepared statement of Ms. Page West follows:]

Testimony of Robin Page West
before the
House Committee on Oversight and Government Reform
Subcommittee on Government Organization, Efficiency and Financial Management
and the
Subcommittee on Healthcare, District of Columbia, Census and the National Archives

December 7, 2011

Thank you Chairman Platts, Chairman Gowdy, Ranking Member Towns, Ranking Member Davis and distinguished members of the Subcommittees for inviting me to discuss Medicaid fraud.

My name is Robin Page West. I am an attorney, and I represented Richard West (no relation) in the Medicaid fraud lawsuit that resulted in a settlement in September of this year in which Maxim Healthcare Services, Inc. agreed to pay $150 million to the federal government and 41 states' Medicaid programs. For the past 20 years, I have focused on bringing cases such as Mr. West's to recover money the government has lost to fraud. I am also the author of a book on this subject published by the American Bar Association, now in its second edition, entitled Advising the Qui Tam Whistleblower: From Identifying a Case to Filing Under the False Claims Act.

In examining ways to improve oversight and accountability of Medicaid, it is helpful to look at the process we followed in bringing Mr. West's Medicaid fraud lawsuit. As he testified, after Mr. West attempted to bring this matter to the government's attention by contacting the state, the Medicaid program, and his social worker, all to no avail, he turned to a private lawyer. We then brought a lawsuit under the False Claims Act ("FCA"), a statute enacted during the civil war to stop unscrupulous defense contractors. This law allows the government not only to to sue fraudsters and recover the amounts stolen, but also to collect civil penalties and treble damages.

What makes the law unusual, and so effective, though, is that an ordinary person can step into the shoes of the government and do it, too If the case is successful, that person is entitled to a share of the recovery. The part of the law allowing this is called the qui tam provision, which stands for a Latin phrase *"Qui tam pro domino rege quam pro se ipso in hac parte sequitur,"* which translates as "He who sues on behalf of the King, as well as for himself." The person who sues on behalf of the government--the whistleblower-- is known as a "qui tam relator."

In 1986, the whistleblower rewards in the statute were strengthened by bipartisan amendment to create what sponsors Senator Charles Grassley and Representative Howard Berman called a "coordinated effort" between private citizens and the government to recover money lost through fraud. The reward to the whistleblower in a successful intervened case can range from 15 to 25% of the government's recovery.

To see just how effective the whistleblower reward provisions have been in driving recoveries under the False Claims Act, we can look at the numbers. According to Taxpayers Against Fraud, (TAF), a non-profit public interest organization that tracks these statistics, before the 1986 amendments, the Department of Justice recovered less than $100 million a year under the False Claims Act. In Fiscal Year 2010, over $3 billion was recovered under the False Claims Act—twice as much as was recovered in FY 2000. Of this amount, nearly 80% was recovered as a direct result of whistleblower lawsuits—a total of $2.39 billion.*

The whistleblower incentives have been so successful in recouping monies lost to fraud that over half the states plus New York City and the District of Columbia have passed their own versions of the federal False Claims Act in order to increase the amount of money coming back to them. As just one example, earlier this year, Quest Diagnostics Inc. agreed to pay $241 million to resolve a California state false claims act lawsuit brought by a competitor that alleged Quest

overbilled the state's Medicaid program.

Mr. West's first step in using the FCA as a tool to stop Medicaid fraud was to locate an attorney with experience using this statute. Many attorneys are not familiar with the unique requirements for filing a False Claims Act suit. The procedures for bringing an action under the FCA are quite different from any other type of lawsuit, and failure to follow these procedures can result in dismissal of the case. For example, unlike most litigation where discovery happens *after* the case is filed, in a qui tam case, substantially all of the evidence the relator has of the fraud must be provided to the government at the very beginning of the case. Also unique to qui tam litigation is a requirement that the case be filed under seal, so that not even the defendant knows about it.

A crucial part of the process is to present the evidence of the fraud, as well as an explanation of the fraud and of the regulatory framework, to the government clearly and concisely. These cases can be complex, but it is not up to the government to figure out how the fraud works—that is the job of the relator and his lawyer. The purpose of qui tam cases is to assist the government's enforcement efforts, not to slough work onto the government. So an experienced FCA lawyer will not merely throw down a bare bones lawsuit. Rather, she will develop the evidence and the theory of the case as much as possible before presenting it to the government. If it does not find the case appealing, the government may choose not to become involved. In fact, the government chooses not to intervene in almost 80% of the qui tam cases filed.* So the lawyer needs to understand what cases will be worthwhile to the government and how to convey their value clearly and concisely.

In Mr. West's case, we collected all the documentation he had that showed how many hours the nurses were in his home, and compared it to how many hours Medicaid was billed. The

documents we used consisted of the time sheets the nurses left with Mr. West after their visits, his day planner, and billing records obtained from Medicaid. We analyzed these records and presented them in a way that juxtaposed the number of hours of service against the number of hours billed to demonstrate how they did not match. In addition, Mr. West had learned, through conversations with various of his nurses, information that made him believe Maxim was doing this on purpose. We provided detailed information to the government about these conversations as well.

After we developed our case, assembled the evidence for the government, and filed the lawsuit under seal, members of the U. S. Attorney's office invited us to meet with them to discuss our submission. Subsequently, the government began its own investigation, which ultimately expanded beyond the Maxim office that was providing Mr West's care to include all states in which Maxim did business.

The FCA provides 60 days for the government to determine whether to intervene in a case. It usually takes the government much longer to make this decision, so it must request the court to grant it additional time. It takes an average of thirteen months* for the government to make its decision whether to pursue a matter, although in my personal experience, the time has averaged closer to three years. If the government chooses not to intervene, the relator may continue on with the case, and if successful, receive a larger reward of up to 30% of the government's recovery.

In Mr. West's case, the government ultimately chose to intervene. Its investigation took seven years, and throughout that time, the judge, on behalf of the court system, and I, on behalf of Mr. West, kept in contact with the government prosecutors to make sure the investigation was moving forward. The comprehensive investigation resulted not only in a civil settlement but in

criminal indictments of eight employees, a deferred prosecution agreement, and a corporate integrity agreement requiring Maxim to report to an independent monitor, who will review Maxim's business operations and regularly report concerning the company's compliance with all federal and state health care laws, regulations, and programs. Details of the settlement are at http://www.homehealthcarefraudsettlement com.

One reason the False Claims Act is so effective is the court oversight that comes about as soon as the 60 day clock starts running on the intervention decision. This is quite different from hotlines that are not accountable for responding to callers or taking any action on their complaints and tips. But even though the False Claims Act requires the government to investigate every case swiftly, it has built-in safeguards against frivolous lawsuits so court and government resources are not squandered:

- Because most False Claims Act lawyers work on a contingency basis, they only get paid if they win. This means that they are unlikely to invest time, money and energy building a case that they themselves do not feel will be productive.
- Under the False Claims Act, a relator can be required to pay the defendant's attorney's fees if the court finds that the claim was frivolous or brought primarily for purposes of harassment, so whistleblowers with unpure motives have a huge disincentive to file a case.
- The FCA is rarely used to correct minor billing mistakes and errors that are not systematic because they do not amount to large sums of money, and such cases will not be chosen for intervention.

There is no doubt that the cases whistleblowers are bringing to the government are of high quality. According to TAF, more than 80 percent of the False Claims Act cases now being pursued by the U.S. Department of Justice were initiated by whistleblowers.*

Many oversight programs and contractors exist to identify improper payments and fraud. These programs and contractors cost the government money, sometimes more than they recover. For example, CMS' Senior Medicare Patrol (SMP) program, which was launched in 1997,

teaches seniors, caregivers and beneficiary family members how to review Medicare notices and Medicaid claims for signs of fraudulent activity and what to do about it. According to its website, http://www.aoa.gov/AoA_programs/Elder_Rights/SMP/index.aspx#data, from 1997 through December 2010, "About $106 million in savings, including Medicare and Medicaid funds recovered, beneficiary savings and other savings have been attributed to the project as a result of documented complaints." This $106 million saved over 14 years, in light of a current annual budget for the program of $9.3 million, leads to the question whether this program, and others like it, are even saving what they cost.

One of the reasons the False Claims Act avoids this problem is that it uses very attractive incentives to mobilize private individuals and their attorneys to do the work at no cost to the government, completely independently of whatever government oversight may or may not be in place, without the need for funds for training or execution of the program. The FCA model is more effective in this regard than even the Medicare Recovery Audit Contractor (RAC) program, which, although it pays contractors a percentage of the improper payments they recoup from providers, still dips into the recouped funds to pay those contingent fees. This is not the case with FCA recoveries. Not one dime comes from taxpayers to pay for these recoveries, because the statute allows for recovery of triple damages *from the fraudster* so that the government can be made whole, not only for the cost of whistleblower awards, but also for the cost of investigations, prosecutions, and lost interest. A TAF study conducted in 2005 found that "For every dollar spent to investigate and prosecute health care fraud in civil cases, the federal government receives nearly thirteen dollars back in return." Moreover,the study found, "[t]he benefit/cost ratio of nearly thirteen to one is likely to be an underestimate of the real return that the taxpayers are receiving on outlays for civil health care fraud enforcement. The indirect

benefits associated with deterrent effects... undoubtedly add substantially to the public's benefit." http://www.taf.org/MedicareFraud040805.pdf A 2012 report by the HHS OIG reports an even higher ratio--$16.7 to $1 expected return on investment. http://oig.hhs.gov/publications/docs/budget/FY2012_HHSOIG_Online_Performance_Appendix.pdf

In closing, one aspect of Mr. West's case that I would like to highlight is that the waiver program that provided his benefits was capped at a monthly amount that, if exceeded, triggered his suspension from the program and temporary denial of further Medicaid benefits. So when Mr. West went to the dentist, he was informed he could not get treatment because he had supposedly exceeded his cap by virtue of nursing services he knew he had not received. In most Medicare, Medicaid, FEHB, TRICARE or other federal and state health programs, that would not happen because there is no cap like this that triggers exclusion. So typically when Medicaid beneficiaries notice suspicious billings on their explanation of benefit forms, they have no incentive to expend time questioning them, because their future Medicaid benefits and healthcare services are not at stake. This is one reason I believe we have not seen more healthcare fraud cases initiated by Medicare and Medicaid beneficiaries.

Thank you again for inviting me to testify. I look forward to answering your questions.

* The Department of Justice's statistics are available at http://www.taf.org/statistics.htm, http://www.taf.org/FCA-stats-2010.pdf and http://www.taf.org/DOJ-HHS-joint-letter-to-Grassley.pdf

Mr. PLATTS. Thank you, Ms. Page. We appreciate, again, all three of you being here with us to share your insights and the experiences you have had in helping to protect American taxpayer dollars as well as to ensure citizens like Mr. West get the care they need and deserve.

We will now begin questions, and I would yield to the subcommittee chairman, Mr. Gowdy, for the purpose of questions.

Mr. GOWDY. Thank you, Mr. Chairman.

Mr. West, on behalf of all of us, I want to thank you for your service to our country, both on this soil and on foreign soil. We are indebted to you. It strikes me, Mr. West, that you brought this to the attention of every single person that you could reasonably have known to bring it to.

Mr. RICHARD WEST. Yes.

Mr. GOWDY. And nobody did anything. You had to go get a private lawyer to do what either the State of New Jersey, CMS, or some social worker should have done, is that correct?

Mr. RICHARD WEST. That's right, yes.

The social worker asked Maxim if they could back up their billing with paperwork. They said yes. So she had no power to audit, or she had no power, so I took it to the State. And the State sat in my living room in August in 2003, I told them I was not getting the nursing they are telling me I'm getting. They did nothing. The person running the program retired. The only person sitting at my dining room table got promoted, and everybody just goes on. If people aren't held accountable, both Maxim and State and Federal workers, there is nowhere for me to go.

Mr. GOWDY. And that is exactly what I want to ask Ms. West. Do you have any criminal practice at all to go along with your civil practice? Have you ever done criminal defense work?

Ms. PAGE WEST. No, I haven't.

Mr. GOWDY. For those of us who are not smart enough to do civil work and had to do criminal work, it has always struck me that nothing gets people's attention quite like the fear of going to prison. And poor folk who steal do go to prison. Rich folk who steal have the corporation pay a fine and then they continue to participate in the Medicaid program. How in the world does that happen?

Ms. PAGE WEST. It is much more difficult to prove a criminal case. The standard is guilty beyond a reasonable doubt, it takes a lot of resources to investigate these cases.

Mr. GOWDY. Let me stop you right there. You have a Vietnam war veteran witness who says that this work was not done on me and you have a document that says that they were billed for it. I think you and I could win that case. I guess that there is a different standard of proof, but there is a different standard of proof in all criminal cases.

Ms. PAGE WEST. Someone in the government is making the decision of whether to prosecute these cases.

Mr. GOWDY. Do you know who that is? Do you know who it is?

Ms. PAGE WEST. The U.S. Attorney's Office.

Mr. GOWDY. In New Jersey?

Ms. PAGE WEST. Yes. And the Department of Justice.

Mr. GOWDY. So they went to a Civil Division to reach an agreement, pay a fine, the shareholders pay, none of the corporate ex-

ecutives go to jail, and then they continue as part of the settlement to be able to participate in the Medicaid program? That is as outrageous as anything I have heard in the 11 months I have been here and I have heard some outrageous things.

Let me ask you this: There have been civilizations that of been formed in less than 7 years. What took 7 years for this case to be resolved?

Ms. PAGE WEST. The investigation started locally and then it expanded to the State of New Jersey, and then it expanded to the States beyond New Jersey eventually expanding nationwide. And during that time, there were numerous audits going on of the documents, there was an independent audit company that was hired to determine what was, what type of document qualified as a proper claim and what was an improper claim. Maxim's attorneys were involved every step of the way. They were allowed to have input into this process, and then at the end, because fraud is difficult to quantify, the settlement had to be reached, and it is often likened to making sausage because there are so many elements that have to be brought together that so many people have to agree on, and that's what also took a long part of the time is the agreement on the various aspects of the settlement, and there was a criminal component to it as well.

Mr. GOWDY. And the criminal component went away as part of the civil settlement? Did anyone go to jail as a result of this?

Ms. PAGE WEST. My understanding is that there were nine indictments, eight of which were of Maxim employees, not executives, but managers.

Mr. GOWDY. And did they go to jail?

Ms. PAGE WEST. I don't know.

Mr. GOWDY. My time is expired, Mr. Chairman.

Mr. PLATTS. I thank the gentleman. I yield to the gentleman from Illinois, the ranking member, Danny Davis.

Mr. DAVIS. Thank you, Mr. Chairman. Mr. West, let me again thank you for taking time to come to Capitol Hill to testify. And I also thank you again for your service to this country during the Vietnam War. The coalition against insurance fraud estimates that 80 percent of health care fraud is committed by providers, 10 percent by consumers, and 10 percent by others such as insurance companies or their employees.

I applaud you for your diligence in maintaining records and keeping such a close eye on the actual number of hours you were receiving home health services and the number of hours Medicaid was being billed.

What I want to ask you is when you receive notice that your services, that you had reached or were going beyond your monthly cap, and your Medicaid services were being temporarily reduced or suspended, how did you feel when you read that letter or got that information?

Mr. RICHARD WEST. I was in a nursing home, and this program allowed me to live in my own home, and in 3 months, I knew what they were doing. I had always been an advocate for people with disabilities, and when I got that notice, I knew that it wasn't me, it was all the other people that these services that were getting screwed that they were going to take my service and I'm going to

fight them. Other people can't do that. I'm on oxygen. And I'm probably too stubborn and arrogant to give up.

But if you're the average person in my position, you can't fight. You're helpless. You are being abused. So, how I felt? I was being abused, and I needed to stand up for everybody.

Mr. DAVIS. And you knew that you were weren't going to take it sitting down?

Mr. RICHARD WEST. I started this as an advocate and through the 7 years, it became more patriotic.

Mr. DAVIS. Thank you very much. Ms. West, let me ask you, you indicate that you have handled any number of cases. What is the typical client or person who comes to you with a situation and asks for your assistance?

Ms. PAGE WEST. More often it's a person who works in the company that's committing the fraud, someone who sees something that seems amiss, and they will go to their supervisor and say, hey, why are we doing this, and the supervisor will try to brush it off, and oftentimes they will escalate it to another superior, and eventually oftentimes they get fired for being nosy, at which point they will come to me or close to the end of that process.

Mr. DAVIS. So they will come, they are whistleblowers who themselves have been abused in a way in terms of losing their jobs?

Ms. PAGE WEST. Exactly, and also in terms of being asked to do things in the job that they know are not right. And as Mr. West pointed out, many of their co-workers know the same thing but they won't come forward because they're afraid of losing their jobs and their health care.

Mr. DAVIS. Thank you very much, Mr. Chairman. My time is expired.

Mr. PLATTS. I thank the gentleman. I yield myself 5 minutes for the purpose of questions.

And again, the case that you shared with us, Mr. West, and your attorney, should not happen, and our efforts as focused here are in trying to ensure it doesn't happen again in the future.

If I understood your written testimony and your responses here today, when you reached out to the State of New Jersey Medicaid, social worker that, other than, if I understood, with the social worker, it looks like they looked at Maxim's records and said, well, they have paper to back up saying they provided this service and they basically took the company's word over your word. Is that a fair statement?

Mr. RICHARD WEST. Correct.

Mr. PLATTS. Did the State of New Jersey or Medicaid itself even get to that point? Or did they just pretty much do nothing?

Mr. RICHARD WEST. They did nothing. I wrote to Governor Corzine, Senator Menendez, they sent the paperwork to the same people that were doing nothing.

Mr. PLATTS. So in addition to your own contacts, to the State and Medicaid, you contacted your elected officials, Governor, U.S. Senator——

Mr. RICHARD WEST. Yes.

Mr. PLATTS. They contacted those entities and still nothing happened?

Mr. RICHARD WEST. Correct.

Mr. PLATTS. It is just as Mr. Gowdy said, just somewhat unbelievable that here you have a citizen trying to do the right thing and protect taxpayers and ensure he receives the services and the government collectively failed you terribly.

When they were denying your claim of fraud and failing to act on it, what was their response as far as how that then related to your care? Because of that fraud, you were being denied dental. Were they saying, we don't believe you that there is fraud, but we are going to provide you care or——

Mr. RICHARD WEST. They don't come out and say we don't believe you. They just don't——

Mr. PLATTS. They just don't do anything.

Mr. RICHARD WEST [continuing]. Return your calls, don't answer your letters, don't respond to your emails. You are a burden to them creating paperwork for them. It is easier for them to do nothing.

Mr. PLATTS. Push you to the side?

Mr. RICHARD WEST. Correct.

Mr. PLATTS. How about on the fact that that fraud was denying your services, did they correct that and ensure that you got the dental care, or did that continue to——

Mr. RICHARD WEST. Eventually, I got the dental care. But at that time, I had nursing 7 hours a day, 7 days a week, and nursing 3 nights a week totaling 18 hours. I lost those 18 hours for 7 years. So if you turn off my ventilator, I have a hard time breathing. But if you let me sit there, I slowly deteriorate, because I'm not getting the care I need.

Mr. PLATTS. I want to make sure I heard you correctly. While the investigation was going on for 7 years, they were denying you the services because saying you were not entitled to it because of the fraud?

Mr. RICHARD WEST. Right.

Mr. PLATTS. Outrageous.

Mr. RICHARD WEST. Yes.

Mr. PLATTS. Thank you for persevering and weathering the terrible care and treatment you received.

Ms. West, a question, and I'm not sure from, as a lawmaker, how our Federal whistleblowers were seeking to strengthen the whistleblower protections provided Federal employees because we want, as you referenced, more often than not, it's an employee who comes forward with what they know is going on in their company or their office.

We're trying to strengthen that law. We've passed legislation out of this committee, out of the full Oversight and Government Reform Committee and now working for a floor vote to give whistleblowers within the Federal Government more protection.

If a Federal employee came to you, I assume then that they are impacted differently going to you for this type of case and bringing forth fraud because they are a Federal employee, is that correct?

Ms. PAGE WEST. Historically in my experience, the government has been less receptive to intervening in whistleblower cases brought by Federal employees.

Mr. PLATTS. They keep it more internal?

Ms. PAGE WEST. It's hard for me for to understand the reasoning that goes behind how an intervention decision is made. I don't know why that is.

Mr. PLATTS. But your experience over 20 years is it's less common for them to intervene?

Ms. PAGE WEST. It's more difficult for them to be accepted as an intervened case.

Mr. PLATTS. So all the more unlikely, given that, for a Federal employee to pursue this type case because they're lease likely to succeed?

Ms. PAGE WEST. Yes. More difficult. Yes.

Mr. PLATTS. Thank you. My time is expired. I yield to the gentleman from New York, Mr. Towns.

Mr. TOWNS. Thank you very much, Mr. Chairman.

Let me, again, thank you, Mr. West, for coming and sharing your story with us, and of course, regret that you had to go through so much in order to make the point, but I appreciate your time here today.

Let me begin by just, can you tell me about the process you went through in trying to contact various agencies? Could you talk for just a moment about the process that you went through trying to reach agencies?

I know that you said that you sent out letters and e-mail and phone calls. Can you just talking talk about the process just briefly?

Mr. RICHARD WEST. The local county social worker comes to the house once a month. So once a month, I'm telling her I'm not getting my services, and I'm calling her in between those visits saying the nurses aren't showing up, I'm having to depend on family, friends. The State workers, the county workers the State workers supposedly, they didn't follow through, and the State program was telling me I had to have a caregiver in my home for when a nurse didn't show up. My son was in high school getting ready to graduate, and I wasn't about to put that burden on him because the nursing aid wasn't doing their job.

So the State decided they wanted to have a meeting in my home. So they all came down, sit at my table and tell me what services I've got. And I said I am not getting the hours of nursing you are telling me I'm getting.

And the State workers said, well, you need a caregiver and you don't have one, so maybe you don't qualify for the program. And I said, I'm not going to have a caregiver, and she said, you're not compliant and I said arrest me. She didn't appreciate that.

And the county social worker told her those discrepancies in the hours, they all went out, had a pow-wow out by the car and went back to Trenton and never followed through with any of it. When I realized the county and the State wasn't doing anything, I went to the Medicaid fraud hotline, called them. They said we'll give you an investigator and we'll look into it. Never heard a word.

So I figured I have to get out of the State of New Jersey because I have no idea who is involved, whether they're involved with Maxim or their own programs. So I went on the Web, looked up Medicaid fraud. That is when I found out that there is a whistleblowers lawsuit. I had no idea. Then I read you could receive a por-

tion of the recovery. I figured, well, hey, I could fish my brain, maybe I will get $5,000. And the first person I called was in Alabama, a whistleblower attorney. He said well if it's not $10 million, I don't even want to talk to you. I was informed of a whistleblower lawyer in California. He said send me the documentation you have. I did. He called me back and said, I think you have a pretty good case but you need an attorney closer to where you're at. Then I found Robin on the Internet, and that's how we proceeded.

Mr. TOWNS. So you found someone with the same last name?

Mr. RICHARD WEST. When I called, her secretary said, who is calling? I said Richard West. And there was a silence. And I said no relation.

Mr. TOWNS. Thank you very much.

Mr. Chairman, I just ask for an additional 30 seconds. I want to ask Ms. Page to submit something to us.

In your written testimony, you indicated that the False Claim Act is both unusual and effective in uncovering fraud in the health care system. If you would be kind enough in writing to summarize your top three arguments for why this law is effective. I'm interested in that because we would like to strengthen the law to improve it so if you would be kind enough to submit that to us in writing, being my time is out.

Ms. PAGE WEST. The top three reasons why it's effective.

Mr. TOWNS. Yes. Thank you.

Mr. PLATTS. I thank the gentleman. The gentleman Mr. DesJarlais is recognized for 5 minutes for questions.

Mr. DESJARLAIS. Thank you, Mr. Chairman.

Mr. West, Admiral Mullens this past year was quoted as saying the biggest threat to our national security is our national debt, so not only did you fight for our country in Vietnam, you are fighting for our country again against a big threat which is spending and debt. So I applaud you for your courage and taking the time to come here and speak with us today.

I just wanted to ask you a few questions about your relationship with the people that spent a lot of time caring for you because with your condition with the trach ventilator I'm assuming you had a respiratory therapist that came to your home?

Mr. RICHARD WEST. No.

Mr. DESJARLAIS. No? You had home health nurses?

Mr. RICHARD WEST. I had nursing.

Mr. DESJARLAIS. And I'm assuming you had nurses aids to help with activities of daily living, they have to help you dress, they have to help you eat.

Mr. RICHARD WEST. Right.

Mr. PLATTS. They have to help you maintain your residence so it's safe?

Mr. RICHARD WEST. Yes.

Mr. DESJARLAIS. So they spent quite a bit of time in your home?

Mr. RICHARD WEST. Correct.

Mr. DESJARLAIS. Did you ever feel like you got close to any of these people? They take care of you. Were they caring people? Did you talk to them on a first name basis? Did any one, say, an aide, stay with you for several months at a time or was it different aides on different days?

Mr. RICHARD WEST. I have a nurse now that has been with me 4 years. Over the course of the 7 years, there have been different nurses, different agencies, but many have been there for extended time.

Mr. DESJARLAIS. So you knew them very well and they knew you very well and it was generally friendly and cordial? Did you like them and they liked you?

Mr. RICHARD WEST. Yes.

Mr. DESJARLAIS. When you first started noticing the fraud, were you able to talk to them about this, and share your concerns?

Mr. RICHARD WEST. They were part.

Mr. DESJARLAIS. I'm sorry?

Mr. RICHARD WEST. They were part of the fraud.

Mr. DESJARLAIS. Did you talk to them and ask them, did they try to make excuses or did they say they'd talk to their managers?

Mr. RICHARD WEST. No. I could tell by what they were saying, what they were telling me, they were getting paid but they weren't putting in for the hours in my home, they were putting in for additional hours. And the company, the nurses told me on several occasions that the Maxim office managers work on a bonus system so the more profitable they are the bigger their bonus.

So these people, despite having a relationship—you liked them, they liked you—you felt they were aware of the fraud that was going on but would do nothing?

Mr. RICHARD WEST. They knew.

Mr. DESJARLAIS. They knew.

Mr. RICHARD WEST. They knew.

Mr. DESJARLAIS. Did you feel like you were betraying them in a sense when you had to go over their head to try to fix this situation?

Mr. RICHARD WEST. You can't betray somebody that is abusing you.

Mr. DESJARLAIS. Okay. Well, I guess I just wonder, you know, how unusual you are.

Ms. West, how many other Medicaid beneficiaries have come to you such as Mr. West? How unusual is Mr. West?

Ms. PAGE WEST. It is very unusual. Just a handful of people have even inquired. And if memory serves, Mr. West is the only beneficiary case that I have taken.

Mr. DESJARLAIS. Okay. So given the success by whistle blowers, why do agencies and officials typically ignore people like Mr. West? What would be your opinion on that?

Ms. PAGE WEST. I don't think it's so much that the False Claims Act isn't serving them and that the government isn't picking up the cases. I think it's that there are not that many beneficiaries who are coming to the False Claims Act attorneys.

Mr. DESJARLAIS. Okay. So why then when someone like Mr. West, who obviously has a legitimate claim that was proven legitimate, why do you think Medicare just chose to ignore it? And I will ask you that and ask Mr. West that.

Ms. PAGE WEST. Well, I think Mr. West is an extremely unusual person. Relaters need to be very tenacious, very intelligent, very persistent. And quite often, Medicare and Medicaid beneficiaries who are sick cannot bring all those qualities and have the stamina

to, you know, figure it all out and bring it to a lawyer. And I think that's basically the issue, is that they are not aware of it. They are not aware of the incentives, and they don't necessarily have the skill set to put it all together and follow through on it.

Mr. DESJARLAIS. Okay. Well, I will just say—and I know I am about out of time, if you will indulge me for a few seconds. As a practicing physician, primary care physician, for 18 years before coming to Congress, I dealt closely with home health. There was a lot of issues of fraud and abuse in the 1990's where people who did not have near your level of disabilities had aides and what not coming to the house. That was kind of reined in a little bit in the 1990's. But I see that it tends to be alive and well as we moved into the next decade as well.

Again, I applaud you, Mr. West, for your efforts. And clearly, I think that CMS and Medicare, who we will have on the next panel, we will get an opportunity to see why people like yourself are being ignored. Thank you so much for stepping forward and fighting again for your country.

I yield back.

Mr. RICHARD WEST. The people in my position don't have the support once they turn people in. If I was a government informant for a mob-related case, you would take care of me. But when I went to the special agent in charge and asked to get nurses so I could continue through this case, there was nothing he could do to help me. So why would those people turn somebody in, knowing they should die? So you have to give support to the patient, client—whatever you want to call me—so he can bring the lawsuit. If the threat is, "you complain, we take you services," where is the incentive? There isn't.

Mr. PLATTS. I thank the gentleman.

Mr. West, along the lines of what you just expressed, it sounds as if—whether through a need for a legislative change or regulatory change—that if you had a beneficiary, as in this case, that the government makes a determination, they are going to take on the case and go forward, that that decision should maybe include a provision, you know, that while the case is being pursued, 1 year or 7 years, in your case, you are given the services on a provisional basis, you know, while it is proceeding. Because, again, otherwise you have a disincentive from reporting it because of being at risk of further losing care.

Mr. RICHARD WEST. Correct.

Mr. PLATTS. I thank the gentleman.

I yield to the distinguished ranking member of the full committee Mr. Cummings from Maryland.

Mr. CUMMINGS. Mr. West, I thank you also for being here. And I agree with you, these folks needed to go to jail. And it's interesting that I now have done a little research to see what happened.

I want to follow up on some of Mr. Gowdy's concerns.

They did go to jail. One went to jail from Maxim, and he got—this was the highest sentence of eight or nine people—5 months in prison and 5 months of home confinement. Most of them got a fine and home imprisonment. That's what they got.

Now 40 miles away from here, I represent Baltimore. And about 6 months ago, I had literally thousands, thousands of young Afri-

can American boys, many of whom may have stolen a bike, may have done something wrong with drugs or whatever, and they got a record, Mr. West. They got a record.

And you know what, they can't get a job. If they live to be 99 years old, they will not be able to get a job. But here we have Maxim, a company that has basically stolen, stolen from the American people—Maxim, a company that has taken away the services, not only from you but so many others, but yet and still, they are in a position to continue to make millions. Something is absolutely wrong with that picture.

And I agree with you. When the people from the CMS and the IG come up, they have to explain to us—and by the way, every member of this panel, every Member of this Congress should be saying, Maxim should be put out of business with regard to doing business with the Federal Government. It is ridiculous how a young man in Baltimore can steal a $300 bike and not be able to get a job for a lifetime, but Maxim can steal millions and continue to do the same thing over and over again. Yeah, they got sentenced. But this sentence is simply a slap on the wrist. If you can pay $150 million fine, this is just a cost of business.

And so, you know, I am very concerned about this.

And I want to enter into the record, Mr. Chairman, the U.S. Attorney's Office, District of New Jersey—it's basically their summary of the sentencing. It is dated November 21, 2011. I would ask that that be made a part of the record.

Mr. PLATTS. Without objection, so ordered.

Mr. CUMMINGS. And a Reuters article dated—I ask that this be made a part of the record, too—dated Monday, September 12, 2011. And it says, in part, Maxim settled with the U.S. Department of Justice and 41 States. Their company entered into a deferred prosecution agreement with the Justice Department under which it paid—it will pay a $20 million fine. If Maxim meets the agreement's requirements, it will avoid charges. And the government said it was willing to enter into an agreement with Maxim in part—in part because of its cooperation and significant personnel changes it has made since 2009.

Mr. PLATTS. Without objection, entered into the record.

Mr. CUMMINGS. Thank you very much.

Well, that's all well and good; but if you are paying people bonuses to screw people and mess them over—and you're right. Everybody's not like you. There are people who are sitting in wheelchairs right now, looking at this right now, who feel helpless, and many of them are going to die. That's why I cannot understand for the life of me how every Member of this Congress should not want to put Maxim out of business, at least with regard to its business with the Federal Government.

Now to you, Ms. West. Ms. West, you stated in your written testimony that you have over 20 years of experience in bringing cases such as Mr. West's to the government's attention. Can you explain how these False Claims Act cases help government work better and save taxpayer dollars?

I'm sorry. I didn't mean to get so upset, but this makes me want to vomit. Go ahead.

Ms. PAGE WEST. The False Claims Act gives the government a bird's eye view into the fraud. Without the whistleblowers, the government really has no way of knowing how the fraud is being committed. Every time there is a fraud that's detected, the government learns about it, comes in, kind of shuts it down. But then there's a new fraud that pops up. And it's a constant never-ending thing. And there is more creativity behind fraud because there is so much money to be made by it. And that's why the False Claims Act is so effective is because it reaches out to the people who are seeing the fraud and understand the fraud and giving them an incentive to tell about it and explain to the government how to stop it.

Mr. CUMMINGS. Ms. West, do you think there are too many False Claims Act lawsuits? And what disincentives are there for bringing a frivolous False Claims lawsuit?

Ms. PAGE WEST. Well, the disincentive for bringing a frivolous False Claims Act lawsuit is there's a provision in the statute that allows the defendant to recover its attorney's fees from the relater if it's shown that the suit was brought for purposes of harassment.

In addition, it's difficult to bring a frivolous lawsuit because the qui tam lawyers work on contingency. And if we don't think a case is really good, we're not going to bring it. Only about 20 percent of the False Claims Act cases brought are intervened in by the government. So we're looking at a very tiny window, and we are looking for the very best cases to bring to the government's attention.

Mr. CUMMINGS. I see my time is expired. Again, Mr. West, I want to thank you very much for you and all others who will benefit from what you are doing.

Mr. PLATTS. I thank the gentleman.

Before yielding to the gentleman from Virginia, Ms. West, the example of having a bird's eye view, the beneficiary goes out on the front lines being able to bring a False Claims Act, in the second panel, we're going to hear about a lot of expenditures of moneys for new technology, new analytical programs and things. Is it a fair statement to characterize your experience here that—rather than the investment of all this money in new programs, that if we had simply better listened to the beneficiary, we would have prevented the fraud?

Ms. PAGE WEST. Yes, I think so. And listen to Malcolm Sparrow, who has analyzed this and feels that the money should not be paid out first. It should be paid out properly, not paid and then followed after to be gotten back.

Mr. PLATTS. Right. So it is being more up front as opposed to the recovery type of audits. It's focus up front.

Ms. PAGE WEST. Exactly.

Mr. PLATTS. I yield to the gentleman from Virginia, Mr. Connolly, for the purpose of questions.

Mr. CONNOLLY. Thank you, Mr. Chairman.

And I want to thank Mr. West particularly for his courage, both serving his country and in serving his country a second time in trying to make sure taxpayers' investments are protected and are made secure and for the courage of persisting when many others might have been daunted and discouraged.

I also want to say to our colleague, if he's still here. I guess Mr. Gowdy isn't here. But if Mr. Gowdy is serious about toughening up

the criminal penalties, he will find allies on this side of the aisle. Our subcommittee has pointed out that there are, every year, $125 billion in improper payments. Now sometimes it's innocent—you know, a mistake in billing. Somebody gets paid who shouldn't have or gets double paid; somebody who's not qualified to receive a benefit gets a benefit. But a lot of it's fraud.

I know that U.S. Attorney's Offices are consumed with Medicare and Medicaid fraud. The U.S. Attorney's Office in Boston just announced a $3 billion recovery. That's 1 out of 99 U.S. Attorney's Offices. So we know it's out there.

If we eliminated improper payments, by the way, we could give a Christmas gift to the supercommittee of $1.25 trillion over the next 10 years, without breaking a sweat, without affecting anyone's benefits, without having political drama, without having to gut any necessary investments.

Mr. PLATTS. Would the gentleman yield?

Mr. CONNOLLY. I yield to the chair.

Mr. PLATTS. I thank the gentleman for yielding.

As you well state, if you took the fraud and improper payments—again, we don't know how much is fraud—improper payments of Medicaid, as you are just discussing here today and as you know from our previous hearing on Medicare, these two programs alone account for about $70 billion a year of that 125. So over 10 years, you are talking $700 billion.

I yield back.

Mr. CONNOLLY. Thank you, Mr. Chairman.

Of course, as you know, some of that money was cited in the financing of the Affordable Health Care Act, some criticized us for that as if we were gutting the program. But in fact, we were simply trying to recover either improperly made payments or illicitly made payments.

I want to just make sure we get the narrative on the record, Ms. West, if you don't mind. I've heard Mr. West. When did Mr. West first discover something was wrong and how?

Ms. PAGE WEST. He testified——

Mr. CONNOLLY. If you could speak into the microphone.

Ms. PAGE WEST. Three months after he came out of the nursing home, he realized something was wrong.

Mr. CONNOLLY. And what made him realize something was wrong?

Ms. PAGE WEST. That he was not getting the care that he was entitled to get under the program. He was getting fewer hours of nursing care.

Mr. CONNOLLY. Okay. And maybe initially he thought that was a mistake?

Mr. RICHARD WEST. Initially, I thought that they were having a hard time servicing my case. But then it became apparent that they would send when they wanted, who they wanted.

Mr. CONNOLLY. Well, the testimony submitted on your behalf by your attorney, Ms. West, says, you attempted to bring the matter to the government's attention by contacting the State. What State was that?

Mr. RICHARD WEST. The State of New Jersey.

Mr. CONNOLLY. New Jersey. The Medicaid program itself—so you went to a local office, okay—and your social worker.
Mr. RICHARD WEST. Correct.
Mr. CONNOLLY. And the testimony says, all to no avail.
Mr. RICHARD WEST. Correct.
Mr. CONNOLLY. Meaning what, they ignored it?
Mr. RICHARD WEST. Yes.
Mr. CONNOLLY. Okay. So you then decided, this isn't right. I'm not getting anywhere, and I'm, therefore, going to turn to a private attorney. And you used actually something Congress did well, the False Claims Act.
Mr. RICHARD WEST. Correct.
Mr. CONNOLLY. Which gave you a vehicle for redress as a, as you put it, qui tam relater.
Mr. RICHARD WEST. Right.
Mr. CONNOLLY. Ms. West, if you could describe for us, what was the reaction of the Medicaid officialdom when faced with this potential fraud, at least on your initial contacts?
Ms. PAGE WEST. Are you asking me?
Mr. CONNOLLY. Yes. I'm asking you, Ms. West.
Ms. PAGE WEST. I did not contact Medicaid. I filed a lawsuit under the False Claims Act. So my first contact was with the U.S. Attorney's Office With the District of New Jersey.
Mr. CONNOLLY. Did Medicaid at any point react to the filing of the lawsuit or the claims contained therein?
Ms. PAGE WEST. Again, I didn't have any contact with anyone from Medicaid. I was coming in through the Department of Justice.
Mr. CONNOLLY. Did your client have any contact with Medicaid in terms of reaction to the filing of the lawsuit or the claims therein?
Ms. PAGE WEST. Well, once we filed the lawsuit, it's under seal, and we aren't allowed to talk about it.
Mr. CONNOLLY. Even with Medicaid?
Ms. PAGE WEST. Not unless there would be a partial lifting of the seal or if they would set up a meeting and Medicaid officials would be there. But there was nothing like that.
Mr. CONNOLLY. And presumably—you made repeated attempts with the Medicaid office, Mr. West. And I know my time is running out—to try to alert them to this and get them to act.
Mr. RICHARD WEST. Yes.
Mr. CONNOLLY. And they were indifferent?
Mr. RICHARD WEST. Correct.
Mr. CONNOLLY. We look forward to their testimony. Thank you. My time has run out.
Thank you, Mr. Chairman.
Mr. PLATTS. I thank the gentleman for yielding back.
Before we conclude, I yield myself just a final minute.
Mr. West, my understanding is, in giving an interview, you shared an example of the lack of cooperation you got as you tried to correct this and that you were in front of a judge or an adjudicative setting where you were told that—well, there's evidence that they did provide these services, and they were not agreeing with you or believing you, and that you made a statement that you would bet that while you were in front of this individual that

Maxim was probably falsely appealing for services to you. Could you share that?

Mr. RICHARD WEST. We went to Scranton to the Federal courthouse. I picked up Robin at the train station. We met with I believe it was Silverman and a special agent, and after they heard my story, I said, I'll bet Maxim bills for a nurse in my home while I'm sitting here with you. I left my home at 6:45 in the morning. My son was driving. We went to Scranton, met with the prosecutors. I said, I'll bet they bill for this time. And they said, no, they couldn't possibly do that.

In January, I sent an email to Robin saying, I told you so. They billed for 7 to 3 for an RN in my home. Me and Adam didn't get home until about 5 that night. They also billed for the same nurse Christmas Day. We were in Pennsylvania, the next State over. And this particular nurse was reading my mail, looking at my email. I had to tell my attorney, do not send anything to my home. All updates and emails, don't mention who they're from or who they're about. I lived in a closet because I couldn't—I had people spying on me in my home while they were stealing from you.

Mr. PLATTS. One more example of how you were being victimized by a very unscrupulous company.

Mr. RICHARD WEST. Yep.

Mr. PLATTS. And its employees. And the fact that while you were sitting with the very investigators, they're falsely billing for services to you just epitomizes the outrageousness of this case. And again, as you reference having left your home at quarter of 7 a.m., and not getting back until 5, another example of your persistency and willingness to do whatever it took to bring justice on behalf of the American people, the taxpayers and to ensure that you were properly provided the services you've earned and deserved, especially as a veteran of our Nation's Armed Forces. I thank each of you again for your testimony here today, but more so than just your testimony here today, your efforts over almost a decade of trying to bring justice on behalf of your fellow citizens.

And Adam, I think it probably goes without me saying, but I imagine you're a very proud son to be Richard West's son and know that he's a true servant of this Nation.

Mr. ADAM WEST. Very much so.

Mr. PLATTS. So God bless each and every one of you. We will recess for 5 minutes as we recess for the second panel.

Mr. RICHARD WEST. May I have 1 minute?

Mr. PLATTS. Yes, you may.

Mr. RICHARD WEST. Today is Pearl Harbor today. And I would like to say, my dad, Thomas L. West, served in the Pacific. My mom, Catherine B. West, worked in a factory during that war. We had a country that worked together for the country. We need that now. We need people like me, people like you to sit down and fix the government.

Mr. PLATTS. Well stated, Mr. West.

Mr. RICHARD WEST. Thank you. I'm honored to be here.

Mr. PLATTS. God bless you. Thank you. We will stand in recess.

[Recess.]

Mr. PLATTS. The hearing is reconvened.

And we thank our second panel of witnesses for being with us and again your knowledge and insights to help educate both of our subcommittees on this important topic of how do we prevent and protect and recover American taxpayers' dollars that have been defrauded through the Medicaid program.

We are delighted to have four witnesses with us: First Ms. Angela Brice-Smith, director of the Medicaid Integrity Group at the Centers for Medicare & Medicaid Services; Mr. Gary Cantrell, assistant inspector general for investigations at the Office of the Inspector General for Health and Human Services; Ms. Carolyn Yocom, director of health care at the Government Accountability Office; and Ms. Valerie Melvin, director of information management and technology resource issues at the Government Accountability Office.

We thank each of you for being with us. And again, as is pursuant to the committee rules, if I could ask each of you to stand and raise your right hand, swear you in before your testimony.

[Witnesses sworn.]

Mr. PLATTS. Thank you. You may be seated.

And the clerk will reflect that all four witnesses affirmed that oath. And again, we have had the chance of reviewing your written testimony and appreciate your providing that to us. It allows us to be a little better prepared for today's hearing, and we will set the clock for roughly 5 minutes for your oral testimony here today.

Ms. Brice-Smith, if you would begin.

STATEMENTS OF ANGELA BRICE-SMITH, DIRECTOR, MEDICAID INTEGRITY GROUP, CENTERS FOR MEDICARE & MEDICAID SERVICES; GARY CANTRELL, ASSISTANT INSPECTOR GENERAL FOR INVESTIGATIONS, OFFICE OF THE INSPECTOR GENERAL, HEALTH & HUMAN SERVICES; CAROLYN YOCOM, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE; AND VALERIE MELVIN, DIRECTOR OF INFORMATION MANAGEMENT AND HUMAN CAPITAL ISSUES, GOVERNMENT ACCOUNTABILITY OFFICE

STATEMENT OF ANGELA BRICE-SMITH

Ms. BRICE-SMITH. Thank you Chairmen Platts and Gowdy, Ranking Members Towns and Davis, and members of the subcommittees.

Thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' efforts to reduce fraud, waste, and abuse in the Medicaid program. Medicaid is the primary source of medical assistance for 56 million low-income and disabled Americans. Although the Federal Government establishes requirements for the program, States design, implement, administer, and oversee their own Medicaid programs. The Federal Government and States share in the cost of the program.

State governments have a great deal of programmatic flexibility within which to tailor their Medicaid programs. As a result, there is variation among the States in eligibility services reimbursement rates and approaches to program integrity.

Prior to 2005, States were solely responsible for the oversight of their Medicaid program. However, in 2005 with the passage of the

Deficit Reduction Act, Congress recognized the need for a greater focus on health care fraud and gave CMS new authority and funding to establish the Medicaid Integrity Program.

I am the director of the Medicaid Integrity Group which implements the Medicaid Integrity Program. The Medicaid Integrity Program is a Federal effort to prevent, identify, and recover inappropriate Medicaid payments. It also supports the program integrity efforts of the State Medicaid agencies through a combination of oversight and technical assistance.

The establishment of the Medicaid Integrity Program began a new era of combating waste and fraud in the Medicaid program, which was once again improved by the creation of the Center for Program Integrity. The Center for Program Integrity brings a coordinated approach to program integrity across all Federal health care programs.

This new focus on program integrity and anti-fraud efforts continue with the Affordable Care Act, which is the most comprehensive legislative step forward to fight health care fraud in over a decade. The administration has made an unprecedented investment to reduce improper payments, invest in program integrity strategies, and rein in waste, fraud, and abuse in Federal health care programs.

Our efforts within the Medicaid Integrity Program focus on protecting Medicaid resources at the beneficiary level, the State level and the national level. Beneficiary involvement is a key component to all of CMS's anti-fraud efforts. We strongly believe that alert and vigilant beneficiaries are one of the most valuable tools in our efforts to stop fraudulent activity.

We are committed to enlisting beneficiaries in our fight against fraud in several ways: For example, our Education Medicaid Integrity Contractor [EMIC], provide beneficiaries with quick facts and tips on how to prevent, spot, and report Medicaid fraud through social network sites, through electronic letters, through public service announcements, and other educational materials. We encourage Medicaid beneficiaries to report suspected fraud, waste, and abuse to their State's Medicaid fraud control unit or Medicaid agency or the HHS fraud tips hotline as examples.

CMS is also committed to supporting our State partners and their program integrity efforts and their efforts to reduce improper payments. Our Medicaid Integrity Institute provides substantive training and support to the States. We have trained more than 2,600 program integrity staff from all 50 States, D.C. and Puerto Rico.

CMS provides boots-on-the-ground teams that can assist States with special investigative audits and emerging threats. Since October 2007, CMS has participated in 10 projects in 3 States, which have resulted in $33.2 million in savings through cost avoidance. In addition, CMS's review and audit MICs, or Medicaid Integrity Contractors, complement and support program integrity efforts underway in the States. Between 2009 and November 1st of this year, the audit MICs have initiated 1,663 audits in 44 States. In addition to the Federal audits, States report that they have recovered $2.3 billion as a result of all Medicaid program integrity activities.

The Affordable Care Act has also strengthened Federal oversight for the Medicaid program by providing new tools to CMS and law enforcement officials to protect Federal health care programs from fraud, waste, and abuse. These tools include the new screening and enrollment requirements, strengthen authority to suspend potentially fraudulent payments, and increased coordination of the anti-fraud actions and policies between Medicare and Medicaid.

The Affordable Care Act expanded the Recovery Audit Contractors to Medicaid, which will help States identify and recover improper Medicaid payments. Over the next 5 years, we project that the Medicaid RAC effort will save the Medicaid program $2.1 billion, of which $910 million will be returned to the States.

CMS is committed to working with and sharing with our law enforcement partners, who take a lead in investigating, determining, and prosecuting alleged fraud. We also continue to work to address the concerns raised by the GAO that could reduce improper payments and potential vulnerabilities in the Medicaid program.

I am happy to announce that the fiscal year 2011 Medicaid's national improper payment rate is 8.1 percent, a drop from the 9.4 percent in fiscal year 2010. Despite this decrease, we remain focused on improving program integrity in Medicaid and are confident that the actions outlined today and in my written testimony as well as the continued efforts of our Federal, State, and public partners will continue to reduce improper payments.

I look forward to working with the subcommittee to ensure that CMS carries out this important work. Thank you.

[The prepared statement of Ms. Brice-Smith follows:]

U.S. House Committee on Oversight & Government Reform
Subcommittee on Government Organization, Efficiency, and Financial Management and
Subcommittee on Health Care, District of Columbia, Census, and the National Archives
December 7, 2011

Chairmen Platts and Gowdy, Ranking Members Towns and Davis, and Members of the Subcommittees, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) efforts to reduce fraud, waste, and abuse in the Medicaid program.

The Affordable Care Act gives new tools to CMS and law enforcement officials to protect Federal health care programs from fraud, waste, and abuse. With this support, we are ramping up our Medicaid anti-fraud efforts by enhancing the quality of data used to detect fraud, investing in data analytics, and providing more "boots on the ground" to fight health care fraud. These efforts will increase our ability to prevent fraud before it happens, and to detect fraud when it does, allowing swifter recovery and corrective action. The Administration is strongly committed to ensuring that public resources are protected against losses from fraud and other improper payments by maintaining the integrity of the Medicaid program.

Background

Medicaid is the primary source of medical assistance for 56 million low-income and disabled Americans. Although the Federal government establishes requirements for the program, States design, implement, administer, and oversee their own Medicaid programs. The Federal government and States share in the cost of the program. State governments have a great deal of programmatic flexibility within which to tailor their Medicaid programs to their unique political, budgetary, and economic environments. As a result, there is variation among the States in eligibility, services, reimbursement rates to providers and health plans, and approaches to program integrity. The Federal government reimburses a portion of State costs for medical services through a statutorily determined matching rate called the Federal Medical Assistance Percentage, or FMAP, which is based on each State's per capita income and normally ranges between 50 and 75 percent. The Federal government also reimburses the States a portion of their administrative costs through varying matching rates determined according to statute, ranging

from 50 percent to 90 percent. The total net Federal Medicaid outlays in fiscal year (FY) 2011 are approximately $275 billion.

Deficit Reduction Act Authorities to Prevent and Reduce Fraud, Waste, and Abuse
Similar to all public and private health care programs, Medicaid can be a target for those who would abuse or defraud a health care program for personal gain. Recognizing the need for a greater focus on health care fraud at the public and private level, Congress gave CMS new authority and funding in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) which modified section 1936 of the Social Security Act to establish and operate the Medicaid Integrity Program. The Medicaid Integrity Program protects Medicaid by administering the national Medicaid audit program while enhancing Federal oversight of State Medicaid programs. The Medicaid Integrity Program accomplishes this by providing States with technical assistance and support that enhances the Federal-State Partnership. Prior to the enactment of the DRA, States performed the majority of program integrity oversight in the Medicaid program.

Section 1936 of the Social Security Act, as modified by the DRA, provides CMS with ongoing authorities to fight fraud by requiring CMS to contract with Medicaid Integrity Contractors (MICs) to review provider claims, audit providers, identify overpayments, and educate providers, managed care entities, beneficiaries, and other individuals about payment integrity and quality of care. CMS works with partner agencies at the Federal and State levels to enhance these efforts, including preventing the enrollment of individuals and organizations that would abuse or defraud the Medicaid program and removing fraudulent or abusive providers when detected.

Analyzing Data
As part of Section 1936 of the Social Security Act, CMS uses "Review of Provider MICs" (Review MICs) to analyze Medicaid claims data provided by States to identify high-risk areas, potential vulnerabilities, and targets for audits. In April 2008, CMS began developing an information technology infrastructure comprised of a central data repository and analytical tools. The system became operational in January 2009. It is primarily populated with Medicaid Statistical Information System (MSIS) data, which is a subset of Medicaid eligibility and claims data from all 50 States and the District of Columbia. This State-submitted data includes over 40

million eligibility records and over 2 billion claims records per year. CMS uses algorithms and modeling to identify potential fraudulent, wasteful, or abusive payments based on analysis of the MSIS data.

CMS is aware of the limitations of the MSIS data because of our extensive use of the data, as well as from feedback from other groups such as the HHS Office of Inspector General (OIG) and State Medicaid Agencies. Limitations include deficiencies in the completeness, accuracy, and timeliness of the data, as well as lack of data standardizations among State programs. As a result, improving the data quality of the MSIS data is vital to program integrity efforts. CMS continues to improve access to better quality Medicaid data by leveraging the data available through the Medicare/Medicaid Data Match Expansion Project (Medi-Medi) and its participating States, as well as working directly with States to obtain Medicaid data for specific collaborative projects. While the MSIS data has limitations, CMS is able to use the MSIS data to identify trends and patterns that exist within individual States, as well as regionally and at the national level in an effort to detect and deter fraud, waste, and abuse in the Medicaid program.

In order to improve CMS and the States' data analysis efforts, the Medicaid and Children's Health Insurance Program (CHIP) Business Information and Solutions Council (MACBIS), an internal CMS governance body, provides leadership and guidance for a more robust and comprehensive information management strategy for Medicaid, CHIP, and State health programs. The council's strategy includes:

- Promoting consistent leadership on key challenges facing State health programs;
- Improving the efficiency and effectiveness of the Federal-State partnership;
- Making data on Medicaid, CHIP, and State health programs more widely available to stakeholders; and
- Reducing duplicative efforts within CMS and minimizing the burden on States.

CMS' Center for Medicaid and CHIP Services (CMCS) leads this effort. The MACBIS projects will lead to the development and deployment of enterprise-wide improvements in data quality and availability for Medicaid program administration, oversight, and integrity. As these efforts

mature, we will be able to better utilize our technical infrastructure and business intelligence tools for program integrity oversight by using analytics, algorithms, and queries.

In addition to efforts to improve the quality of the Medicaid data, CMS is actively pursuing ways to apply advanced data analytics technology, including predictive analytics, to the Medicaid Integrity Program. CMS' goal is to utilize predictive modeling to enhance its analytic capabilities and increase information sharing and collaboration among State Medicaid agencies to detect and deter aberrant billing and servicing patterns at the State level and on a regional or national scale.

Auditing Claims

Once claims have been analyzed through CMS' data system and shared with the State, the "Audit of Provider" MICs (Audit MICs) conduct post-payment audits of all types of Medicaid providers and advise States of potential overpayments made to these providers. Between the completion of the solicitation process for MICs in 2009 and November 1, 2011, Audit MICs have initiated 1,663 audits in 44 States. Those efforts have identified an estimated $15.2 million in overpayments, through both direct provider audits and automated reviews of State claims. In addition to Federal audits, States reported that they conducted an additional 122,631 audits in FY 2009. Those State efforts have identified an estimated $964 million in overpayments.

Educating Providers and Others on Medicaid Program Integrity Issues

The Medicaid Integrity Institute (MII) remains one of CMS' most significant achievements in fighting Medicaid fraud, in partnership with our colleagues at the U.S. Department of Justice (DOJ). In its four years of operations, the MII has offered numerous courses and trained more than 2,624 State employees at no cost to the States. Courses have included enhanced investigative and analytical skills, Medicaid program integrity fundamentals, and a symposium to exchange ideas, create best practice models, and identify emerging fraud trends.

States continue to report immediate value and benefit from the training offered at the MII. As a result of several MII courses, State staff from across the country have the opportunity to engage in productive dialogues about the challenges they face combating fraud, waste, and abuse issues

unique to their State Medicaid programs. This interaction permits participants to share their success stories, learn from others' best practices, give their Medicaid programs a wider range of perspectives on policy options, and help identify problem providers who attempt to migrate from one State Medicaid program to another. For example, one State recently reported it recovered $3.15 million through provider audits it conducted as the direct result of knowledge gained at the MII. We have also sponsored intensive Certified Professional Coder training[1] and auditing courses for 359 additional State employees.

In addition, "Education MICs" assist in the education of providers and beneficiaries on program integrity efforts by developing materials and conducting training. For example, Education MICs help CMS enlist beneficiaries in our fight against fraud, including efforts such as the Protect Yourself, Protect Medicaid Campaign. CMS strongly believes that alert and vigilant Medicaid beneficiaries are one of the most valuable tools we have to stop fraudulent activity. Our Education MICs create public service announcements, distribute e-letters, and regularly update social networking sites to provide beneficiaries quick facts and tips about how to prevent, spot, and report Medicaid fraud. Education MICs encourage Medicaid beneficiaries to report fraud, waste, and abuse or criminal activities to their State's Medicaid Fraud Control Unit (MFCU) which is the State-administered law enforcement agency, Medicaid agency, the HHS fraud tips hotline, and the HHS OIG.

Due to the enactment of the DRA and Affordable Care Act, the creation of the Medicaid Integrity Program, and the establishment of our MICs, we have made great strides in combating Medicaid fraud. Today, thanks to increased funding and resources, we are able to investigate allegations of fraud quickly and competently, and report cases to law enforcement, as appropriate.

Supporting State Efforts to Combat Fraud, Waste, and Abuse

Because of Medicaid's unique Federal-State partnership, all of the strategies described above protect and enhance State Medicaid programs at a foundational level. We have also developed

[1] The MII's Certified Coder Boot Camp teaches the fundamentals of Current Procedural Terminology (CPT), ICD-9, and Healthcare Common Procedure Coding System (HCPCS) Level II coding.

initiatives that specifically work to assist States in strengthening their own efforts to combat fraud, waste, and abuse.

To provide and gauge effective support and assistance to States to combat Medicaid fraud, waste, and abuse, CMS conducts triennial comprehensive reviews of each State's program integrity activities. We use the State Program Integrity Reviews to identify and disseminate best practices. The review areas include provider enrollment, provider disclosures, program integrity, managed care operations, and the interaction between the State's Medicaid agency and its MFCU. We also conduct follow-up reviews to evaluate the success of the State's corrective actions.

Through its reviews, CMS has identified 52 unduplicated program integrity "best practices" that we have publicized to all States through annual summaries of our efforts. The guidance includes specific examples of how States have created well-functioning and committed partnerships between the State Medicaid agency and its MFCU. CMS, working with State Medicaid agencies and MFCUs, issued guidance in September 2008 entitled "Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit." CMS, State Medicaid agencies, and MFCUs developed this performance standard to provide State program integrity units with a clear understanding of how to comply with requirements for making referrals of fraud to MFCUs. In concert with the release of the performance standard, MIG issued a second guidance document, "Best Practices for Medicaid Program Integrity Units' Interactions with Medicaid Fraud Control Units." This document advises State program integrity units of the circumstances under which they should refer cases to their MFCUs, and provides guidance for interactions between State program integrity units and their MFCUs, with specific examples of actions taken by States that have created well-functioning and committed partnerships between the two entities.

The MFCU, as a State-administered law enforcement agency independent of the State Medicaid Agency, investigates and prosecutes Medicaid fraud as well as patient abuse and neglect in health care facilities. The Federal government funds MFCUs on a 75 percent matching basis. The HHS OIG certifies, and annually recertifies, each MFCU.

CMS also developed the State Program Integrity Assessment (SPIA). Through the SPIA, CMS annually collects standardized, national data on State Medicaid program integrity activities for program evaluation and technical assistance support. The States and CMS use the SPIA to gauge their collective progress in improving the overall integrity of the Medicaid program. In FY 2009, States reported recovering $2.3 billion through program integrity efforts funded at $393.5 million, for a $5.58 to $1 return on investment.

CMS also provides States assistance with "boots on the ground" for special investigative audits. Since October 2007, CMS has participated in 10 projects in three States, with the majority of activity occurring in Florida. States reported these reviews have resulted in $33.2 million in savings through cost avoidance. CMS helped States review 654 providers, 43 home health agencies and DME suppliers, and 52 group homes. During those reviews, CMS and States interviewed 1,150 beneficiaries and took more than 400 actions against non-compliant providers (including, but not limited to fines, suspensions, licensing referrals, and MFCU referrals). Besides identifying inappropriate provider activities, these reviews also result in an ongoing sentinel effect in these vulnerable areas of the Medicaid program.

Since 1998, the Medicaid Fraud & Abuse Technical Advisory Group (TAG) and its State subject matter experts have provided guidance to CMS on a variety of program integrity issues. The TAG is comprised of a chair and 10 regional representatives, all of whom are senior State program integrity officials. CMS meets with the TAG as well as other State program integrity officials in a monthly national teleconference and in annual face-to-face meetings. The Medicaid Fraud & Abuse TAG provides our State partners a critical voice in CMS' program integrity efforts.

To further build on this support, the Office of Management and Budget recently approved $2.9 million to fund a pilot project that tests an automated tool that screens providers for risk of fraud through the Partnership Fund for Program Integrity Innovation. Currently, HHS and the States lack standardized Medicaid provider data, which hampers the detection of potential fraud. This tool, which is being developed and tested in conjunction with four State partners,

could help prevent improper payments by weeding out fraudulent providers and focusing limited State resources on areas where fraud is most likely to occur. By reconfiguring how HHS and the States identify fraud trends, this new pilot aims to improve fraud detection capabilities and drive significant savings. Pilot results are expected in November 2012.

The Affordable Care Act and new Fraud-Fighting Tools at CMS

In addition to State and Federal efforts already underway, in March 2010, the President signed into law the Affordable Care Act, which included additional program integrity provisions that strengthened Medicaid integrity efforts. Several of these provisions were based on proposals from CMS, State Medicaid agencies, and law enforcement agencies. The Affordable Care Act also incorporated many provisions supporting the goal of the President's Executive Order 13520, *Reducing Improper Payments*, signed in November 2009.

Further, in April 2010, the Secretary of HHS created the Center for Program Integrity (CPI) to coordinate fraud, waste, and abuse prevention, detection, and enforcement efforts across CMS' Medicare, Medicaid, and CHIP programs. CPI's four major approaches to key anti-fraud activities are:

- **Prevention:** CPI will prevent fraud, waste, and abuse by expanding the breadth of the program integrity strategy beyond post-payment recoveries to preventing improper payments and resolving problems as they occur.
- **Detection:** CPI will focus on risk and reward compliance by targeting initiatives that identify bad actors while reducing the burden on legitimate providers and suppliers.
- **Increasing transparency and accountability:** CPI will be transparent and accountable to its stakeholders by sharing performance metrics on key program integrity activities.
- **Recovery:** CPI will focus on key strategies that increase recoveries to the Medicare Trust Funds and the Treasury.

Enhanced Screening and Other Enrollment Requirements

On January 24, 2011, CMS announced a final rule (CMS-6028-FC) implementing a number of the Affordable Care Act's powerful new fraud prevention legislative tools. The final rule:

- **Creates a rigorous screening process** for providers and suppliers enrolling in Medicare, Medicaid, and CHIP to keep fraudulent providers out of those programs. Categories of providers and suppliers that pose a moderate or high risk of fraud, for example durable medical equipment suppliers and home health agencies, are subject to additional screening requirements. States must follow the same screening procedure for Medicaid-only providers that CMS requires for Medicare providers. States may rely on CMS' screening results for providers enrolled in both Medicare and Medicaid. States may also rely on the results of the screenings provided by another State for the same provider. In addition, a provider must be terminated from any State Medicaid or CHIP program if the provider has been terminated from Medicare or another State's Medicaid or CHIP program for cause.
- **Permits temporary enrollment moratoria of new providers and suppliers.** Medicare and State Medicaid programs can temporarily stop enrollment of a category of providers or of providers within a geographic area that has been identified as high risk, as long as that will not impact access to care for patients.
- **Permits the suspension of payments** to providers and suppliers suspected of fraud. The Secretary of HHS or the State Medicaid Agency can suspend payments pending the investigation of a credible allegation of fraud, stopping the flow of money to potentially fraudulent providers.

CMS also issued rules on May 5, 2010 (CMS-6010-IFC) implementing Affordable Care Act provisions that require providers and suppliers who order and refer certain items or services for Medicare and Medicaid beneficiaries to enroll in Medicare and Medicaid, maintain documentation on those orders and referrals, and include the National Provider Identifier on all fee-for-service (FFS) enrollment applications and claims.

Established State Medicaid Recovery Audit Contractor (RAC) Program

On September 14, 2011, CMS released the final rule for the Medicaid Recovery Audit Contractor (RAC) program, a key part of the Affordable Care Act's initiatives to curb fraud, waste, and abuse. The Medicaid RAC program will help States identify and recover improper Medicaid payments, and States are required to have their RAC programs in place, absent an

exception, by January 1, 2012. Similar to the Medicare FFS Recovery Audit Program, States will pay the RACs a contingency fee out of any overpayments recovered. RACs review claims after payment, using both simple and detailed reviews that include medical records. RACs are required to employ trained medical professionals, certified coders, and a physician, unless CMS grants an exception. Further, CMS' Medicaid Recovery Audit Contractor At-A-Glance web page on the CMS website[2] provides basic information to the public and interested stakeholders about each State's Recovery Audit program.

The Affordable Care Act expanded RACs to Medicaid because of RACs' success within original Medicare – between October 1, 2010 and September 30, 2011, the Medicare FFS Recovery Audit Program has corrected a total of $939 million in improper payments. Over the next five years, we project that the Medicaid RAC effort will save the Medicaid program $2.1 billion, of which $910 million will be returned to the States. This effort complements the other efforts described above that target fraud, waste, and abuse in the health care system.

Partnering with Stakeholders to Improve Medicaid Program Integrity

Many of the Affordable Care Act provisions increase coordination between States, CMS, and our law enforcement partners at the HHS OIG and the DOJ. CMS is committed to working with our law enforcement partners, who take a lead role in investigating, determining, and prosecuting alleged fraud. By sharing information and requiring all States to terminate any provider or supplier that Medicare or another State terminated for cause, the Affordable Care Act ensures that fraudulent providers and suppliers cannot easily move from State to State or between Medicare and Medicaid. We are also providing training in the use of data analytic systems to the HHS OIG and DOJ, enabling investigators and law enforcement agents to more quickly detect and prosecute fraud schemes.

We also appreciate the efforts of the Government Accountability Office (GAO) and their recommendations on how to improve Medicaid program integrity. We continue to work to address the concerns raised by the GAO and to reduce improper payments and potential vulnerabilities in the Medicaid program. As a reminder, improper payments include both

[2] https://www.cms.gov/medicaidracs/home.aspx

overpayments and underpayments, and are not necessarily fraudulent in nature. CMS' commitment to reducing improper payments is demonstrated by the review and audit activities described above, as well as our collaborative efforts with the States, and the establishment of the RAC program and other Affordable Care Act initiatives. For FY 2011, Medicaid's national improper payment rate is 8.1 percent -- a drop from 9.4 percent in FY 2010. Despite this decrease, we remain focused on improving program integrity in Medicaid, and are confident that the actions outlined in this testimony, as well as the continued efforts of our Federal, State, and public partners, will continue to reduce improper payments.

Conclusion

CMS is committed to the integrity of the Medicaid program, and ensuring that we continue to advance in fraud prevention and detection. This Administration has made an unprecedented effort to reduce improper payments in Federal health care programs, invest in program integrity strategies, and rein in fraud, waste, and abuse. With the Affordable Care Act provisions, anti-fraud strategies, and partnerships discussed today, we have more resources than ever before to implement important strategic changes in pursuing fraud, waste, and abuse. Through partnerships between stakeholders, we have learned from each other how to protect our health care system. I am confident that the smarter we work today, with our partners, technology, and through training and education, the stronger our system will be for years to come. I look forward to working with you in the future as we continue to make improvements in protecting the integrity of Medicaid and safeguarding taxpayer resources.

Mr. PLATTS. Thank you Ms. Brice-Smith.
Mr. Cantrell.

STATEMENT OF GARY CANTRELL

Mr. CANTRELL. I am Gary Cantrell, assistant inspector general for investigations with the U.S. Department of Health and Human Services Office of Inspector General. I appreciate the opportunity to testify today about our efforts to combat Medicaid fraud.

First and foremost, I would like to thank Mr. West for coming forward with allegations of billing fraud on the part of Maxim Health-care Services. OIG recognizes that our success is dependent upon cooperation with courageous individuals like Mr. West. The documentation that he provided was critical to us in helping us unravel a broader scheme within Maxim Health-care that spanned across the Nation.

Our investigation resulted in Maxim agreeing to pay more than $150 million to resolve civil and criminal allegations of fraud, the largest-ever settlement relating to home health services. Nine individuals, including three senior managers, also pled guilty to felony charges. This example highlights the potential for citizens and government to collaborate and curtail schemes that are harming the Nation's most vulnerable citizens. OIG encourages citizens to report suspected fraud, so we can investigate and bring to justice those responsible.

Medicaid fraud drains vital Federal and State program dollars that harms both recipients relying on those services as well as the American taxpayers. OIG has a team of over 480 highly skilled criminal investigators located throughout the country. And in fiscal year 2011, our enforcement efforts resulted in record numbers that included over 720 criminal convictions and $4.6 billion in expected recoveries. Nearly 400 of these actions addressed schemes related to Medicaid fraud, and over $1.1 billion is expected to be returned to the program.

The types of schemes perpetrated in the Medicaid program in many ways mirror Medicare fraud schemes. For example, we see billing for services not rendered, medical identity theft, false statements, bribery and kickbacks. These have been especially common in relation to home health prescription drugs charitable medical equipment and transportation services.

Data access is critical to our enforcement efforts in both Medicare and Medicaid. OIG has worked closely with CMS to expand our access to national Medicare claims data. This improved access has enabled OIG to more effectively identify Medicare fraud trends. And that allows our agents to more efficiently investigate allegations of fraud. Unfortunately, this is not the case on the Medicaid side.

Our inability to access timely comprehensive data impedes effective oversight of the program. CMS's Medicaid statistical information system is the only source of nationwide Medicaid claims data, and weaknesses in the system limit its usefulness for effective oversight and monitoring of the program. For example, the system does not capture many of the data elements necessary for us to detect fraud, waste, and abuse.

As in the Maxim case, Medicaid presents our investigators with unique data challenges. Why? It's because the data does not exist in a single location. Rather, it exists in independent systems across 50 States and the District of Columbia. We understand that CMS is taking steps to collect more timely comprehensive data from the States, and we hope they move quickly to accomplish this goal.

State Medicaid fraud control units have been valuable partners in our investigative efforts. Our number of joint investigations has nearly doubled over the last 5 years. And to improve on our success, we believe that Medicaid fraud control units could also benefit from enhanced analytic capabilities with regard to their State Medicaid data. This will lead to improved oversight and enforcement.

In closing, we need to make a lasting impact on Medicaid fraud. The need has never been more important. The Congressional Budget Office estimates that in 2014, 16 million new recipients will be added to the Medicaid program. Therefore, it is especially critical that OIG have access to timely comprehensive data in order to protect these Federal and State dollars.

Together, we must work to eliminate vulnerabilities and ensure that we are positioned to effectively oversee this program for years to come. Thank you for your support of our mission and I would be happy to answer any questions you have.

[The prepared statement of Mr. Cantrell follows:]

Testimony of:
Gary Cantrell
Assistant Inspector General for Investigations
U.S. Department of Health and Human Services
Office of Inspector General

INTRODUCTION

Good morning Chairmen, Ranking Members, and other distinguished Members of the Subcommittees. I am Gary Cantrell, Assistant Inspector General for Investigations with the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG). Thank you for the opportunity to testify about OIG's efforts to combat Medicaid fraud. My testimony will provide an overview of certain areas of Medicaid fraud, describe our law enforcement efforts and investigative challenges, and make recommendations to improve Medicaid oversight.

BACKGROUND

OIG's mission is to protect the integrity of over 300 HHS programs, as well as the health and welfare of program beneficiaries. In fulfillment of this mission, we investigate and hold accountable those who defraud and abuse the Department's programs, promote provider compliance, and recommend program safeguards.

OIG has a robust program of audits, evaluations, and investigations directed towards identifying, preventing, and stopping Medicaid fraud, waste, and abuse. OIG employs more than 1,700 dedicated professionals, including a cadre of over 480 highly skilled criminal investigators, trained to conduct criminal, civil, and administrative investigations of fraud related to HHS programs and operations. Our special agents have full law enforcement authority to effect a broad range of actions, including the execution of search and arrest warrants. We use state-of-the-art technologies and a wide range of tools in carrying out these important responsibilities. We are the Nation's premiere health care fraud law enforcement agency.

Our constituents are the American taxpayers, and we work hard to ensure that their money is not stolen or misused. In fiscal year 2011, OIG opened over 2,000 investigations. Enforcement efforts for the same fiscal year resulted in record numbers that included over 1,100 criminal and

civil actions and $4.6 billion in expected recoveries. Of this, nearly 400 criminal and civil actions are related to Medicaid and over $1.1 billion in restitutions or recoveries are to be returned to Federal and State Medicaid programs.

MEDICAID FRAUD OVERVIEW

Medicaid is an important health care benefit for approximately 56 million Americans with limited incomes or disabilities that rely on the program for medical care. The program is funded jointly by Federal and State governments. Generally speaking, the Federal Government sets broad guidelines for Medicaid, and the States have flexibility to administer the program within those guidelines. The scope and composition of each Medicaid program vary significantly across States. In fiscal year 2011, the program accounted for nearly $275 billion in Federal spending. Medicaid fraud drains vital Federal and State program dollars, in turn, harming both recipients and the American taxpayers.

OIG is leading the fight against health care fraud

OIG brings a formidable combination of cutting edge techniques and traditional investigative skills to the fight against Medicaid fraud. This has been useful in uncovering a range of schemes, especially those relating to home health and personal care services, prescription drug diversion, durable medical equipment, and ambulance transportation. These schemes have involved many types of fraud, including billing for equipment not provided or for services not rendered, medical identity theft, false statements, bribery, and kickbacks.

We receive information related to these schemes through a variety of sources, including the Centers for Medicare & Medicaid Services (CMS) as well as qui tam referrals from the Department of Justice (DOJ).

One such example is our recent investigation of Maxim Healthcare Services, Inc. (Maxim), which was initiated on the basis of Mr. Richard West's qui tam complaint against the company. Mr. West was a patient of Maxim, one of the Nation's leading providers of home health services. The settlement resolved allegations that between 1998 and 2009, Maxim filed false claims with State Medicaid programs and the Department of Veterans Affairs for services either not provided, not sufficiently documented to show they were provided, or delivered from unlicensed offices. Our investigation resulted in a settlement in which Maxim agreed to pay more than $150 million to resolve civil and criminal charges. The settlement represents the largest-ever involving home health services. The company has also entered into a 5-year Corporate Integrity Agreement (CIA) with OIG, which requires additional reforms and monitoring under our supervision.

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

The Maxim case is also an example of a recent increase in fraud cases involving home health and personal care providers. According to data obtained from the Medicaid Fraud Control Units (MFCUs), as of the fourth quarter of 2010, we are now seeing more Medicaid fraud cases involving home health services than any other single program area. The vast majority involve personal care services, which are nonmedical services provided by unskilled aides who assist recipients with activities of daily living, such as bathing, meal preparation, and feeding.

As stated above, we are also witnessing persistent fraud trends surrounding misuse of prescription drugs. These cases are among the most deplorable because they involve the over-prescribing of dangerous narcotics and sometimes the diversion of dangerous narcotics to street drugs, often causing harmful or deadly results to those who abuse them. We saw a particularly

egregious example of this in the State of Washington, which resulted in the death of a patient from an overdose of Oxycodone prescribed by the patient's physician. The physician had established relationships in the local heroin-user community and was writing medically unnecessary prescriptions to patients for narcotics, including Oxycodone and Vicodin. In this case, the physician was incarcerated and ordered to pay $700,000 in restitution. The physician also lost her medical license and was excluded from all Federal health care programs.

OIG is collaborating with Medicaid Fraud Control Units

State MFCUs have played a significant role in helping us identify the fraudulent activities discussed above and other fraud trends in Medicaid. The number of our joint investigations with MFCUs nearly doubled in the past 5 years from 621 to over 1,100. The collaboration with MFCUs and other law enforcement partners has been critical, as many of the providers defrauding Medicaid have operations throughout the United States.

For nationwide investigations, the National Association of Medicaid Fraud Control Units (NAMFCU) plays a coordinating role in marshaling the investigative efforts of the many individual States affected by fraud. In a recent nationwide investigation, OIG collaborated with the MFCUs, through a NAMFCU committee, as well as other law enforcement partners, to investigate the pediatric dental clinic Small Smiles, managed by FORBA Holdings, LLC (FORBA). The investigation revealed that FORBA, among other things, allegedly caused the submission of claims to Medicaid for dental services that either were not medically necessary or did not meet professionally recognized standards of care. These unnecessary services included pulpotomies (baby root canals), placing multiple crowns, administering anesthesia, performing extractions, and providing fillings and/or sealants. This investigation resulted in an agreement from FORBA to pay over $24 million plus interest and enter into a 5-year quality-of-care CIA to settle allegations that it performed unnecessary and often painful services on children to maximize Medicaid reimbursement.

OIG is engaging health care providers and the public in the fight against fraud

OIG is using a variety of tools to engage all our stakeholders in our efforts to prevent, detect, and combat health care fraud. OIG is extensively using the Internet to enlist the health care industry and the public in the fight against fraud. Our Web site, www.oig.hhs.gov, offers a wide range of information to health care providers and patients about ways to reduce the risk of fraud and abuse. These resources include OIG's provider compliance training, voluntary compliance program guidance, fraud alerts, self-disclosure protocol, and advisory opinions on fraud and abuse laws.[1] OIG also offers a guide to prevent medical identity theft.[2] And we recently published *A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse*,[3] which summarizes five main Federal fraud and abuse laws and provides guidance on how physicians should comply with these laws in their relationships with payers, vendors, and fellow providers.

The OIG Hotline is another valuable fraud-fighting tool, which allows individuals to contact OIG directly through our Web site or by calling 1-800-HHS-TIPS to provide information regarding these and other types of fraud, waste, and abuse schemes in HHS programs.[4]

We have also posted OIG's list of the 10 most wanted health care fraud fugitives, including photographs and details about the individuals and their schemes.[5] One of our top most wanted fugitives, Dr. Gautam Gupta, is wanted for allegedly defrauding Medicaid and private insurance companies of millions of dollars. Gupta owned and operated several weight loss nutrition clinics in northern Illinois and the Chicago metropolitan area. According to the arrest warrant, the clinic defrauded Medicaid and private insurance companies of as much as $24 million from unwarranted medical tests and false billings for doctor visits.

[1] Available at http://oig.hhs.gov/compliance/.
[2] Available at http://oig.hhs.gov/fraud/medical-id-theft/index.asp.
[3] Available at http://oig.hhs.gov/compliance/physician-education/index.asp.
[4] Information about the OIG Hotline can be found at http://oig.hhs.gov/fraud/report-fraud/index.asp.
[5] Available at http://oig.hhs.gov/fraud/fugitives/index.asp.

We are asking the public to help us bring these fugitives to justice by reporting any information about their whereabouts to our Web site or Fugitive Hotline (1-888-476-4453). A recent call to the Hotline led to the capture of one of OIG's top 10 most wanted fugitives; we hope, with the public's help, to also bring Gupta to justice in the near future.

RECOMMENDATIONS TO IMPROVE MEDICAID OVERSIGHT

OIG uses data to detect possible fraudulent billing at the earliest possible stage. In combating Medicare fraud, OIG has worked closely with its partners, including CMS, to provide our special agents with access to more data sources and real-time access to Medicare claims data. This has been critical in our enforcement efforts and has enabled us to develop a consolidated data analysis center, which integrates business intelligence tools and develops new data analytics to enhance our fraud detection efforts. This has improved OIG's ability to access, analyze, and share data with our law enforcement partners and accomplish this in a manner consistent with applicable privacy, security, and disclosure requirements. The centralized data analysis center has already enhanced the efficiency and coordination of our collective efforts by enabling law enforcement to identify a broader range of potentially fraudulent activities and more efficiently use our investigative resources. Much of our Medicare enforcement success can be attributed to our timely access to useful data, which has played a pivotal role in our recent enforcement results.

Inability to access useful, timely Medicaid data hinders oversight efforts

In contrast to Medicare, our efforts to use data analytics to oversee Medicaid have been impeded by the lack of national-level, timely Medicaid data. Medicaid presents unique data challenges because key program operations occur across 50 States, the District of Columbia, and U.S. territories, rather than on a national level. The Medicaid Statistical Information System (MSIS) is the only source of nationwide Medicaid claims information, and weaknesses in MSIS data limit its usefulness for oversight and monitoring of the program. In a 2009 report, OIG

determined that MSIS data were an average of 1 1/2 years old when released by CMS to users for data analysis purposes.[6] In law enforcement, a 1 1/2-year timelag is an eternity, especially when dealing with astute criminals who cash out quickly and move on to the next scheme. Moreover, MSIS was not designed for anti-fraud efforts and lacks many basic data elements that can assist in fraud, waste, and abuse detection. Additionally, MSIS does not include complete data received through managed care plans, despite the fact that the majority of Medicaid beneficiaries received their health care services through Medicaid managed care.[7]

Our investigation of Maxim illustrates challenges faced in conducting nationwide investigations involving Medicaid fraud. Maxim is a nationwide conglomerate providing home health services in over 40 States, which made it difficult to collect comprehensive Medicaid claims data in support of our investigation. We understand that CMS is working to address these and other data issues. We hope that CMS moves forward expeditiously to systematically collect comprehensive data and make the data available to us.

We further recommend that MFCUs' abilities to access data be enhanced. Our goal is to help them establish their own analytic capabilities with regard to their respective State Medicaid data. To support this, OIG issued a notice of proposed rulemaking to permit MFCUs, under certain conditions, to use Federal matching funds to identify fraud through screening and analyzing State Medicaid claims data.[8] We believe this will enhance our enforcement efforts and improve Medicaid oversight.

CONCLUSION

The need to protect Medicaid from fraud has never been more important. The Congressional Budget Office estimates that in 2014, 16 million new recipients will join the Medicaid program.

[6] "MSIS Data Usefulness for Detecting Fraud, Waste, and Abuse," OEI-04-07-00240, August 2009, available at http://oig.hhs.gov/oei/reports/oei-04-07-00240.pdf.
[7] "Medicaid Managed Care Encounter Data: Collection and Use," OEI-07-06-00540, May 2009, available at http://oig.hhs.gov/oei/reports/oei-07-06-00540.pdf.
[8] 76 Fed. Reg. 52 (March 17, 2011), pp. 14637–14641.

States and the Federal Government alike must work to eliminate vulnerabilities and ensure that we are positioned to effectively oversee the program in the years to come. It is critical that OIG have access to timely and accurate Medicaid data to protect program recipients and expenditures. As shown through our accomplishments in Medicare, data analysis is vital to fighting health care fraud. We believe comparable access to Medicaid data will yield similar successes.

To that end, OIG will continue moving forward to implement mechanisms to protect the integrity and vitality of Medicaid and punish those who defraud the program. We will continue partnering with those who share our objectives to safeguard the programs that protect the health of all Americans and provide essential health care to those in need.

Thank you for your support of OIG's mission. I would be happy to answer any questions.

Mr. PLATTS. Thank you Mr. Cantrell.
Ms. Yocom.

STATEMENT OF CAROLYN YOCOM

Ms. YOCOM. Mr. Chairmen, ranking members, and members of the subcommittees, I am pleased to be here as you discuss improper payments in fraud in the Medicaid program. My remarks today will focus on an important challenge as well as opportunities that CMS faces, given its expanded role in Medicaid program integrity.

In 2005, GAO testified that CMS needed to increase its commitment to helping States fight Medicaid fraud, waste, and abuse. That year, Congress passed the Deficit Reduction Act, which provided for the creation of the Medicaid Integrity Program and other provisions. The Patient Protection and Affordable Care Act gave CMS and States added responsibilities and new oversight tools. Thus CMS's spending for and attention to Medicaid program integrity activities has grown, primarily through the creation of the Medicare Integrity Group or the MIG.

The MIG gradually hired staff and contractors to implement a set of core activities, such as reviewing and auditing Medicaid provider claims and providing education to State officials and Medicaid providers. In 2005, CMS had approximately 8 staff years focused on program integrity. Today it has over 80 of the 100 statutorily required positions authorized in the DRA.

However, more is not necessarily better. A key challenge faced by the MIG is the need to avoid duplication of Federal and State program integrity efforts, particularly in auditing provider claims, which has been primarily a State function. The amount of overpayments that the MIG identifies is not commensurate with its costs or with amounts identified by some States. For example, in a similar number of audits, New York reported identifying more than $372 million in overpayments compared with $15 million identified through the national provider audits.

In 2011, the MIG reported plans to redesign its national provider audit program to allow for greater coordination with States on data policies and audit measures. While it remains to be seen whether these changes would help identify additional overpayments, the proposed redesign appears promising. In particular, the collaborative projects currently underway in 13 States would first allow States to augment their own resources; second, address audit targets that States have too few resources to handle; and third, assist States with less analytic capability. These projects could help avoid duplication as well as strengthen Federal and State efforts.

CMS's expanded role also offers the opportunity to enhance State program integrity efforts, but more consistent data are needed. For example, two core activities of the MIG, triannual comprehensive reviews and annual assessments, collect similar information such as States' program integrity planning, prevention activities, and recoveries. However, some of the data that States report show implausible and/or inconsistent State responses. Improved data would allow CMS to further target assistance to States through the MIG's primary training initiative, the Medicaid Integrity Institute. Not only is the training offered at no cost to States, but such venues

provide opportunities for State program integrity officials to develop relationships with their counterparts in other States. Such relationships are critical in a program like Medicaid where providers and beneficiaries can cross State lines and repeat improper or even fraudulent behaviors.

Since fiscal year 2008, the institute has trained over 2,200 State employees. Instituted expenditures are a small portion of MIG's spending, just $1.3 million of its $75 million budget. Yet they could greatly increase networks across States and disseminate best practices for ensuring appropriate payments in Medicaid.

For many years, Medicaid has been a critical part of the health care safety, providing health care services to some of our Nation's most vulnerable populations. This heightens CMS's responsibility to ensure that billions of program dollars are appropriately spent. In these difficult economic times, it creates an even greater imperative. The challenges of coordination are significant for States and for CMS. No less significant is the need for improved data to prevent overpayments.

But there's also an opportunity for the MIG to work with States to disseminate and improve oversight of program spending and hopefully decrease the level of improper payments. This concludes my prepared remarks. I'd be happy to answer any questions you or members of the subcommittees may have.

[The prepared statement of Ms. Yocom follows:]

United States Government Accountability Office

GAO

Testimony

Before the Subcommittees on Government Organization, Efficiency and Financial Management and Health Care, District of Columbia, Census and the National Archives, Committee on Oversight and Government Reform, House of Representatives

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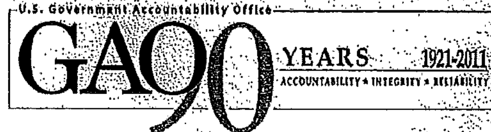
MEDICAID PROGRAM INTEGRITY

Expanded Federal Role Presents Challenges to and Opportunities for Assisting States

Statement of Carolyn L. Yocom
Director, Health Care



GAO-12-288T

Highlights

Highlights of GAO-12-288T, a testimony before the Subcommittees on Government Organization, Efficiency and Financial Management and Health Care, District of Columbia, Census and the National Archives, Committee on Oversight and Government Reform, House of Representatives

Why GAO Prepared This Testimony

The Centers for Medicare & Medicaid Services (CMS), the federal agency that oversees Medicaid, estimated that improper payments in the federal-state Medicaid program were $21.9 billion in fiscal year 2011. The Deficit Reduction Act of 2005 established the Medicaid Integrity Program and gave CMS an expanded role in assisting and improving the effectiveness of state activities to ensure proper payments. Making effective use of this expanded role, however, requires that federal resources are targeted appropriately and do not duplicate state activities.

GAO was asked to testify on Medicaid program integrity. GAO's statement focuses on how CMS's expanded role in ensuring Medicaid program integrity (1) poses a challenge because of overlapping state and federal activities regarding provider audits and (2) presents opportunities through oversight to enhance state program integrity efforts.

To do this work, GAO reviewed CMS reports and documents on Medicaid program integrity as well as its own and others' reports on this topic. In particular, GAO reviewed CMS reports that documented the results of its state oversight and monitoring activities. GAO also interviewed CMS officials in the agency's Medicaid Integrity Group (MIG), which was established to implement the Medicaid Integrity Program. This work was conducted in November and December 2011. GAO discussed the facts in this statement with CMS officials.

View GAO-12-288T. For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

December 7, 2011

MEDICAID PROGRAM INTEGRITY

Expanded Federal Role Presents Challenges to and Opportunities for Assisting States

What GAO Found

The key challenge faced by the Medicaid Integrity Group (MIG) is the need to avoid duplication of federal and state program integrity efforts, particularly in the area of auditing provider claims. In 2011, the MIG reported that it was redesigning its national provider audit program. Previously, its audit contractors were using incomplete claims data to identify overpayments. According to MIG data, overpayments identified by its audit contractors since fiscal year 2009 were not commensurate with its contractors' costs. The MIG's redesign will result in greater coordination with states on a variety of factors, including the data to be used. It remains to be seen, however, whether these changes will result in an increase in identified overpayments. The table below highlights the MIG's core oversight activities, which were implemented from fiscal years 2007 through 2009.

MIG's Core Oversight Activities and Fiscal Year Implemented

MIG activities	Description
Comprehensive program integrity reviews (fiscal year 2007)	Every 3 years, the MIG conducts a comprehensive management review of each state's Medicaid program integrity procedures and processes. Through the reviews, CMS assesses the effectiveness of the state's program integrity efforts and determines whether the state's policies and procedures comply with federal regulations.
Technical assistance (fiscal year 2007)	In fiscal year 2009, the MIG responded to 504 requests for technical assistance from 49 states, providers, advocates and others. Common topics included policy/regulatory requirements on disclosures, law enforcement activities, and fraud detection tools.
Medicaid Integrity Institute (fiscal year 2007)	The institute is the first national Medicaid integrity training program. CMS executed an interagency agreement with the Department of Justice to house the institute at the Department's National Advocacy Center, located at the University of South Carolina. The institute offers substantive training, technical assistance, and support to states in a structured learning environment.
National Provider Audit Program (fiscal year 2009)	Separate contractors (1) analyze claims data to identify aberrant claims, and potential billing vulnerabilities; and (2) conduct post-payment audits based on data analysis leads in order to identify overpayments to Medicaid providers.
State program integrity assessments (fiscal year 2009)	These annual assessments represent the first national baseline collection of data on state Medicaid integrity activities for the purposes of program evaluation and technical assistance support. The data provided by states are used to populate a one-page profile covering topics such as program integrity staffing and expenditures, audits, fraud referrals, and recoveries.
Education contractors (fiscal year 2009)	The education contractors develop materials in order to educate and train providers on payment integrity and quality of care issues.

Source: CMS.

The MIG's core oversight activities present an opportunity to enhance state efforts through the provision of technical assistance and the identification of training opportunities. The MIG's assessment of state program integrity efforts during triennial onsite reviews and annual assessments will need to address data inconsistencies identified during these two activities. Improved consistency will help ensure that the MIG is appropriately targeting its resources. The Medicaid Integrity Institute appears to address a state training need and create networking opportunities for program integrity staff.

Chairmen Platts, Gowdy, and Members of the Subcommittees:

I am pleased to be here today to discuss Medicaid program integrity, that is, preventing improper payments that result from fraud, waste, and abuse.[1] Until the Deficit Reduction Act of 2005 (DRA) expanded the role of the Centers for Medicare & Medicaid Services (CMS), the federal agency that oversees Medicaid, Medicaid program integrity had been primarily a state responsibility.[2] CMS's expanded role presents an opportunity to assist and improve the effectiveness of state activities, but also requires that federal resources are targeted appropriately and do not duplicate state activities.

Medicaid is jointly funded by federal and state governments. It is one of the largest social programs in the federal budget—covering about 67 million people in fiscal year 2010—and one of the largest components of state budgets. In fiscal year 2010, Medicaid expenditures totaled about $401 billion, with a federal share of $270 billion and a state share of $132 billion. As a result of flexibility in the program's design, Medicaid consists of 56 distinct state-based programs.[3] The challenges inherent in overseeing a program of Medicaid's size and diversity make the program vulnerable to improper payments, which may be the result of fraud, waste, and abuse.[4] Because of the program's risk of improper payments as well as insufficient federal and state oversight, we added Medicaid to

[1]Medicaid is the federal-state program that covers acute health care, long-term care, and other services for certain categories of low-income individuals.

[2]See Pub. L. No. 109-171, § 6034, 120 Stat. 3, 74-78 (2006).

[3]The federal government matches states' expenditures for most Medicaid services using a statutory formula based on each state's per capita income. The 56 Medicaid programs include one for each of the 50 states, the District of Columbia, Puerto Rico, Samoa, Guam, the Commonwealth of the Northern Mariana Islands, and the United States Virgin Islands.

[4]Fraud involves an intentional act or representation to deceive with the knowledge that the action or representation could result in gain. Waste results from clerical errors or the provision of medically unnecessary services. Abuse typically involves actions that are inconsistent with acceptable business and medical practices that result in unnecessary program costs. See, e.g., 42 C.F.R. § 455.2 (2010).

our list of high-risk programs in January 2003.[5] CMS estimated that Medicaid improper payments were $21.9 billion for fiscal year 2011.[6]

States are the first line of defense against Medicaid improper payments. Specifically, they must comply with federal requirements to ensure the qualifications of the providers who bill the program, detect improper payments, recover overpayments, and refer suspected cases of fraud and abuse to law enforcement authorities. At the federal level, CMS, an agency within the Department of Health and Human Services (HHS), is responsible for supporting and overseeing state Medicaid program integrity activities.

In 2005, we testified that CMS needed to increase its commitment—both the alignment of resources and strategic planning—to helping states fight Medicaid fraud, waste and abuse.[7] Subsequently, the DRA established the Medicaid Integrity Program and included other provisions designed to increase CMS's support for state activities to address Medicaid fraud, waste, and abuse. The DRA provided appropriations to implement the Medicaid Integrity Program, and the Patient Protection and Affordable Care Act (PPACA) enacted in March 2010 gave CMS and states additional provider and program integrity oversight tools.[8]

You asked GAO to testify today on Medicaid program integrity. My remarks focus on how CMS's expanded role in ensuring Medicaid program integrity (1) poses a challenge because of overlapping state and federal activities, particularly in the area of auditing provider claims; and (2) presents opportunities through oversight to enhance state program

[5]See GAO, *Major Management Challenges and Program Risks: Department of Health and Human Services*, GAO-03-101 (Washington, D.C.: January 2003).

[6]In its *Fiscal Year 2011 Agency Financial Report*, HHS calculated and reported the 3-year (2009, 2010, and 2011) weighted average national payment error rate for Medicaid of 8.1 percent. See *Department of Health and Human Services FY 2011 Agency Financial Report* (Washington, D.C.: Nov. 15, 2011).

[7]See GAO, *Medicaid Fraud and Abuse: CMS's Commitment to Helping States Safeguard Program Dollars Is Limited*, GAO-05-855T (Washington, D.C.: June 28, 2005).

[8]Pub. L. No. 111-148, 124 Stat. 119, as amended by the Health Care Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029. For example, PPACA required states to have Medicaid Recovery Audit Contractors, increased provider ownership reporting requirements, and allowed CMS to suspend payments to providers on the basis of a credible allegation of fraud.

integrity efforts. To do this work, we reviewed CMS reports and documents on Medicaid program integrity as well as our own and others' reports on this topic. In particular, we reviewed CMS reports that documented the results of its state oversight and monitoring activities. We also interviewed CMS officials in the agency's Medicaid Integrity Group, which was established to implement the Medicaid Integrity Program. We conducted our work in November and December 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. The data presented in this statement were obtained from CMS and we did not independently verify their reliability. We believe that the evidence obtained provides a reasonable basis or our findings and conclusions based on our audit objectives.

Background

CMS is responsible for overseeing Medicaid and state Medicaid agencies are responsible for administering the program. Although each state is subject to federal requirements, it develops its own Medicaid administrative structure for carrying out the program including its approach to program integrity. Within broad federal guidelines, each state establishes eligibility standards and enrolls eligible individuals; determines the type, amount, duration, and scope of covered services; sets payment rates for covered services; establishes standards for providers and managed care plans; and ensures that state and federal funds are not spent improperly or diverted by fraudulent providers. However, state Medicaid programs do not work in isolation on program integrity; instead, there are a large number of federal agencies, other state entities, and contractors with which states must coordinate.

State Medicaid Program Integrity Activities

Generally, each state's Medicaid program integrity unit uses its own data models, data warehouses, and approach to analysis. States often augment their in-house capabilities by contracting with companies that specialize in Medicaid claims and utilization reviews. However, as program administrators, states have primary responsibility for conducting program integrity activities that address provider enrollment, claims review, and case referrals. Specifically, CMS expects states to

- collect and verify basic information on providers, including whether the providers meet state licensure requirements and are not prohibited from participating in federal health care programs

- maintain a mechanized claims processing and information system known as the Medicaid Management Information System (MMIS). MMIS can be used to make payments and to verify the accuracy of claims, the correct use of payment codes, and a beneficiary's Medicaid eligibility.[9]

- operate a Surveillance and Utilization Review Subsystem (SURS) in conjunction with the MMIS that is intended to develop statistical profiles on services, providers, and beneficiaries in order to identify potential improper payments. For example, SURS may apply automatic post-payment screens to Medicaid claims in order to identify aberrant billing patterns.

- submit all processed Medicaid claims electronically to CMS's Medical Statistical Information System (MSIS). MSIS does not contain billing information, such as the referring provider's identification number or beneficiary's name, because it is a subset of the claims data submitted by states. States provide data on a quarterly basis and CMS uses the data to (1) analyze Medicaid program characteristics and utilization for services covered by state Medicaid programs, and (2) generate various public use reports on national Medicaid populations and expenditures.

- refer suspected overpayments or overutilization cases to other units in the Medicaid agency for corrective action and refer potential fraud cases to other appropriate entities for investigation and prosecution.

Our reports and testimonies from 2001 through 2006 identified gaps in state program integrity activities and noted that the support provided by CMS to states was hampered by resource constraints.[10] For example, in 2004, we reported that 15 of 47 states responding to our questionnaire

[9]States provide CMS with claims data for use in estimating a Medicaid payment error rate. CMS developed the Payment Error Rate Measurement program to comply with the Improper Payments Information Act of 2002. The error rate is not a "fraud rate" but simply a measurement of payments made that did not meet statutory, regulatory, or administrative requirements.

[10]See GAO, *Medicaid: State Efforts to Control Improper Payments Vary*, GAO-01-662 (Washington, D.C.: June 7, 2001); *Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments*, GAO-04-707 (Washington, D.C.: July 16, 2004); GAO-05-855T; *Medicaid Integrity: Implementation of New Program Provides Opportunities For Federal Leadership to Combat Fraud, Waste, and Abuse*, GAO-06-578T (Washington, D.C.: March 28, 2006).

did not affirm that they conducted data mining, defined as analysis of large data sets to identify unusual utilization patterns, which might indicate provider abuse.

Recent Legislation Has Conferred New Responsibilities on CMS and States

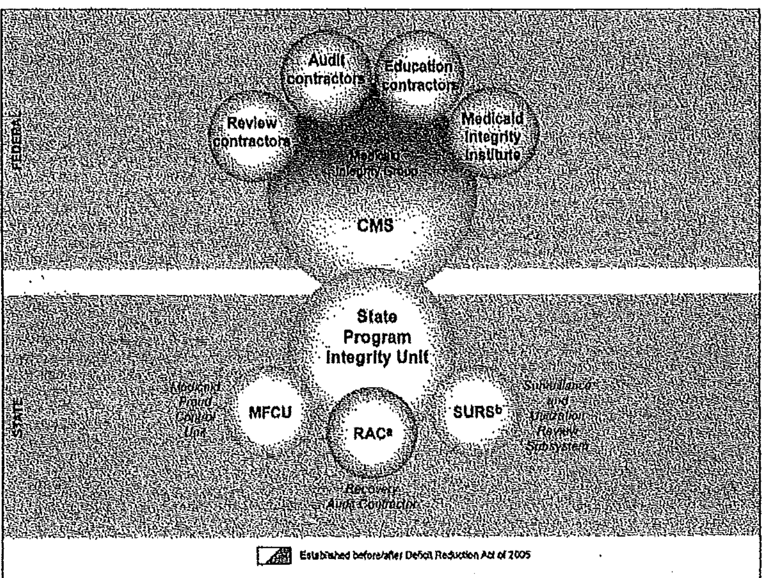
The DRA established the Medicaid Integrity Program to provide effective federal support and assistance to states to combat fraud, waste, and abuse. To implement the Medicaid Integrity Program, CMS created the Medicaid Integrity Group (MIG), which is now located within the agency's Center for Program Integrity. The DRA also required CMS to hire contractors to review and audit provider claims and to educate providers on issues such as appropriate billing practices.

The Medicaid Recovery Audit Contractor (RAC) program was established by PPACA.[11] Each state must contract with a RAC, which is tasked with identifying and recovering Medicaid overpayments and identifying underpayments. Each state's RAC is required to be operational by January 1, 2012. Medicaid RACs will be paid on a contingency fee basis—up to 12.5 percent—of any recovered overpayments and states are required to establish incentive payments for the detection of underpayments.[12] Figure 1 identifies the key federal and state entities responsible for Medicaid program integrity.

[11]Pub. L. No. 111-148, §6411, 124 Stat. 119,773.

[12]CMS will not provide federal financial participation for administrative expenditure claims if a state establishes a RAC contingency fee that is in excess of the highest Medicare RAC contingency fee rate, unless a state requests an exception from CMS and provides an acceptable justification. Any additional fees must be paid out of state-only funds.

Figure 1: Key Federal and State Entities Responsible for Medicaid Program Integrity before and after the Deficit Reduction Act of 2005



Source: GAO.

Notes: Other federal entities involved in Medicaid program integrity not included in this figure include: CMS's Office of Financial Management and its Center for Medicaid, CHIP, Survey and Certification; the Department of Health and Human Services' Office of Inspector General; the Federal Bureau of Investigation; and the Department of Justice.

[a]States are required to contract with at least one RAC, which must be operational beginning January 2012.

[b]SURS may be performed by an outside contractor (as depicted here) or state program integrity staff may carry out the SURS function, in which case it would be integral to the State Program Integrity Unit.

Fraud Investigation and Prosecution

Fraud detection and investigations often require more specialized skills than are required for the identification of improper payments because investigators must establish that an individual or entity *intended* to falsify a claim to achieve some gain. As a result, fraud is more difficult to prove than improper payments and requires the involvement of entities that can investigate and prosecute fraud cases. In 1977, Congress authorized federal matching funds for the establishment of independent state Medicaid Fraud Control Units (MFCU).[13] MFCUs are responsible for investigating and prosecuting Medicaid fraud. In general, they are located in State Attorneys Generals' offices. MFCUs can, in turn, refer some cases to federal agencies that have longstanding responsibility for combating fraud, waste, and abuse in Medicare and Medicaid—the HHS's Office of Inspector General (HHS-OIG), the Federal Bureau of Investigation (FBI), and the Department of Justice.

CMS's MIG Implemented Core Activities from 2006 through 2009 but Effective Coordination Is Needed Because of Overlap with Ongoing State Efforts

A key challenge CMS faces in implementing the statutorily required federal Medicaid Integrity Program is ensuring effective coordination to avoid duplicating state program integrity efforts. CMS established the MIG in 2006 and it gradually hired staff and contractors to implement a set of core activities, including the (1) review and audit of Medicaid provider claims; (2) education of state program integrity officials and Medicaid providers; and (3) oversight of state program integrity activities and provision of assistance. Because states also routinely review and audit provider claims, the MIG recognized that coordination was key to avoiding duplication of effort. In 2011, the MIG reported that it was redesigning its national provider audit program to allow for greater coordination with states on data, policies, and audit measures. According to MIG data, overpayments identified by its review and audit contractors over the first 3 years of the national audit program were not commensurate with the contractors' costs.

Core MIG Activities Were Implemented Gradually from 2006 to 2009

The DRA provided CMS with the resources to hire staff whose sole duties are to assist states in protecting the integrity of the Medicaid program. The MIG's core activities were implemented gradually from fiscal year 2006 to 2009. The DRA provided start up funding of $5 million for fiscal

[13]Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub. L. No. 95-142, §91 Stat. 1176, 1201.

year 2006, increasing to $50 million for each of the subsequent 2 fiscal years, and $75 million per year for fiscal year 2009 and beyond.[14] One of the first activities initiated by the MIG in fiscal year 2007 was comprehensive program integrity reviews to assess the effectiveness of states' activities, which involved eight, week-long onsite visits that year.[15] One of the last activities to be implemented was the statutorily required National Provider Audit Program where MIG contractors review and audit Medicaid provider claims. In fiscal year 2005, we reported that CMS devoted 8.1 full time equivalent staff years to support and oversee states' anti-fraud-and-abuse operations, which, in 2010, had grown to 83 out of the 100 DRA authorized full time equivalent staff years.[16] Table 1 describes six core MIG activities and the fiscal year in which those activities began.

[14]HCERA provided that for each fiscal year after 2010 the amount appropriated would be adjusted to take into account inflation. §1303(b)(3), 124 Stat. at 1058.

[15]The states the MIG visited included Arkansas, Connecticut, Delaware, Michigan, Missouri, Nevada, Oregon, and Virginia.

[16]See GAO-05-855T.

Table 1: Medicaid Integrity Group's Core Oversight Activities, by Fiscal Year Implemented

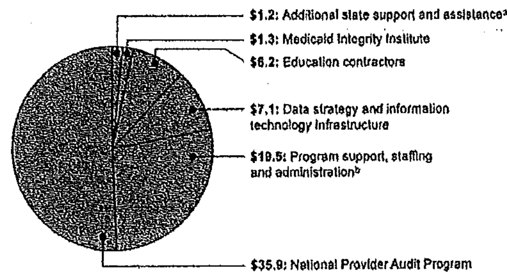
MIG activities	Description
	Fiscal year 2007
Comprehensive program integrity reviews	Every 3 years, the MIG conducts a comprehensive management review of each state's Medicaid program integrity procedures and processes. Through the reviews, the MIG assesses the effectiveness of the state's program integrity efforts and determines whether the state's policies and procedures comply with federal statutes and regulations. The review areas include provider enrollment, provider disclosures, program integrity, managed care operations, and the interaction between the state's Medicaid agency and its Medicaid Fraud Control Unit (MFCU). Each review results in a report which is posted on CMS's Web site that summarizes best practices, compliance issues, and vulnerabilities. The MIG also conducts follow-up reviews to evaluate state's corrective action plans addressing any identified vulnerabilities.
Technical assistance	In fiscal year 2009, the MIG responded to 504 requests for technical assistance from 49 states, providers, advocates and others. Common topics included the National Provider Audit Program, policy/regulatory requirements on disclosures, law-enforcement activities, and fraud detection tools. Examples of other assistance provided to the states included (1) hosting regional State Program Integrity Director conference calls to discuss emerging issues and best practices, and (2) issuing a State Medicaid Director letter in January 2009 which provided guidance to Medicaid providers on screening their employees and contractors for individuals excluded from participation in the program.
Medicaid integrity institute	The institute is the first national Medicaid integrity training program. CMS executed an interagency agreement with the Department of Justice to house the institute at the National Advocacy Center, located at the University of South Carolina. The institute offers substantive training, technical assistance, and support to states in a structured learning environment. In time, the institute intends to create a credentialing process to elevate the professional qualifications of state Medicaid program integrity staff.
	Fiscal year 2009
National Provider Audit Program[a]	Separate contractors (1) analyze claims data to identify aberrant claims and potential billing vulnerabilities, and (2) conduct post-payment audits based on data analysis leads in order to identify overpayments to Medicaid providers.
State program integrity assessments	These annual assessments represent the first national baseline collection of data on state Medicaid integrity activities for the purposes of program evaluation and technical assistance support. The data provided by states are used to populate a one page profile covering topics such as program integrity staffing and expenditures, audits, fraud referrals to the state's MFCU, and recoveries.
Education contractors	The education contractors develop materials in order to educate and train providers on payment integrity and quality of care issues.

Source: CMS

[a]To gain a better understanding of audit processes and procedures as well as variation across the states, the MIG initiated test audits in fiscal year 2007, prior to the implementation of the National Provider Audit Program.

Figure 2 shows MIG expenditures by program category for fiscal year 2010. The Medicaid Integrity Institute accounted for about 2 percent of the MIG's fiscal year 2010 expenditures, while the National Provider Audit Program accounted for about half of expenditures.

Figure 2: MIG Expenditures by Program Category, Fiscal Year 2010, in Millions



Source: CMS

[a]These activities include courses as well as technical assistance and outreach to states specific to the implementation of PPACA.

[b]These activities include the comprehensive program integrity reviews, state program integrity assessments, and technical assistance.

The MIG Recognized the Need for Effective Coordination

At the outset, the MIG recognized that effective coordination with internal and external stakeholders was essential to the success of the Medicaid Integrity Program. In a report issued prior to establishment of the program, we found that CMS had a disjointed organizational structure and lacked the strategic planning necessary to face the risks involved with the Medicaid program.[17] We identified the need for CMS to develop a strategic plan in order to provide direction to the agency, its contractors, states, and its law enforcement partners. In designing and implementing the program, the MIG convened an advisory committee consisting of

[17]See GAO-05-855T.

(1) state program integrity, Medicaid, and MFCU directors from 16 states; and (2) representatives of the FBI, HHS-OIG, and CMS regional offices. This committee provided planning input and strategic advice and identified key issues that the MIG needed to address, including

- The MIG's efforts should support and complement states' Medicaid integrity efforts, not be redundant of existing auditing efforts.
- Program integrity activities of the MIG and other federal entities require coordination with states regarding auditing and data requests.
- The focus of state activities should be shifted from postpayment audits to prepayment prevention activities.

The advisory committee also highlighted the lack of state resources for staffing, technology, and training. CMS's July 2009 Comprehensive Medicaid Integrity Plan, the fourth such plan since 2006, stated that fostering collaboration with internal and external stakeholders of the Medicaid Integrity Program was a primary goal of the MIG.

In implementing more recent statutory requirements, CMS again stressed the need for effective coordination and collaboration. CMS's commentary accompanying the final rule on the implementation of Medicaid RACs acknowledged the potential for duplication with states' ongoing efforts to identify Medicaid overpayments. States have been responsible for the recovery of all identified overpayments, including those identified since fiscal year 2009 by the MIG's audit contractors. The new requirement for states to contract with an independent Medicaid RAC introduces another auditor to identify and collect Medicaid overpayments. The Medicaid RAC program was modeled after a similar Medicare program, which was implemented in March 2009 after a 3-year demonstration.[18] Because Medicare RACs are paid a fixed percentage of the dollar value of any improper payments identified, they generally focused on costly services such as inpatient hospital stays. Our prior work on Medicare RACs noted

[18]The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 directed CMS to conduct a project to demonstrate how effective the use of RACs would be in identifying underpayments and overpayments, and in recouping overpayments in Medicare. Pub. L. No. 108-173, § 306, 117 Stat. 2066, 2256. Subsequently, in December 2006 the Tax Relief and Health Care Act of 2006 required CMS to implement a national Medicare RAC program by January 1, 2010. Pub. L. No. 109-342, div. B, title III, § 302, 120 Stat. 2924, 2991 (codified at 42 U.S.C. § 1395ddd(h)).

that the postpayment review activities of CMS's other contractors would overlap less with the RACs' audits if those activities focused on different Medicare services where improper payments were known to be high, such as home health.[19] Because Medicaid RACs are not required to be operational until January 1, 2012, the extent to which states will structure their RAC programs to avoid duplication and complement their own provider review and audit activities remains to be seen.

The MIG Is Redesigning the National Provider Audit Program, Whose Returns Were Not Commensurate with Contractors' Costs

In its most recent annual report to the Congress, the MIG indicated that it was redesigning the National Provider Audit Program. According to the MIG, the National Provider Audit Program has not identified overpayments in the Medicaid program commensurate with the related contractor costs. About 50 percent of the MIG's $75 million annual budget supports the activities of its review and audit contractors. From fiscal years 2009 through 2011, the MIG authorized 1,663 provider audits in 44 states. However, the MIG's reported return on investment from these audits was negative. While its contractors identified $15.2 million in overpayments, the combined cost of the National Provider Audit Program was about $36 million in fiscal year 2010. The actual amount of overpayments recovered is not known because states are responsible for recovering overpayments and the MIG is not the CMS entity that tracks recoveries. Actual recoveries may be less than the identified overpayments.

The National Provider Audit Program has generally relied on MSIS, which is summary data submitted by states on a quarterly basis that may not reflect voided or adjusted claims payments. As a result, the MIG's audit contractors may identify two MSIS claims as duplicates when the state has already voided or denied payment on one of these claims. For their program integrity efforts, states use their own MMIS data systems, which generally reflect real-time payments and adjustments of detailed claims for each health care service. States are required to have a SURS component that performs data mining as a part of their program integrity efforts. The MIG's review contractors use data mining techniques that may be similar to those employed by states, and they may not identify any additional improper claims.

[19] See GAO, *Medicare and Medicaid Fraud, Waste, and Abuse: Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payments*, GAO-11-409T (Washington, D.C.: Mar. 9, 2011).

Moreover, MIG officials told us that the National Provider Audit Program did not prioritize the activities according to the dollar amount of the claim, that is, it did not concentrate its efforts on audits with the greatest potential for significant recoveries. Although the amount of overpayment identified from any given audit can vary by thousands or millions of dollars, the MIG's comprehensive reviews of several states' Medicaid integrity programs show that these states identified significantly higher levels of overpayments in 1 year than the National Provider Audit Program identified over 3 years. For example, the number of national provider audits (1,663) over three fiscal years was similar to the number that New York conducted in fiscal year 2008 (1,352), yet CMS reported that New York had identified more than $372 million in overpayments—considerably more than the $15.2 million identified through national provider audits.[20]

The MIG's proposed redesign of the National Provider Audit Program appears to allow for greater coordination between its contractors and states on a variety of factors, including the data to be used.[21] In fiscal year 2010, the MIG launched collaborative audits in 13 states. For these audits, the states and the MIG agreed on the audit issues to review and, in some cases, states provided the MIG's audit contractors with more timely and complete claims data. These collaborative projects (1) allowed states to augment their own audit resources, (2) addressed audit targets that states may not have been able to initiate because of a lack of staff, and (3) provided data analytic support for states that lacked that capability. Although these activities are ongoing and the results have not yet been finalized, such collaborative projects appear to be a promising approach to audits that avoids a duplication of federal and state efforts. It remains to be seen, however, whether these changes will result in an increase in identified overpayments.

[20]Department of Health and Human Services, Centers for Medicare & Medicaid Services, *New York Comprehensive Program Integrity Review: Final Report* (Washington, D.C.: 2010).

[21]Kathleen Sebelius, Secretary of Health and Human Services, *Annual Report to Congress on the Medicaid Integrity Program for Fiscal Year 2010* (Washington, D.C.: 2011).

Expanded Role Offers Opportunity to Enhance State Efforts, but More Consistent Data Are Needed

While the MIG's audit program is challenged to avoid duplicating states' own audit activities, its other core functions present an opportunity to enhance states' efforts. The MIG's state oversight activities are extensive and labor intensive. Although the data collected during reviews and assessments are not always consistent with each other, these oversight activities have a strong potential to inform the MIG's technical assistance and help identify training opportunities. The Medicaid Integrity Institute appears to address an important state training need.

MIG's Core Oversight Activities Are Broad, but the Data Collected During Reviews and Assessments Were Not Always Consistent with Each Other

The MIG's core oversight activities—triennial comprehensive state program integrity reviews and annual assessments—are broad in scope and provide a basis for the development of appropriate technical assistance. However, we found that the information collected during reviews and the information collected from assessments was sometimes inconsistent with each other.

As of November 2011, the MIG had completed the first round of reviews for 50 states and had initiated a second round of reviews in 10 states. The reviews cover the entirety of a state's program integrity activities and assess compliance with federal regulations. In advance of the MIG's week-long onsite visit, state program integrity officials are asked to respond to a 71-page protocol containing 195 questions and to provide considerable documentation.[22] Table 2 summarizes the topics covered in the protocol. Typical compliance issues and vulnerabilities identified during the reviews include provider enrollment weaknesses, inadequate oversight of providers in Medicaid managed care, and ineffective fraud referrals to state MFCUs.

[22]The MFCU and managed care entities receive separate protocols and requests for documentation.

Table 2: Topics Covered in MIG's Comprehensive State Program Integrity Review Protocol

Modules	Number of questions
Program integrity organization and staffing	29
Claims payment review	10
Prepayment review	37
Post-payment review	13
Recovery audit contractors	6
Payment error rate measurement	6
Sampling and extrapolation	14
Fraud identification, investigation, and referral	
Methods	10
Preliminary investigation	4
Full investigation	8
Resolution of full investigation	7
Reporting requirements	3
Provider statements	7
Recipient verification	9
Cooperation with MFCUs	16
Withholding payments	4
Federal reimbursement for operation of data systems	3
False Claims Act requirements	4
Technical assistance	5

Source: CMS's fiscal year 2011 comprehensive state program integrity review protocol

Much of the information collected during the assessments—Medicaid program integrity characteristics, program integrity planning, prevention, detection, investigation and recoveries—is also collected during the triennial comprehensive reviews.[23] In addition, we found inconsistencies between the information reported in the comprehensive reviews and in the assessments for several states that were conducted at about the same time. For example, there was a significant discrepancy for one state in the number of staff it reported as being dedicated to program integrity activities. According to the MIG, knowing the size of state program

[23] The MIG collects the data for the assessments through an online questionnaire that has 56 questions. The responses are used to develop a one-page profile on state activities.

integrity staff helps it to more appropriately tailor content during training events. Improved consistency will help the MIG ensure that it is targeting its training and technical assistance resources appropriately. Despite the frequency of the annual assessments, the most current data cover fiscal year 2008, which the MIG began collecting in fiscal year 2010.

Although the MIG provides states with a glossary explaining each of the requested data elements, it is not clear that the information submitted is reliable or comparable across states. Our review of a sample of assessments revealed missing data and a few implausible measures, such as one state reporting over 38 million managed care enrollees. In other states, there were dramatic changes in the data reported from 2007 to 2008, which either raises a question about the reliability of the data or suggests that states be allowed to explain significant changes from year to year. For example, the number of audits in one state declined from 203 to 35.

According to MIG officials, the comprehensive reviews and the assessments inform the MIG's technical assistance activities with the states. For example, we found that the MIG published best practices guidance in 2008 after finding weaknesses in coordination between state program integrity officials and their respective MFCU's in a number of states. In its report to Congress on fiscal year 2010 activities, the MIG indicated it completed 420 requests for technical assistance from 43 states, providers, and others. The most common topics included the National Provider Audit Program, policy and regulatory requirements on disclosures, provider exclusions and enrollment, and requests for statistical assistance related to criminal and civil court actions. Examples of assistance provided to the states by the MIG included (1) hosting regional state program integrity director conference calls to discuss program integrity issues and best practices; and (2) helping develop a State Medicaid Director Letter (issued in July 2010) on the return of federal share of overpayments under PPACA.

Medicaid Integrity Institute Trains State Staff and Facilitates Networking

The federally sponsored Medicaid Integrity Institute not only offers state officials free training but also provides opportunities to develop relationships with program integrity staff from other states. The Institute addresses our prior finding that CMS did not sponsor any fraud and abuse workshops or training from 2000 through 2005.[24] From fiscal years

[24]See GAO-05-855T.

2008 through 2012, the institute will have trained over 2,265 state employees at no cost to states. Given the financial challenges states currently face, it is likely that expenditures for training and travel are limited. Expenditures on the institute accounted for about $1.3 million of the MIG's $75 million annual budget. MIG officials told us that states uniformly praised the opportunity to network and learn about best practices from other states. A special June 2011 session at the institute brought together Medicaid program integrity officials and representatives of MFCUs from 39 states in an effort to improve the working relations between these important program integrity partners.

In addition to the institute, the MIG has a contractor that provides (1) education to broad groups of providers and beneficiaries, and (2) targeted education to specific providers on certain topics.[25] For example, the education contractor has provided outreach through its attendance at 17 conferences with about 36,000 attendees. These conferences were sponsored by organizations devoted to combating health care fraud such as the National Association of Medicaid Program Integrity and National Health Care Anti-Fraud Association, as well as meetings of national and regional provider organizations (hospital, home care and hospice and pharmacy). An example of a more targeted activity is one focused on pharmacy providers. The MIG's education contractor is tasked with developing provider education materials to promote best prescribing practices for certain therapeutic drug classes and remind providers of the appropriate prescribing guidelines based on FDA approved labeling. The education program includes some face-to-face conversations, mailings to providers, and distribution of materials on a website and at conferences and meetings. These activities are collaborative efforts with the states so that states are: aware of the aberrant providers, participate in the education program, and can implement policy changes to address these issues, as appropriate.

We discussed the facts in this statement with CMS officials.

[25]The MIG has two education contractors, however, it has only issued task orders to one of the contractors.

Chairmen Platts and Gowdy, this concludes my prepared remarks. I would be happy to answer any questions that you or other Members may have.

GAO Contact and Staff Acknowledgments

For further information about this statement, please contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relation and Public Affairs may be found on the last page of this statement. Walter Ochinko, Assistant Director; Sean DeBlieck; Iola D'Souza; Leslie V. Gordon; Drew Long; Jessica Smith; and Jennifer Whitworth were key contributors to this statement.

Appendix I: Abbreviations

CMS	Centers for Medicare & Medicaid Services
DRA	Deficit Reduction Act of 2005
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
HCERA	Health Care Education and Reconciliation Act of 2010
HHS	Department of Health and Human Services
MFCU	Medicaid Fraud Control Unit
MIG	Medicaid Integrity Group
MIP	Medicaid Integrity Program
MMIS	Medicaid Management Information System
MSIS	Medicaid Statistical Information System
OIG	Office of Inspector General
PERM	Payment Error Rate Measurement
PPACA	Patient Protection and Affordable Care Act
RAC	Recovery Audit Contractor
SURS	Surveillance and Utilization Review Subsystem

Related GAO Products

Fraud Detection Systems: Additional Actions Needed to Support Program Integrity Efforts at Centers for Medicare and Medicaid Services. GAO-11-822T. Washington, D.C.: July 12, 2011.

Fraud Detection Systems: Centers for Medicare and Medicaid Services Needs to Ensure More Widespread Use. GAO-11-475. Washington, D.C.: June 30, 2011.

Improper Payments: Recent Efforts to Address Improper Payments and Remaining Challenges. GAO-11-575T. Washington, D.C.: April 15, 2011.

Status of Fiscal Year 2010 Federal Improper Payments Reporting. GAO-11-443R. Washington, D.C.: March 25, 2011.

Medicare and Medicaid Fraud, Waste, and Abuse: Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payments. GAO-11-409T. Washington, D.C.: March 9, 2011.

Medicare: Program Remains at High Risk Because of Continuing Management Challenges. GAO-11-430T. Washington, D.C.: March 2, 2011.

Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue. GAO-11-318SP. Washington, D.C.: March 1, 2011.

High-Risk Series: An Update. GAO-11-278. Washington, D.C.: February 2011.

Medicare Recovery Audit Contracting: Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, Although Improvements Made to Contractor Oversight. GAO-10-143. Washington, D.C.: March 31, 2010.

Medicaid: Fraud and Abuse Related to Controlled Substances Identified in Selected States. GAO-09-1004T. Washington, D.C.: September 30, 2009.

Medicaid: Fraud and Abuse Related to Controlled Substances Identified in Selected States. GAO-09-957. Washington, D.C.: September 9, 2009.

Improper Payments: Progress Made but Challenges Remain in Estimating and Reducing Improper Payments. GAO-09-628T. Washington, D.C.: April 22, 2009.

Medicaid: Thousands of Medicaid Providers Abuse the Federal Tax System. GAO-08-239T. Washington, D.C.: November 14, 2007.

Medicaid: Thousands of Medicaid Providers Abuse the Federal Tax System. GAO-08-17. Washington, D.C.: November 14, 2007.

Medicaid Financial Management: Steps Taken to Improve Federal Oversight but Other Actions Needed to Sustain Efforts. GAO-06-705. Washington, D.C.: June 22, 2006.

Medicaid Integrity: Implementation of New Program Provides Opportunities for Federal Leadership to Combat Fraud, Waste, and Abuse. GAO-06-578T. Washington, D.C.: March 28, 2006.

Medicaid Fraud and Abuse: CMS's Commitment to Helping States Safeguard Program Dollars Is Limited. GAO-05-855T. Washington, D.C.: June 28, 2005.

Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments. GAO-04-707. Washington, D.C.: July 16, 2004.

Medicaid: State Efforts to Control Improper Payments. GAO-01-662. Washington, D.C.: June 7, 2001.

Mr. PLATTS. Thank you, Ms. Yocom.
Ms. Melvin.

STATEMENT OF VALERIE MELVIN

Ms. MELVIN. Chairmen Platts and Gowdy, Ranking Members Towns and Davis and members of the subcommittee, thank you for inviting me to testify at today's hearing on fraud and improper payments in the Medicaid program. At your request, my testimony will summarize findings from a report that we issued earlier this year on CMS's efforts to protect the integrity of the Medicare and Medicaid programs through the use of information technology.

Specifically, in June 2011, we reported on two programs that CMS initiated in 2006 to help improve the ability to detect fraud, waste, and abuse: The integrated data repository or IDR, which is intended to provide a single source of data on Medicare and Medicaid claims and the one program integrity or one PI system, a Web-based portal that is to provide CMS staff and contractors with a single source of access to the data contained in IDR as well as tools for analyzing that data.

Our work examined the extent to which IDR and one PI had been developed and implemented as well as CMS's efforts to identify, measure, and track benefits resulting from these programs. We also provided recommendations on actions CMS should take to achieve its goals of reduced fraud and waste.

Regarding IDR, we noted that this data repository had been in use since 2006. However, it did not include all of the data that were planned to be in the system by 2010. For example, IDR included most types of Medicare claims data but no Medicaid data. IDR also did not include data from other CMS systems that can help analysts prevent improper payments. Moreover CMS had not finalized plans or developed reliable schedules for efforts to incorporate these data.

Further, while one PI had been developed and deployed, we found that few analysts were trained in using the system. Program officials had planned for 639 analysts to be using the system by the end of fiscal year 2010. However, as of October 2010, only 41 were actively using the portal and tools. None of these users included Medicaid program integrity analysts.

We pointed out that until program officials finalized plans and schedules for training and expanding the use of one PI, the agency may continue to experience delays. With one PI, CMS anticipated that it would achieve financial benefits of about $21 billion. As we have previously reported, agencies should forecast expected benefits and then measure the actual results accrued through the implementation of programs.

However, CMS was not positioned to do this. As a result, it was unknown whether the program had provided any financial benefits. CMS officials told us that it was too early to determine whether the program had provided benefits since it had not met its goals for widespread use.

To help ensure that the development and implementation of IDR and one PI are successful in helping CMS meet the goals of its program integrity initiatives and possibly save tens of billions of dollars, we made several recommendations to CMS. Among our rec-

ommendations was that the agency finalized plans and schedules for incorporating additional data into IDR, finalized plans and schedules for training all program integrity analysts intended to use one PI, and establish and track outcome-based performance measures that gauge progress toward meeting program goals. In commenting on a draft of our report, CMS agreed with our recommendations. The agency's timely implementation of these recommendations could lead to reduced fraud and waste and overall substantial savings in the Medicare and Medicaid programs. This concludes my oral statement. I look forward to addressing your questions.

[The prepared statement of Ms. Melvin follows:]

United States Government Accountability Office

GAO

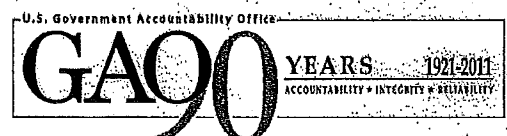
Testimony before the Subcommittees on Government Organization, Efficiency and Financial Management; and Health Care, District of Columbia, Census and the National Archives; Committee on Oversight and Government Reform, House of Representatives

For Release on Delivery
Expected at 10:00 a.m. EST
Wednesday, December 7, 2011

FRAUD DETECTION SYSTEMS

Centers for Medicare and Medicaid Services Needs to Expand Efforts to Support Program Integrity Initiatives

Statement of Valerie C. Melvin, Director
Information Management
and Technology Resources Issues



GAO-12-292T

Highlights

Highlights of GAO-12-292T, a testimony for Subcommittees of the Committee on Oversight and Government Reform, House of Representatives

December 2011

FRAUD DETECTION SYSTEMS

Centers for Medicare and Medicaid Services Needs to Expand Efforts to Support Program Integrity Initiatives

Why GAO Did This Study

The Centers for Medicare and Medicaid Services (CMS) is responsible for administering and safeguarding its programs from loss of funds. As GAO reported in June 2011, CMS utilizes automated systems and tools to help improve the detection of improper payments for fraudulent, wasteful, and abusive claims. To integrate claims information and improve its ability to detect fraud, waste, and abuse in these programs, CMS initiated two information technology system programs: the Integrated Data Repository (IDR) and One Program Integrity (One PI).

GAO was asked to testify on its June 2011 report that examined CMS's efforts to protect the integrity of the Medicare and Medicaid programs through the use of information technology (GAO-11-475). In that prior study, GAO assessed the extent to which IDR and One PI have been developed and implemented, and CMS's progress toward achieving its goals and objectives for using these systems to detect fraud, waste, and abuse.

What GAO Recommends

GAO recommended in June 2011 that CMS take actions to finalize plans and schedules for achieving widespread use of IDR and One PI, and to define measurable benefits. CMS concurred with GAO's recommendations.

View GAO-12-292T or key components. For more information, contact Valerie Melvin at (202) 512-6304 or melvinv@gao.gov.

What GAO Found

GAO previously reported that CMS had developed and begun using both IDR and One PI, but had not incorporated into IDR all data as planned. IDR is intended to be the central repository of Medicare and Medicaid data needed to help CMS and states' program integrity staff and contractors prevent and detect improper payments. Program integrity analysts use these data to identify patterns of unusual activities or transactions that may indicate fraudulent charges or other types of improper payments. IDR has been operational and in use since September 2006 but did not include all the data that were planned to be incorporated by fiscal year 2010. For example, IDR included most types of Medicare claims data, but not the Medicaid data needed to help analysts detect improper payments of Medicaid claims. According to program officials, these data were not incorporated because of obstacles introduced by technical issues and delays in funding. Until the agency finalizes plans and develops reliable schedules for efforts to incorporate these data, CMS may face additional delays in making available all the data that are needed to support enhanced Medicare and Medicaid program integrity efforts.

Additionally, CMS had not taken steps to ensure widespread use of One PI to enhance efforts to detect fraud, waste, and abuse. One PI is a web-based portal that is to provide CMS staff and contractors, and Medicaid analysts with a single source of access to data contained in IDR, as well as tools for analyzing those data. While One PI had been developed and deployed to users, no Medicaid analysts and only a few Medicare program integrity analysts were trained and using the system. Specifically, One PI program officials planned for 639 program integrity analysts, including 130 Medicaid analysts, to be using the system by the end of fiscal year 2010; however, as of October 2010, only 41—less than 7 percent—were actively using the portal and tools. According to program officials, the agency's initial training plans were insufficient and, as a result, they were not able to train the intended community of users. Until program officials finalize plans and develop reliable schedules for training users and expanding the use of One PI, the agency may continue to experience delays in reaching widespread use of the system.

While CMS had made progress toward its goals to provide a single repository of data and enhanced analytical capabilities for program integrity efforts, the agency was not yet positioned to identify, measure, and track benefits realized from its efforts. As a result, it was unknown whether IDR and One PI as implemented had provided financial benefits. According to IDR officials, they did not measure benefits realized from increases in the detection rate for improper payments because they relied on business owners to do so; One PI officials stated that, because of the limited use of that system, there were not enough data to measure and gauge the program's success toward achieving the $21 billion in financial benefits that the agency projected.

Chairmen Platts and Gowdy, Ranking Members Towns and Davis, and Members of the Subcommittees:

I am pleased to participate in today's hearing on fraud and improper payments in the Medicaid program. At your request, my testimony will focus on our report earlier this year that examined the Centers for Medicare and Medicaid Services' (CMS) efforts to protect the integrity of the Medicare and Medicaid programs through the use of information technology. Specifically, in June 2011 we reported on CMS's utilization of automated systems and tools to help improve the detection of fraudulent, wasteful, and abusive claims that contribute to the billions of taxpayers' dollars lost each year to improper payments within these programs.[1]

Operating within the Department of Health and Human Services, CMS conducts reviews to prevent improper payments before Medicare and Medicaid claims are paid and to detect claims that were paid in error. These activities are predominantly carried out by contractors who, along with CMS personnel, use various information technology solutions to consolidate and analyze data to help identify the improper payment of claims. For example, these program integrity analysts may use software tools to access data about claims and then use those data to identify patterns of unusual activities by attempting to match services with patients' diagnoses.

In 2006, CMS initiated activities to centralize and make more accessible the data needed to conduct these analyses and to improve the analytical tools available to its own and contractor analysts. Our June 2011 report discussed two of these initiatives—the Integrated Data Repository (IDR), which is intended to provide a single source of data related to Medicare and Medicaid claims, and the One Program Integrity (One PI) system, a web-based portal[2] and suite of analytical software tools used to extract data from IDR and enable complex analyses of these data. According to CMS officials responsible for developing and implementing IDR and One PI, the agency had spent approximately $161 million on these initiatives by the end of fiscal year 2010..

[1]GAO, *Fraud Detection Systems: Centers for Medicare and Medicaid Services Needs to Ensure More Widespread Use*, GAO-11-475 (Washington, D.C.: June 30, 2011).

[2]The One PI portal is a web-based user interface that enables a single login through centralized, role-based access to the system.

My testimony summarizes the results of our prior study, which specifically assessed the extent to which IDR and One PI had been developed and implemented, and CMS's progress toward achieving its goals and objectives for using these systems to detect fraud, waste, and abuse. The information presented is based primarily on our previous work at CMS. Additional information on our scope and methodology is available in the issued report.[3] We also obtained and conducted a review of more recent documentation pertaining to the agency's efforts to develop and implement the systems. We conducted this work in support of our testimony during November and December 2011 at CMS headquarters in Baltimore, Maryland. All work on which this testimony is based was conducted in accordance with generally accepted government auditing standards.

Background

Like financial institutions, credit card companies, telecommunications firms, and other private sector companies that take steps to protect customers' accounts, CMS uses information technology to help predict or detect cases of improper claims and payments. For more than a decade, the agency and its contractors have used automated software tools to analyze data from various sources to detect patterns of unusual activities or financial transactions that indicate payments could be made for fraudulent charges or improper payments. For example, to identify unusual billing patterns and support investigations and referrals for prosecutions of cases, analysts and investigators access information about key actions taken to process claims as they are filed and the specific details about claims already paid. This would include accessing information on claims as they are billed, adjusted, and paid or denied; check numbers on payments of claims; and other specific information that could help establish provider intent.

CMS uses many different means to store and manipulate data and, since the establishment of the agency's program integrity initiatives in the 1990s, has built multiple disparate databases and analytical software tools to meet individual and unique needs of various programs within the agency. In addition, data on Medicaid claims are scattered among the states in multiple systems and data stores, and are not readily available to CMS. According to agency program documentation, these

[3] GAO-11-475.

geographically distributed, regional approaches to storing and analyzing data result in duplicate data and limit the agency's ability to conduct analyses of data on a nationwide basis.

CMS has been working for most of the past decade to consolidate its disparate data and analytical tools. The agency's efforts led to the IDR and One PI programs, which are intended to provide CMS and its program integrity contractors with a centralized source of Medicare and Medicaid data and a web-based portal and set of analytical tools by which these data can be accessed and analyzed to help detect cases of fraud, waste, and abuse.

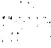
CMS's Initiative to Develop a Centralized Source of Medicare and Medicaid Data

In 2006, CMS officials expanded the scope of a 3-year-old data modernization strategy to not only modernize data storage technology, but also to integrate Medicare and Medicaid data into a centralized repository so that CMS and its partners could access the data from a single source. They called the expanded program IDR.

According to program officials, the agency's vision was for IDR to become the single repository for CMS's data and enable data analysis within and across programs. Specifically, this repository was to establish the infrastructure for storing data related to Medicaid and Medicare Parts A, B, and D claims processing,[4] as well as a variety of other agency functions, such as program management, research, analytics, and business intelligence. CMS envisioned an incremental approach to incorporating data into IDR. Specifically, it intended to incorporate data related to paid claims for Medicare Part D by the end of fiscal year 2006, and for Medicare Parts A and B by the end of fiscal year 2007. The agency also planned to begin to incrementally add all Medicaid data for the 50 states in fiscal year 2009 and to complete this effort by the end of fiscal year 2012.

Initial program plans and schedules also included the incorporation of additional data from legacy CMS claims-processing systems that store

[4]Medicare Part A provides payment for inpatient hospital, skilled nursing facility, some home health, and hospice services, while Part B pays for hospital outpatient, physician, some home health, durable medical equipment, and preventive services. Further, all Medicare beneficiaries may purchase coverage for outpatient prescription drugs under Medicare Part D.



and process data related to the entry, correction, and adjustment of claims as they are being processed, along with detailed financial data related to paid claims. According to program officials, these data, called "shared systems" data, are needed to support the agency's plans to incorporate tools to conduct predictive analysis of claims as they are being processed, helping to prevent improper payments. Shared systems data, such as check numbers and amounts related to claims that have been paid, are also needed by law enforcement agencies to help with fraud investigations. CMS initially planned to have all the shared systems data included in IDR by July 2008.

Table 1, presented in our prior report, summarized CMS's original planned dates and actual dates for incorporating the various types of data into IDR as of the end of fiscal year 2010.

Table 1: Data Incorporated into IDR as of the End of Fiscal Year 2010

Type of data	Original planned date	Actual date
Medicare Part D	January 2006	January 2006
Medicare Part B	September 2007	May 2008
Medicare Part A	September 2008	May 2008
Shared systems	July 2008	Not incorporated (planned for November 2011)
Medicaid for 5 states	September 2009	Not incorporated (planned for September 2014)
Medicaid for 20 states	September 2010	Not incorporated (planned for September 2014)
Medicaid for 35 states	September 2011	Not incorporated (planned for September 2014)
Medicaid for 50 states	September 2012	Not incorporated (planned for September 2014)

Source: GAO analysis of CMS data

CMS's Initiative to Develop and Implement Analytical Tools for Detecting Fraud, Waste, and Abuse

Also.in 2006, CMS initiated the One PI program with the intention of developing and implementing a portal and software tools that would enable access to and analysis of claims, provider, and beneficiary data from a centralized source. The agency's goal for One PI was to support the needs of a broad program integrity user community, including agency program integrity personnel and contractors who analyze Medicare claims data, along with state agencies that monitor Medicaid claims. To achieve its goal, CMS officials planned to implement a tool set that would provide a single source of information to enable consistent, reliable, and timely

analyses and improve the agency's ability to detect fraud, waste, and abuse. These tools were to be used to gather data from IDR about beneficiaries, providers, and procedures and, combined with other data, find billing aberrancies or outliers. For example, an analyst could use software tools to identify potentially fraudulent trends in ambulance services by gathering the data about claims for ambulance services and medical treatments, and then use other software to determine associations between the two types of services. If the analyst found claims for ambulance travel costs but no corresponding claims for medical treatment, it might indicate that further investigation could prove that the billings for those services were fraudulent.

According to agency program planning documentation, the One PI system was also to be developed incrementally to provide access to IDR data, analytical tools, and portal functionality. CMS planned to implement the One PI portal and two analytical tools for use by program integrity analysts on a widespread basis by the end of fiscal year 2009. The agency engaged contractors to develop the system.

IDR and One PI Were in Use, but Lacked Data and Functionality Essential to CMS's Program Integrity Efforts

IDR had been in use by CMS and its contractors who conduct Medicare program integrity analysis since September 2006 and incorporated data related to claims for reimbursement of services under Medicare Parts A, B, and D. According to program officials, the integration of these data into IDR established a centralized source of data previously accessed from multiple disparate system files.

However, although the agency had been incorporating data from various data sources since 2006, our prior report noted that IDR did not include all the data that were planned to be incorporated by the end of 2010 and that are needed to support enhanced program integrity initiatives. For example, IDR did not include the Medicaid data that are critical to analysts' ability to detect fraud, waste, and abuse in this program. While program officials initially planned to incorporate 20 states' Medicaid data into IDR by the end of fiscal year 2010, the agency had not incorporated any of these data into the repository. Program officials told us that the original plans and schedules for obtaining Medicaid data did not account for the lack of funding for states to provide Medicaid data to CMS, or the variations in the types and formats of data stored in disparate state Medicaid systems. Consequently, the officials were not able to collect the data from the states as easily as they expected and did not complete this activity as originally planned.

In December 2009, CMS initiated another agencywide program intended to, among other things, identify ways to collect Medicaid data from the many disparate state systems and incorporate the data into a single data store. As envisioned by CMS, this program, the Medicaid and Children's Health Insurance Program Business Information and Solutions (MACBIS) program, was to include activities in addition to providing expedited access to current data from state Medicaid programs. According to agency planning documentation, as a result of efforts to be initiated under the MACBIS program, CMS would incorporate Medicaid data for all 50 states into IDR by the end of fiscal year 2014.

However, program officials had not defined plans and reliable schedules for incorporating these data into IDR. Until the agency does so, it cannot ensure that current development, implementation, and deployment efforts will provide the data and technical capabilities needed to enhance efforts to detect potential cases of fraud, waste, and abuse.

In addition to the Medicaid data, initial program integrity requirements included the incorporation of the shared systems data by July 2008; however, all of these data had not been added to IDR. According to IDR program officials, the shared systems data were not incorporated as planned because funding for the development of the software and acquisition of the hardware needed to meet this requirement was not approved until the summer of 2010. Subsequently, IDR program officials developed project plans and identified user requirements. In updating us on the status of this activity, the officials told us in November 2011 that they began incorporating shared systems data in September 2011 and plan to make them available to program integrity analysts in spring 2012.

Beyond the IDR initiative, CMS program integrity officials had not taken appropriate actions to ensure the use of One PI on a widespread basis for program integrity purposes. According to program officials, the system was deployed to support Medicare program integrity goals in September 2009 as originally planned and consisted of a portal that provided web-based access to software tools used by CMS and contractor analysts to retrieve and analyze data stored in IDR. As implemented, the system provided access to two analytical tools—a commercial off-the-shelf decision support tool that is used to perform data analysis to, for example, detect patterns of activities that may identify or confirm suspected cases of fraud, waste, or abuse, and another tool that provides users extended capabilities to perform more complex analyses of data. For example, it allows the user to

customize and create ad hoc queries of claims data across the three Medicare plans.

However, while program officials deployed the One PI portal and two analytical tools, the system was not being used as widely as planned because CMS and contractor analysts had not received the necessary training. In this regard, program planning documentation from August 2009 indicated that One PI program officials had planned for 639 analysts to be trained and using the system by the end of fiscal year 2010, including 130 analysts who conduct reviews of Medicaid claims.[5] However, CMS confirmed that by the end of October 2010, only 42 Medicare analysts who were intended to use One PI had been trained, with 41 actively using the portal and tools. These users represented fewer than 7 percent of the users originally intended for the program.

Further, no Medicaid analysts had been trained to use the system. While the use of One PI cannot be fully optimized for Medicaid integrity purposes until the states' Medicaid claims data are incorporated into IDR, the tools provided by the system could be used to supplement data currently available to Medicaid program integrity analysts and to enhance their ability to detect payments of fraudulent claims. For example, with training, Medicaid analysts may be able to compare data from their state systems to Medicare claims data in IDR to identify duplicate claims for the same service.

Program officials responsible for implementing the system acknowledged that their initial training plans and efforts had been insufficient and that they had consequently initiated activities and redirected resources to redesign the One PI training plan in April 2010; they began to implement the new training program in July of that year.

As we reported in June, One PI officials stated that 62 additional analysts had signed up to be trained in 2011, and that the number of training classes for One PI had been increased from two to four per month. Agency officials, in commenting on our report, stated that since January

[5] This group of analysts included state Medicaid program integrity personnel along with CMS analysts who implement the Medi-Medi data match program. This program was established in 2001 and was designed to identify improper billing and utilization patterns by matching Medicare and Medicaid claims information on providers and beneficiaries to reduce fraudulent schemes that cross program boundaries.

2011, 58 new users had been trained; however, they did not identify an increase in the number of actual users of the system.[6]

Nonetheless, while these activities indicated some progress toward increasing the number of One PI users, the number of users reported to be trained and using the system represented a fraction of the population of 639 intended users. Moreover, One PI program officials had not yet made detailed plans and developed schedules for completing training of all the intended users. Agency officials concurred with our conclusion that CMS needed to take more aggressive steps to ensure that its broad community of analysts is trained, including those who conduct analyses of Medicaid claims data. Until it does so, the use of One PI may remain limited to a much smaller group of users than the agency intended and CMS will continue to face obstacles in its efforts to deploy One PI for widespread use throughout its community of program integrity analysts.

CMS Was Not Yet Positioned to Identify Financial Benefits or to Fully Meet Program Integrity Goals and Objectives through the Use of IDR and One PI

Because IDR and One PI were not being used as planned, CMS officials were not in a position to determine the extent to which the systems were providing financial benefits or supporting the agency's initiatives to meet program integrity goals and objectives. As we have reported, agencies should forecast expected benefits and then measure actual financial benefits accrued through the implementation of IT programs.[7] Further, the Office of Management and Budget (OMB) requires agencies to report progress against performance measures and targets for meeting them that reflect the goals and objectives of the programs.[8] To do this, performance measures should be outcome-based and developed with stakeholder input, and program performance must be monitored, measured, and compared to expected results so that agency officials are

[6] In further updating these data, on November 30, 2011, CMS officials reported to us that a total of 215 program integrity analysts had been trained and were using One PI, including 51 Medi-Medi and state Medicaid analysts. However, we did not validate the data provided to us by program officials on November 30, 2011.

[7] GAO, *Secure Border Initiative: DHS Needs to Reconsider Its Proposed Investment in Key Technology Program*, GAO-10-340 (Washington, D.C.: May 5, 2010) and *DOD Business Systems Modernization: Planned Investment in Navy Program to Create Cashless Shipboard Environment Needs to be Justified and Better Managed*, GAO-08-922 (Washington, D.C.: Sept. 8, 2008).

[8] Office of the President, Office of Management and Budget, *Guide to the Program Assessment Rating Tool* (Washington, D.C.: January 2008).

able to determine the extent to which goals and objectives are being met. In addition, industry experts describe the need for performance measures to be developed with stakeholders' input early in a project's planning process to provide a central management and planning tool and to monitor the performance of the project against plans and stakeholders' needs.

While CMS had shown some progress toward meeting the programs' goals of providing a centralized data repository and enhanced analytical capabilities for detecting improper payments due to fraud, waste, and abuse, the implementation of IDR and One PI did not yet position the agency to identify, measure, and track financial benefits realized from reductions in improper payments as a result of the implementation of either system. For example, program officials stated that they had developed estimates of financial benefits expected to be realized through the use of IDR. Their projection of total financial benefits was reported to be $187 million, based on estimates of the amount of improper payments the agency expected to recover as a result of analyzing data provided by IDR. With estimated life cycle program costs of $90 million through fiscal year 2018, the resulting net benefit expected from implementing IDR was projected to be $97 million. However, as of March 2011, program officials had not identified actual financial benefits of implementing IDR.

Further, program officials' projection of financial benefits expected as a result of implementing One PI was reported to be approximately $21 billion. This estimate was increased from initial expectations based on assumptions that accelerated plans to integrate Medicare and Medicaid data into IDR would enable One PI users to identify increasing numbers of improper payments sooner than previously estimated, thus allowing the agency to recover more funds that have been lost due to payment errors.

However, the implementation of One PI had not yet produced outcomes that positioned the agency to identify or measure financial benefits. CMS officials stated at the end of fiscal year 2010—more than a year after deploying One PI—that it was too early to determine whether the program had provided any financial benefits. They explained that, since the program had not met its goal for widespread use of One PI, there were not enough data available to quantify financial benefits attributable to the use of the system. These officials said that as the user community expanded, they expected to be able to begin to identify and measure financial and other benefits of using the system.

In addition, program officials had not developed and tracked outcome-based performance measures to help ensure that efforts to implement One PI and IDR would meet the agency's goals and objectives for improving the results of its program integrity initiatives. For example, outcome-based measures for the programs would indicate improvements to the agency's ability to recover funds lost because of improper payments of fraudulent claims. However, while program officials defined and reported to OMB performance targets for IDR related to some of the program's goals, they did not reflect the goal of the program to provide a single source of Medicare and Medicaid data that supports enhanced program integrity efforts. Additionally, CMS officials had not developed quantifiable measures for meeting the One PI program's goals. For example, performance measures and targets for One PI included increases in the detection of improper payments for Medicare Parts A and B claims. However, the limited use of the system had not generated enough data to quantify the amount of funds recovered from improper payments.

Moreover, measures of One PI's program performance did not accurately reflect the existing state of the program. Specifically, indicators to be measured for the program included the number of states using One PI for Medicaid integrity purposes and decreases in the Medicaid payment error rate; however, One PI did not have access to those data because they were not yet incorporated into IDR.

Because it lacked meaningful outcome-based performance measures and sufficient data for tracking progress toward meeting performance targets, CMS did not have the information needed to ensure that the systems were useful to the extent that benefits realized from their implementation could help the agency meet program integrity goals. Until the agency is better positioned to identify and measure financial benefits and establishes outcome-based performance measures to help gauge progress toward meeting program integrity goals, it cannot be assured that the systems will contribute to improvements in CMS's ability to detect and prevent fraud, waste, and abuse, and improper payments of Medicare and Medicaid claims.

CMS Needs to Take Actions to Achieve Widespread Use of IDR and One PI

Given the critical need for CMS to reduce improper payments within the Medicare and Medicaid programs, we included in our June 2011 report a number of recommended actions that we consider vital to helping the agency achieve more widespread use of IDR and One PI for program integrity purposes. Specifically, we recommended that the Administrator of CMS

- finalize plans and develop schedules for incorporating additional data into IDR that identify all resources and activities needed to complete tasks and that consider risks and obstacles to the IDR program;
- implement and manage plans for incorporating data in IDR to meet schedule milestones;
- establish plans and reliable schedules for training all program integrity analysts intended to use One PI;
- establish and communicate deadlines for program integrity contractors to complete training and use One PI in their work;
- conduct training in accordance with plans and established deadlines to ensure schedules are met and program integrity contractors are trained and able to meet requirements for using One PI;
- define any measurable financial benefits expected from the implementation of IDR and One PI; and
- with stakeholder input, establish measurable, outcome-based performance measures for IDR and One PI that gauge progress toward meeting program goals.

In commenting on a draft of our report, CMS agreed with the recommendations and indicated that it planned to take steps to address the challenges and problems that we identified during our study.

In conclusion, CMS's success toward meeting goals to enhance program integrity efforts through the use of IDR and One PI depends upon the incorporation of all needed data into IDR, and effective use of the systems by the agency's broad community of Medicare and Medicaid program integrity analysts. It is also essential that the agency identify measurable financial benefits and performance goals expected to be attained through improvements in its ability to prevent and detect

fraudulent, wasteful, and abusive claims and resulting improper payments. In taking these steps, the agency will better position itself to determine whether these systems are useful for enhancing CMS's ability to identify fraud, waste, and abuse and, consequently, reduce the loss of billions of dollars to improper payments of Medicare and Medicaid claims.

Chairmen Platts and Gowdy, Ranking Members Towns and Davis, and Members of the Subcommittees, this concludes my prepared statement. I would be pleased to answer any questions that you may have.

GAO Contact and Staff Acknowledgments

If you have questions concerning this statement, please contact Valerie C. Melvin, Director, Information Management and Technology Resources Issues, at (202) 512-6304 or melvinv@gao.gov. Other individuals who made key contributions include Teresa F. Tucker (Assistant Director), Amanda C. Gill, and Lee A. McCracken.

Mr. PLATTS. Thank you, Ms. Melvin.

We will begin questions. I will yield myself 5 minutes to begin this round of questions. And I certainly appreciate all four of your testimonies and your efforts in regard to protecting American taxpayer funds and ensuring that we are properly caring for and providing services.

Ms. Brice-Smith, I am going to begin with you. And I certainly appreciate the breadth and depth of your testimony on what we are trying to do. I have to be honest with you that I am surprised after hearing the testimony of Mr. West that as a representative of CMS, you did not acknowledge how badly we failed him and how I believe CMS—specifically our government in total—owes him an apology. And I worry that that's a sign of trouble for us in trying to address this issue because we can have great programs in place, but if we're not listening to the beneficiaries—I mean, having a hotline's great. Teaching beneficiaries how to detect and report fraud is great. He did. And we didn't do anything in response.

So I do have to express that I was disappointed that you did not acknowledge what he went through to make sure that we, as a government, did right by the taxpayers and by him. Because if he was denied services, how many other citizens are out there who are being denied services because of fraudulent conduct? So more of a statement there than a question, I guess.

But specific to his case is, to the best of your knowledge, has CMS begun and conducted any investigation of why we did not heed Mr. West's claims of fraud and that it resorted to him hiring a private attorney to have it investigated?

Ms. BRICE-SMITH. When I heard Mr. West's story, I was very much touched by what he said. And I was trying to figure out what was the root cause and how did that happen. But when he said that he communicated with State officials, I felt like that was appropriate. Medicaid is run by the States. And he indicated he spoke with local people. That was in 2004. And as Ms. Melvin indicated, we had less than six full-time equivalents that even—there was no Medicaid Integrity Group back in 2004. The DRA didn't happen until 2005. We started the building of that infrastructure for staff in 2006. So there was no existence of Federal level contact, if you will. We had—prior to 2005—six full-time equivalents that had no funding, that supported the States when questions came into CMS. So there was really no structural vehicle at the Federal level in 2004.

Mr. PLATTS. I think the point's well made. And that's what your testimony is for, we are trying to do much better today at the Federal level.

But I guess while we didn't have it in 2004 in place, New Jersey, as the operator or the provider of the Medicare services that we're helping to fund, did and was responsible. And I guess what I'm saying, have we even gone back to New Jersey and said, Listen, this is a case where you blatantly failed somebody that we're paying you know a huge share of you to provide this service; and because of your failure, you know, tens of millions of dollars was being lost and but for that private citizen's efforts would have been forever lost. So what has New Jersey done—in other words, what did New Jersey do to better ensure that it's not repeated?

And even though that may be at the State level in addition to what we're doing, CMS has a responsibility to make sure they are doing that. Have we made those types of inquiries to New Jersey to make sure they're doing much better?

Ms. BRICE-SMITH. Yes, we have. We did contact New Jersey and request information about what happened and what was their information in terms of how the communications took place. We're still looking at that information to understand what actions that they plan to take to mitigate that in the future.

In the meantime, CMS has taken a number of actions related to how to report fraud, who are the contacts in the State, even through the 1–800 Medicare line. There's a clear vehicle for people to be able to reach us at any time.

Mr. PLATTS. And I think that's critically important because of the efforts of trying to encourage beneficiaries who, as we talked with the previous panel, are truly on the front lines. They are the ones who see the inaccurate information, you know, if they're diligent as Mr. West was and those are the ones who are suffering the consequences if they're fraudulently taken advantage of because of denying services.

So having a system in place is one thing, but making sure we respond to the information that comes in to that system is going to be key.

A final question here and then my time is going to be up. Regarding Maxim itself. Can you—I don't know if you have it here with you today or if can estimate. For this year, fiscal year 2011 that just ended, roughly how much money did Maxim receive under the Medicaid program nationally?

Ms. BRICE-SMITH. I would have to research that question. I don't have that information.

Mr. PLATTS. If you could provide that. My guess is it's hundreds of millions, if not billions of dollars as a provider in 41 States, they're probably receiving. And as Mr. Cummings in the previous round specified, it just is, to me, incredible that someone who knowingly, intentionally a company defrauded the American people to the tune of tens of millions and if not more—this is what we know of—and would never have known of but for the heroic efforts of a private citizen that that company is still receiving hundreds of millions, if not billions, of dollars from the American taxpayers to provide a service. And it just, to me, sends a terrible message, as Mr. Cummings said, that companies are going to just look at this as the cost of doing business. Hey, if we get caught, we just pay a fine and we just factor that in, but we keep getting the business. And in the real world, the private sector, if you defrauded somebody $130—$150 million, I guarantee you, you are not going to be doing business with that company anymore. And they shouldn't be doing business with the American taxpayers. So we need to do much better. And I know there's also a criminal side that we may get into with Mr. Gowdy.

So my time is well expired. I yield to the ranking member, Mr. Davis from Illinois.

Mr. DAVIS. Thank you very much, Mr. Chairman. The Affordable Care Act put into place various provisions. And of course, it was just passed last year to help fight fraud and abuse in Medicare and

Medicaid. The Congressional Budget Office estimates that these provisions, when fully implemented, will save the American taxpayers $7 billion over the next 10 years.

Ms. Brice-Smith, can you describe the tools and technical changes to the anti-fraud laws that are included in the Affordable Care Act that will directly benefit your office?

Ms. BRICE-SMITH. Sure. In the Affordable Care Act, it offered up several things related to provider enrollment and screening. And we believe that that's the best tool for making sure that we keep people who are more fraudulent or fraudsters out of the program and also be in a place to reverify and validate them over time to make sure that we can keep them out of the program or adjust our scrutiny of them through risk assessments, if you will, over time. So that's part of that.

Then there is the payment of suspension activity with respect to changing the level of proof, if you will, from a reliable evidence-based allegation to a credible allegation; that will also give us additional flexibility.

Then there's also the opportunity for a temporary moratorium that can be effectuated through that vehicle as well.

And also Congress recognized the shortcomings of the data, as we've recognized the shortcomings of the data, in the Medicaid program and offered up section 6504 that will allow us to strengthen the data elements that we desire and need for program integrity purposes.

Mr. DAVIS. Thank you. Mr. Cantrell, what specific aspects of fraud detection do you think will be most positively impacted by the activity that has been included or the provisions included in the Affordable Care Act?

Mr. CANTRELL. One of the things that was included in the Affordable Care Act are stiffer penalties, stiffer sentences for those convicted of health care fraud. And we believe, as was discussed during the first panel, that stiffer sentences are important in deterring ongoing fraud.

Mr. DAVIS. Let me ask you and Ms. Brice-Smith, knowing that there are some of our colleagues who have put forth efforts and have continued to push for a repeal of the Affordable Care Act, if that was to happen, do you see your organizations being affected in any way, certainly negatively affected if we were to repeal the Affordable Care Act?

Ms. BRICE-SMITH. Before the Affordable Care Act, we had improper payments. One would argue that I think we would still have the concerns around improper payments. I think we are working very diligently to address them.

I think many of the concerns I think around repeal seem to be around the growth or the expansion of the programs, and what I have seen from Congress is a recognition that you have provided commensurate administrative tools and authorities to expand our efforts commensurate with that growth.

Mr. CANTRELL. We did receive additional funding for our organization through the Affordable Care Act, and we were able to hire almost 100 new investigators so that was certainly welcome.

Mr. DAVIS. Could I suggest that the Affordable Care Act strengthens your ability to weed out fraud and abuse in Medicare and Medicaid?

Ms. BRICE-SMITH. I would agree with that, yes.

Mr. CANTRELL. Some of the tools and certainly the additional agents on the ground will definitely assist us in weeding out additional fraud.

Mr. DAVIS. Thank you very much and thank you Mr. Chairman.

Mr. PLATTS. I thank the gentleman for yielding back.

I recognize the subcommittee chairman Mr. Gowdy.

Mr. GOWDY. Thank you, Mr. Chairman.

Ms. Brice-Smith, which States have the highest rate of improper payments?

Ms. BRICE-SMITH. That is a very good question. We are aware of which States they are. We do what we refer to as a payment error rate measurement that bans 17 States on a 3-year cycle. We engage those States and expect corrective actions from those individual States. But we do not release it publicly.

Mr. GOWDY. Well, I was looking for the name of a State because it strikes me that you want to put your law enforcement/prosecutorial resources where there is the highest level of graft or fraud or waste or abuse.

So which five States would have the highest improper payment ratios?

Ms. BRICE-SMITH. We would gladly share any of those data with our law enforcement partners, but we usually do not disclose them.

Mr. GOWDY. Why? There are four States being sued right now by the Department of Justice for having the unmitigated temerity to want to enforce immigration laws. Why the reluctance to say which States can't get their act together with respect to Medicaid payments? What is the reluctance?

Ms. BRICE-SMITH. I think it could be perceived as somewhat punitive. I think there is a desire by CMS to work with our State partners to address the improper payments in a meaningful way. We are continuing to do that. The States know who they are. We work with them on a corrective action plans. We follow up on that.

Mr. GOWDY. Do this for me then: Tell me are there any States that on an annual basis just don't seem to get their act together? I can understand not wanting to dime out an episodic State that just had one bad year but then later engaged in corrective actions. Are there any States that just have a history of Medicaid overpayments?

Ms. BRICE-SMITH. I cannot for certain give you the repeated findings because it is early in the per-measurement cycles. We have now completed the fourth year of measuring the States, so we have passed the cycle of the first 17 States now being examined for the second time.

Mr. GOWDY. So you know who the States are, agreed?

Ms. BRICE-SMITH. I do not personally know who the States are, but my colleagues do.

Mr. GOWDY. Someone does know, and they've made the decision to not publicize the States that are doing the worst job?

Ms. BRICE-SMITH. I think our desire is to work with our State partners, and we are continuing to do that in a meaningful way, and we will continue to do so.

Mr. GOWDY. Mr. Cantrell, I was under the mistaken impression, apparently, that the amount of loss impacted the amount of time you went to jail. Apparently, that's not the case, because in the Maxim case, other than watching television at home for 3 months, I only saw one person go to a Federal Bureau of Prison. And that was for what, 5 months? So has that changed since I left the U.S. Attorney's Office? Is the amount of loss or the amount of the fraud no longer a factor in the length of a prison sentence?

Mr. CANTRELL. The amount of fraud is a factor in the prison sentence, and it would depend though on the individuals who were convicted the amount of fraud that was actually attributed to them.

Mr. GOWDY. They still don't have relevant conduct.

Mr. CANTRELL. There is relevant conduct that is taken into consideration.

Mr. GOWDY. They do in the drug cases, they take the lowest mule in a cocaine conspiracy, and they dump all the drugs they can possibly dump on them. But it doesn't happen when it's rich folk committing the crime.

Mr. CANTRELL. I don't think that is the case, sir. I think a recent example we are seeing increased sentences throughout the country——

Mr. GOWDY. Let me ask you about that. Let me ask you about that. How many motions for upward departure are you aware of being filed?

Mr. CANTRELL. I don't have that information, sir. That would be the Department of Justice.

Mr. GOWDY. Can you get that for me? Can you find out? Because that is a really good indicator to me about how serious someone is about criminal activity, whether or not they are going to move that the sentence be higher than what the guideline was? If you can tell me where to find that, I will be happy to do that myself.

Mr. PLATTS. If the gentleman would yield.

Mr. Cantrell, if you could submit that to the committee for the record, that would be great.

Mr. CANTRELL. We will have to get that information from the Department of Justice, but we will work with them to identify what we need to get and provide it to you.

Mr. PLATTS. I thank the gentleman for yielding.

Mr. GOWDY. Thank you, Mr. Chairman.

My final question is, do you believe there is a presumption in favor of criminal prosecution over civil enforcement? When you prosecute somebody criminally, not only can you recoup the losses, but you also get to punish people. So is there a presumption in favor of criminal over civil?

Mr. CANTRELL. That is our presumption in the Office of Inspector General, Office of Investigations.

Mr. GOWDY. What about the U.S. Attorney's Office in the Department of Justice?

Mr. CANTRELL. I believe that is also the case with the U.S. Attorney's Office when there is evidence to support a criminal indictment.

Mr. GOWDY. You heard the facts of Mr. West's case. That wouldn't be a hard case for you and I to win would it?

Mr. CANTRELL. I can't comment on the specifics of that.

Mr. GOWDY. Sure you can. He just announced it to the whole world. Even you and I can win a case where you are billing someone while they're at the U.S. Attorney's Office for a meeting; you and I could win that, couldn't we?

Mr. CANTRELL. That case, it sounds obvious, there are I'm sure several factors that we went into decisions at the U.S. Attorney's Office to determine who to prosecute and who not to prosecute.

Mr. GOWDY. I yield back.

Mr. PLATTS. I thank the gentleman for yielding back.

The ranking member of the full committee, Mr. Cummings, recognized for 5 minutes.

Mr. CUMMINGS. To Ms. Brice-Smith and to Mr. Cantrell, as you heard, I was very upset that a kid from Baltimore, thousands of them by the way, thousands, can face a lifetime of economic punishment over a few hundred dollars stolen, yet a company like Maxim can be found guilty of stealing from taxpayers, pay a fine and continue to bill the Federal Government for millions of dollars of services each year.

Ms. Brice-Smith, do you share that sentiment? Something is wrong with that picture.

Ms. BRICE-SMITH. I'm equally concerned about the equity that you have pointed out.

Mr. CUMMINGS. Yeah, and who has the power, by the way, do you all have the power, who has the power to debar these companies?

Mr. CANTRELL. We do have the power to exclude providers.

Mr. CUMMINGS. Have you ever done it can?

Mr. CANTRELL. Certainly, we do.

Mr. CUMMINGS. Why not this company?

Mr. CANTRELL. The decisions on who to exclude is based on several factors, including access to care as well as the specific conduct and the expectation of whether they will continue the bad behavior or not. We utilize, in cases where we do not exclude corporations, we utilize corporate integrity agreements, in this case, there was a deferred prosecution agreement where we will monitor this corporation in hopes to——

Mr. CUMMINGS. To hell with monitoring. They've already done it. If you had somebody working in your house, cleaning your house and you came home and your wife's bracelet that was worth $50 is missing, you don't hire them again. Duh.

What do mean deferred prosecution? This company needs to go. How many other companies are like this or, in other words, have defrauded the people of the United States of America, have taken away services from people like our witness, our earlier witnesses, and are still doing business with Medicaid? How many?

You're the IG. You sat up here and you said all these wonderful things, sounds nice, oh we're doing this, and we're doing that. That's real nice. But what I'm trying to tell you is that your normal is not good enough. If you're going to come in here with a badge on your chest and talk about what you've done in a company that's taken millions of dollars away from taxpayers is still doing busi-

ness, and they come in 41 States and have said, all right, we're ready to do business again, yeah, we've stolen from you, but we're ready to go. And we say, okay, all right, we'll do it. Something is wrong with that picture, and you're the IG. So is that the normal that we should expect?

Here we are slashing budgets, people talking about slashing Medicare, slashing Medicaid, slashing Social Security, and we've got some greedy folks who are out there stealing money from people, and you're going to tell me that we have the power to debar, and we're not using it? In what case will we use it?

Mr. CANTRELL. We use it, on average, nearly 3,000 times every year.

Mr. CUMMINGS. Well, why not this company?

Mr. CANTRELL. As I said, there are factors that play into the decision, depending on whether they are criminally convicted or whether there's going to be an impact to access to care going forward and their expectation of whether or not they will continue to commit the fraud or whether we believe that, through compliance monitoring, we can bring them into the fold and allow them to continue to provide services to the population that they are serving.

Mr. CUMMINGS. Oh. Oh. The fact that maybe they steal your wife's broach, you say to her, or the cleaning person, you say to her, oh, Ms. Jane or Mr. Johnson, yeah, you have stolen a broach, but we want you to come back in because we think you can be rehabilitated. We think the next time you have a cleaning assignment, you won't take the diamond ring. Something is wrong with that picture. And I guess what I'm trying to get through to you is that that is not the normal. Our country is better than that.

And there are people in my district that are suffering because they can't get the services they need, but yet and still, we are letting these companies do this.

And by the way, there are other situations in government where people did much less than this, and they'd be out. Again, I go back to the young boys and girls in my district, some of whom live in my block and if they stole a $300 bike, they would be punished for a lifetime, not a day, not an hour. And they damn sure wouldn't get a multimillion dollar contract and multimillion dollar contracts in 41 States.

I would be embarrassed to even come in here and stick out my chest talking about what I have accomplished when the company is still—they've got to be looking at us like we're fools. So I'm hoping that we'll be able to work in a bipartisan way to get rid of Maxim because see, all of this stuff you're talking about, it does not matter if the end result, Mr. Gowdy said part of it—I'm almost finished, Mr. Chairman—part of it is making sure somebody goes to jail, but there is another part.

That other part is saying to them that we are not going to allow you to do business and screw over the American people any more. That's the second part. And you can do all these things you're talking about, bring in all the technology you want to talk about all these wonderful things you're doing, but if there's not that end result, do you know what they do? They just come right back, and they pay the price, but they come right back.

Thank you, Mr. Chairman.

Mr. PLATTS. I thank the gentleman.

The gentleman from Arizona, Dr. Gosar, is recognized.

Mr. GOSAR. I got to tell you, this is great playing the closer on these two gentlemen right here. I couldn't agree more. Being a health care provider who did Medicaid for 7 years and left it for all the reasons they talked about, I did not stop; I just provided it for free.

This system, we are starting to talk about access to care, and the only provider is those that are thieving in one of the most densely populated parts of the country is absurd to me folks, absolutely absurd to me.

So I'm going to ask you something real quickly. I want to give you the opportunity to give yourself a grade in front of the American people on how you think you have done this job in regards to policing yourself.

Mrs. Brice-Smith, give yourself a grade.

Ms. BRICE-SMITH. In light of our youngness of our program——

Mr. GOSAR. I don't really care. Give me a grade.

Ms. BRICE-SMITH. C.

Mr. PLATTS. Mr. Cantrell.

Mr. CANTRELL. I would give us a B. I know—we know there is much more fraud out there that we need to attack, but we are improving every year. This last year was a record year with 720-plus criminal convictions, which is over 50 more than our previous record year, and $4.6 billion in recoveries through these criminal and civil fraud investigations.

Mr. GOSAR. I'm going to interrupt you there, because I think what you have to do is you are working on behalf of the American people, and I doubt that they would give you a above a D. Don't you agree with me?

I think so. I have been out there on Main Street walking this, and so I understand this very well. Because there is a missing component; the process, the whole process is broken here because the problem for this gentleman, Mr. West, here would have been a lot less if he was empowered to help make those decisions on the ground. And we have failed to do that.

Let me ask you a question, Ms. Brice-Smith, when we were looking at these innovative ideas of making some change, did you contact Visa or MasterCard on what may be some ideas they may have to reduce some of the fraud, waste and abuse?

Ms. BRICE-SMITH. CMS has engaged credit card companies in using the analytics and tools that they have available and try to apply that in the Medicare claims.

Mr. GOSAR. How would you look at that as far as the IT systems? I know that in a lot of the States in the IT system its lowest bid buys. That is not usually a good investment, as far as I'm concerned. Dentists love their toys, okay, and the better the IT, the better, and so sometimes it's not the most frugal decision that is always is better.

Would you agree?

Ms. BRICE-SMITH. Yes.

Mr. GOSAR. Do you work with the States in allowing them to have the flexibility to working with that?

Ms. BRICE-SMITH. Yes, we do. In fact, we have incentivized the States to upgrade and enhance their IT systems for the future. We have done that through setting what we refer to as a matching a 90–10 match, where they get additional funding, but we apply criteria or expectations to that funding so we can have a better system at the State level for the Medicaid claims.

Mr. GOSAR. So when you start looking at, I look at these two gentlemen looking at criminal prosecution, and very few people or fewer people, I should say, in the criminal division really want to renege on their rules of parole. And the reason I look at that and I bring it to point is called bounty hunters, is because they have a lot more eyes on the prize. There are some incentives. And it seems to me when you lot these F maps on reimbursement rates, we ought to be engaging the States for activity, as well as patients.

The first person who is going to know is the patient. And giving them some oversight on their bill. That's why it needs to be in hand. And I think that what we are trying to do is we're putting a Band-Aid here. And I will tell you I'm one of these people speaking I'm tired of Band-Aids here. I came to Congress to recorrect things. I think trying to reconstruct doing the same things over and over and expecting a different result is insanity, absolutely insanity.

But we need to start empowering patients. And that's not what you've done. There is no part of this—that does not empower these patients. And I can tell you I have firsthand knowledge of that. I served our dental patients who couldn't be seen by a federally qualified health center. I can repeat stories, not as bad as this because they're dental, but I can repeat this all day long. It's sad. Because I think what we ought to be doing is sharing that information all across the sandbox, not playing and not explaining who is a bad player here, and allowing them to be still participating to the rules is criminal. And it is criminal on our part for not changing it.

That's what's wrong here.

So let me ask you a question, I want to see thinking outside the box, how could you envision something that we could empower patients like Mr. West to have some skin in the game, to be one of those whistleblowers and to uphold their ability and right? Give me some ideas, Ms. Brice-Smith.

Ms. BRICE-SMITH. We have already observed that there are a handful of States that have developed sort of reward programs, if you will, that are short of sort of the qui tam approach of the False Claims Act but will give cash for tips, if you will, related to health care fraud.

So there are already a handful of innovative States that have recognized that that is an additional insight and benefit to fighting fraud.

Mr. GOSAR. Do you have an insider newsletter that says, hey, listen, these State are on cutting edge, days to crime, days to time?

Ms. BRICE-SMITH. We are using our education to be able to communicate and outreach that information. We also use best practices summaries for the States so that we can inform other states of what States that are being innovative are doing. So we use our

Web sites, we use forums and meetings and our Medicaid institute to communicate that information.

Mr. GOSAR. Thank you. I'm out of time.

Mr. PLATTS. I thank the gentleman.

I'm going to go to a second round here, while we have the opportunity for a few more questions. Yielding myself 5 minutes. First, to follow up on the questions of Mr. Gowdy about the States that are most egregious as far as improper payments. It sounds like your contention is that information is not subject to the Freedom of Information Act [FOIA].

Ms. BRICE-SMITH. I am not sure FOIA, but we could certainly, I could certainly look into that.

Mr. PLATTS. Because I've shared his, I guess, statements regarding the fact that American taxpayers are sending $275 billion to States to handle properly, and I think the American taxpayers have a right to know which States are doing it well and which States are not. And I'm not sure, I would be interested in any additional feedback from CMS as to why we don't want to share—often in cases of deadbeat dads, one of the ways we can get them to pay is we publicize that they are not paying. We shame them into paying.

Well, maybe we need to shame these States into doing a better job of protecting the American people's money. So I do look forward to further interaction with you and CMS on that.

Mr. Cantrell, on the specific case of Mr. West, appreciate various factors. I find it somewhat unbelievable that we are still doing business with this entity.

Can you tell me when, the 41 States, as part of the agreement, in addition to Mr. West's case in New Jersey, was there evidence of other similar misconduct in other States regarding this company?

Mr. CANTRELL. Yes, there was. The $250—$150 million was not related specifically to Mr. West's scenario. It was a broader issue.

Mr. PLATTS. In how many States would, if you know, or estimate that we found this misconduct?

Mr. CANTRELL. I don't know specifically. The answer to that.

Mr. PLATTS. That, to me, would go to, if it was just New Jersey, and we had some bad apples in one subdivision of this large company, that is one thing to say we're not going to punish the whole company. But if we found similar misconduct in half, 20 of the 41 States, that's a very different story.

So if you could provide to the subcommittee how many States and how many different States do we find similar misconduct by Maxim?

Mr. CANTRELL. I don't believe our evidence suggested that they were committing 100 percent fraud across the country, but I don't know how many States. But we will get back to you on that.

Mr. PLATTS. We would welcome that information.

Also, looking at an analogy to the private individuals in a criminal sense, when we have a victim, because most of our focus has been about the money, which is very important, but it is also about the care provided. As we heard from the testimony of Mr. West, because of the fraud Maxim committed, it wasn't just the money being lost; it was care to an individual. And that is an even more

serious crime in my opinion; because of their intentional fraudulent conduct, they denied medical care.

Given that he was a victim directly, taxpayers in total were victim, but he was a victim directly of their misconduct, was he consulted or any other similar victims consulted as to whether they felt the settlement with Maxim was acceptable punishment for their wrongdoing?

Mr. CANTRELL. I believe, as in most of these cases, the attorneys for Mr. West, Ms. Page, would probably have been participating in some of those discussions, yes. I don't know specifically in this case how it was, but that is, I believe, the routine.

Mr. PLATTS. So and they are given the opportunity to say, yes, I sign off on this, or they are just aware of this.

Mr. CANTRELL. I think they're aware of it. I don't know that they have the ability to stop, stop it from happening.

Mr. PLATTS. In a sentencing in a court, there is a formal process where the victims can offer testimony to the final decider. Do you know if there is any formal process of that nature where a victim can make a presentation to the U.S. attorney directly that is going to make that decision?

Mr. CANTRELL. Certainly, there is the opportunity. I don't think there was a sentencing hearing in this case, so there was no, may not have been the opportunity to do it in a courtroom, but I believe it have would been conversations between U.S. Attorney's Office and the assistant U.S. attorney, Mr. West.

Mr. PLATTS. My hope is that we make sure that is a formal process, a routine part of any settlement. Because I do acknowledge that you can have somebody who had some bad apples in a small way, that's got to be factored in versus a more deliberate across-the-board fraudulent case. But we have to remember there are victims here that aren't just about money; it is about care being denied, and that is a very serious crime in my opinion.

I want to quickly get to two other issues. In your testimony, Mr. Cantrell, you talk about the Medicaid statistical information service, and you reference in your testimony about some of the data is 12 years old? How common is that?

Mr. CANTRELL. Sir, let me correct the record. That is 1 and a half years old.

Mr. PLATTS. Twelve years just seems so outrageous. But even 1 and a half, when you talk about then trying to correct it, it goes to the point of I guess what you talked about and Ms. Brice-Smith of trying to much more quickly identify, respond to and prevent, because 1 and a half years even is the money is long gone.

Mr. CANTRELL. We agree. The more timely the data, as close as we can get to real time, the better we are. On the Medicare side, as I said, we have a lot more success to talk about. We use that data, which is much more timely to mine for fraud, identify areas where we have hotspots of fraud. We had the strike force model, which we utilized. We deploy those to areas of the country where there is high instances of the fraud, such as south Florida, Bronx, New York, Detroit, Los Angeles, Dallas, Houston.

Mr. PLATTS. Seeking to replicate where you have had success for Medicare to Medicaid?

Mr. CANTRELL. Absolutely.

Mr. PLATTS. And that's one of the things that came through to me in preparing for this is that it seems like there is almost a conscious decision within CMS to devote much more attention and resources to Medicare fraud than to Medicaid fraud. Is that a fair, until the last, say, 5 years. Is that a fair statement?

Mr. CANTRELL. I would have to defer to my colleague on that question.

Mr. PLATTS. Ms. Brice-Smith, is that it, that we are kind of late to the game on the Medicaid side?

Ms. BRICE-SMITH. I think you're recognizing certainly the support that Congress gave us through DRA in that 5 year period.

But I think one could take that a step further. The Medicaid program was structured to be administered day to day by the States, so those claims are going to the States or their fiscal agents. And we are engaged at the postpay with the subset of data to try to oversee the——

Mr. PLATTS. I think a very valid point. In the Deficit Reduction Act and as Mr. Davis well reflected in the Affordable Care Act, there is a greater understanding here in Washington in the last 5 years that maybe it's State administered, but bottom line is we are paying the majority of the bill. And so we need to be a little more proactive in protecting the taxpayer funds. And that is why I said I think we're late to the game, but we are finally getting there and being more, I think, hands on in trying to protect those dollars.

I know, I'm one last question. I appreciate my colleagues' indulgence here with being way over my time, and Ms. Yocom, in your testimony, you talk about the, again, the Medicaid statistical information system and you talk about what States are supposed to provide. But it says MSIS does not contain billing information such as referring provider's identification number or beneficiary's name. The less information provided, the harder it is to say, hey, this provider, obviously, is billing for an inordinate number, and that would be one of the flags that would jump out that there may be something askew here.

Can you try to address, based on your knowledge, why aren't we requiring States to provide all of that information to make the MSIS system a more useful tool, to be more timely, but also more comprehensive?

Ms. YOCOM. I can't speak to why we don't require it, but I can speak to the effect of not having that information available. As you say, it's impossible to do some of the data mining techniques on things that are done routinely on the Medicare program.

GAO does have some work underway right now, and that is just looking at the States' capabilities and their activities in this regard.

Mr. PLATT. Thank you.

Ms. BRICE-SMITH. May I speak a little bit to that?

Mr. PLATTS. Yes.

Ms. BRICE-SMITH. I just want you to be aware that we are taking active actions to actually enhance that data. We are referring to it as transformed MSIS data, which is largely expanded. We're currently pilot testing it now to test drive, if you will, if that data will give us a better output in terms of program integrity activity among 10 volunteer States. So we are very excited about that.

Mr. PLATTS. My hope is that that is successful, and I will say more successful than IDR and the one program integrity, which many years in doesn't seem that we're getting the results that were intended and certainly not in the timeframe, and I am way over my time.

Mr. Davis, I don't know if you had other questions. I yield to the ranking member, Mr. Davis.

Mr. DAVIS. Thank you very much, Mr. Chairman.

The cap on services and denial of his dental needs were a major red flag to Mr. West that something was awry, that something was wrong, something was not right with his benefits.

Ms. Brice-Smith, to those patients without a similar cap, are they less likely to ensure that their services are properly being rendered and billed to Medicaid correctly?

Ms. BRICE-SMITH. I think what we've learned about fraud if you, many fraudsters can submit a very clean looking claim. And you have to examine many other factors, such as complaints from beneficiaries, such as our own data analytics in terms of patterns and trends to see, does this really make sense? Is this even feasible that he could have used that many services for example.

Mr. DAVIS. The 1–800 Health and Human Services tips hotline is widely publicized as an avenue that individuals can use to provide information that assist in combating fraud waste or abuse in Federal health care programs.

While the extent of health care fraud is estimated to be in the billions of dollars each year, HHS emphasizes that Medicare and Medicaid beneficiaries are the frontline of defense in detecting Medicare and Medicaid fraud because they have firsthand knowledge of the health care services they have received.

Mr. West contends that there was no follow-up to his hotline calls.

So, Mr. Cantrell, could you provide information on the 800 HHS tips hotline, what procedures are followed, and any timeframes there might be to handling or responding to complaints?

Mr. CANTRELL. Sure. We have the 1–800 HHS tips telephone line, which in this case, Mr. West, we don't believe he contacted that. I think he called the State and local offices. But we have that phone number. We also have a Web site, where we collect complaints via Web forum. And between those two mechanisms, we receive thousands of complaints every year. And we have a process for evaluating those complaints, determining the—whether there's enough information there to proceed with an investigation or whether there isn't enough information.

In some cases, we refer those complaints out to our regional offices for our investigators to look at further, and in other cases, we refer them directly to CMS for administrative review.

Mr. DAVIS. While our focus today has been on Medicaid fraud, I will just point out that there is also fraud in the private sector, in private health care. For example, in 2009, United Health paid $350 million to settle lawsuits related to the intentional manipulation of the reasonable and customary rate. And also Pfizer, in 2009, paid a $2.3 billion civil and criminal penalty for unlawfully marketing medications for conditions that they had not been approved for by the Food and Drug Administration.

Ms. Melvin, Ms. Yocom, could you comment on the challenges, from GAO's perspective, of looking seriously into the private sector fraud and abuse situations?

Ms. YOCOM. Well, one of the challenges of looking into the private sector, I think, particularly on Medicaid, might be the Federal State partnership. That is an unusual circumstance to begin with.

Data is also a huge challenge in terms of combating fraud. And the steps that CMS is taking right now are in the right direction, but there is a lot of work to be done there.

Mr. DAVIS. Ms. Melvin.

Ms. MELVIN. From a technical perspective, in looking at moving data, for example, from the States into the integrated data repository, a lot of the key challenge stems or surrounds having to make sure that the data is of a format, that the their data elements follow formats that are consistent with the IDR requirements for a file format. So there are technical challenges in being able to do that.

One of the concerns we raised in our report is CMS's plan, as we understand it, to try to bring all of the 50 States or 50 plus programs data into IDR by September 2014, I believe. The concern we have is what type of planning they will have in place to make sure that they can, in fact, bring that data, consolidate it, identify all the data elements that are very different.

We talked previously about disparate systems in all of the different State programs, and those have to be addressed, the differences in data have to be addressed and brought into the system in a common format.

We have not seen plans yet. We haven't done the work that would allow us to know how effectively CMS is handling that particular challenge.

Mr. DAVIS. Thank you very much.

I want to thank all of the witnesses.

And thank you, Mr. Chairman, for this hearing. And I yield back.

Mr. PLATTS. I thank the gentleman.

Dr. Gosar.

Mr. GOSAR. So let me ask you a question. We are talking about fraud. Is it just limited to the private sector, or is it also for public health? Ms. Brice-Smith.

Ms. BRICE-SMITH. I believe that there are equally concerns in private and public sector in terms of fraud, waste and abuse. And I think evidence of that certainly is the American Medical Association's own fourth annual report card on health insurers, which showed their error rate was double, more than double certainly the Medicaid error rate.

So when you think about extrapolating even that out, you're talking about a savings in the private sector of $70 billion right there. So I think that is an example.

I think with Medicaid and Medicare, two big high priority programs, we certainly recognize that we tend to report and disclose, and we are transparent, as we should be, but many private companies don't have to be transparent about the fraudulent activities that might be occurring.

Mr. GOSAR. I also want to highlight federally qualified health centers. I'm a dentist, just to make sure that we all get that out

there, that when we work a rule, for example, a child, we numb up the whole quadrant, and then we only do one tooth at a time because of the reimbursement rate. Would you call that fraud? I do.

Ms. BRICE-SMITH. It sounds like there are a lot of things going on that we would have to take into consideration in terms of how that billing is occurring. It sounds like that might be an effort to unbundle services possibly. It might draw some suspicions depending on how——

Mr. GOSAR. Do we have the same scrutiny on federally qualified health centers as we do everybody else?

Ms. BRICE-SMITH. Certainly, they are inclusive. Although I think our efforts tend to be focused on where we relieve the greater Medicaid expenditures and the greater vulnerabilities are and the categories of services that tend to drive the error rate as we know it today.

Mr. GOSAR. Ms. Yocom, do you believe that the Medicaid, the State Medicaid systems are maybe too big and unwieldy the way they are?

Ms. YOCOM. Too big——

Mr. GOSAR. To oversee properly? We're finding a big problem here, and it just seems like it is unwieldy.

Ms. YOCOM. I think the actions taken by the Congress under the Deficit Reduction Act and under the Patient Protection and Affordable Care Act meant a lot of activity which can help oversee these programs in a better fashion.

To speak to the States on this, this is a partnership, but CMS also needs to be able and willing to——

Mr. GOSAR. Give up some of the rules.

Ms. YOCOM. Yeah.

Mr. GOSAR. It seems to me like we're talking about a broken system. It is very obvious to me. I'm from rural Arizona. We don't get paid. I can tell you right now, in dentistry, you might be getting paid in 6 months. So I don't know too many people that can make a business work that way. Somehow we do.

But in this government take-over of health care, that's the only way I can talk about it, okay, we are going to dump another 20 million people into this, into a broken system. I don't see a lot of urgency in fixing this situation and looking outside the box for solutions.

Do you agree with me?

Ms. YOCOM. Well, it's not my position to agree or disagree.

Mr. GOSAR. Do you agree it's broken right now?

Ms. YOCOM. I think the facts are we need to do better on program integrity, yes.

Mr. GOSAR. And it's going to be problematic when you dump another 20 million people in there.

Ms. YOCOM. And the best approaches are, frankly, to keep the payment from happening at the beginning.

Mr. GOSAR. In Medicare, most of our Medicare patients are older, right? They are very responsible, and they have been empowered to look at bills, which gets back to my point about empowering people in being part of that.

I want to go back to that and ask you a question.

Do any States use the advanced analytics, like the credit card industry, that would spot in realtime an outlier of billing practice before payment goes out the door?

Ms. MELVIN. We have just started work to look at that, so I'm not in a position yet to say exactly what States are doing. We do know there are analytical tools that are being used in some capacity by them at this point, but I couldn't speak to how much or to what extent they are using them.

Mr. GOSAR. Are there any rewards to utilizing the analytic tool?

Mr. MELVIN. The analytic tools, as I understand them, are to be used to in particular to help prevent improper payment so that it allows them to analyze, say, if you will, mined data and really make calls on data that would help them to prevent fraud and improper payments on the front end versus, for example, the integrated data repository and one PI tools that we have currently assessed, which are, at this point at least, focused on the back end in terms of identifying improper payments after they've been made.

Mr. GOSAR. Indulge me just for a second. To me, it seems like there is a common tool here I want to get to. It's on the front end with a card empowering the patient to pay to make the system a lot faster.

Because here is another part to this. There's also the State board because when you defraud a patient on a billing process directly when they're paying for it, it is also a standard of care issue. So, therefore, there is a better penalty that we're talking about.

So I think that there should be some aspect that we look at the front end more so the back end in empowering patients. And I think you've got something that works very, very well.

I come from a State that the dental board is extremely active. Arizona is not one, two or three in the country for population, but we are for activity, because patients are empowered. And that's where we need to go. And I think that's what we're failing to do is empowering people.

And I see constantly, I'm approached by the WIC program, saying, Dr. Gosar, we need you to sign a contract? And I say, why are we signing a contract? What's the deal? Why is it taking a WIC mother six or seven visits just to see the doctor? Something is wrong there. But there's also something right because women are speaking out about that process.

And I think the more eyes on the prize, the stiffer the penalties, I think the better opportunity that that happens in empowering States to make those jurisdictions really helps and I think standard of care is a remarkable tool.

Mr. PLATTS. I thank the gentleman.

And I would just comment, as we heard Mr. West's testimony, it seems like not only empowering the patient, the beneficiary, but in this case, we heard we discouraged and prevented them from taking hold. So we do certainly do need to do much better.

And I think as we wrap up here kind of a final comment and that's that we need to remember that there are two issues at hand here. First, it's protecting tax dollars, and while certainly we're glad to have the improper payment rate for Medicaid to be down, we're still talking about $22 billion of improper payments this last past year that we know of. And again, using Mr. West's case, but

for his individual heroic efforts to uncover the fraud, we would not have known about Maxim. And so how many other Maxims are out there that we don't know about? The $22 billion is what we do know about of improper payments. So when we talk about the whole number of $125 billion, there are some estimates that that is probably at least $200 billion, but we only know of $125 billion. So we certainly have a lot of work to do.

I want to thank each of our witnesses for your testimony here today, both your written testimony, which is, again, very helpful in preparing, and your oral testimony here today, and most importantly, for your efforts day in and day out.

I know we are all on the same page, that we are trying to seek the same result, and I think that with the Deficit Reduction Act of 2005, the Affordable Care Act language on trying to better go after fraud, we're all collectively better acknowledging and starting to commit the resources necessary to protect ours, ensure the care that is earned and deserved is provided and not denied inappropriately.

So I commend you for your efforts, and we certainly as a committee look forward to continuing to work with you, both subcommittees, work with you and your respective agencies on this important issue.

We will keep the record open for 2 weeks for additional information as was requested to be submitted, and we stand adjourned.

[Whereupon, at 1 p.m., the subcommittees were adjourned.]

[The prepared statement of Hon. Gerald E. Connolly and additional information submitted for the hearing record follow:]

Statement of Congressman Gerald E. Connolly
Preventing Medicaid Fraud
December 7th, 2011

Reducing Medicaid improper payments contributes directly to the long term health of these essential health care programs. I appreciate our two subcommittees holding a hearing on the different anti-fraud programs within Health and Human Services (HHS) and Centers on Medicare and Medicaid Services (CMS). While HHS and CMS are devoting unprecedented attention to reducing Medicaid fraud, it is clear that we must do more to reduce improper payments and protect the economic security of individuals such as Richard West who have lost benefits temporarily as a result of attacking Medicaid and Medicare fraud.

As the written testimony for this hearing makes clear, Congress and the administration have devoted a great deal of effort to reducing improper payments within the last decade. In 2005 Congress passed the Deficit Reduction Act, which established the Medicaid Integrity Program (MIP). The MIP provides states with technical assistance to identify and prevent fraud, which is appropriate since states administer Medicaid. The Deficit Reduction Act also requires CMS to work with Medicaid Integrity Contractors (MICs) to ferret out overpayments, conduct audits, and educate program participants about fraud prevention. CMS uses this and other data for its Medicaid Statistical Information System (MSIS), which includes eligibility and claims information across the United States. By maintaining a central database CMS can conduct analyses which identify possible fraud or areas where fraud is likely to occur. CMS also works with agencies to duplicate best practices, and has identified 52 best practices that could be replicated.

Despite these laudable efforts, it is clear that more can be done to reduce fraudulent Medicaid payments. As the testimony of Richard West and Robin Page West demonstrates, CMS has not always been responsive to reports of fraud. I look forward to learning more from Ms. Brice-Smith and Mr. Cantrell about what CMS is doing to prevent such negligence from occurring in the future. Ensuring robust implementation of existing policies is essential because CMS also must implement important new reforms enacted under the Affordable Care Act.

As Ms. Brice-Smith notes in her testimony, the Affordable Care Act, sometimes referred to as "ObamaCare," significantly strengthens anti-fraud programs. These include elementary reforms such as requiring service providers and suppliers to document orders and referrals. The Affordable Care Act established the Medicaid Recovery Audit Contractor (RAC) program to create incentives for contractors to reduce fraudulent payments. In conjunction with Secretary Sebelius' Center for Program Integrity, the Affordable Care Act is designed to identify improper fraud payments before they are issued by CMS.

I hope today's testimony illuminates the progress we have already made and additional administrative improvements which would reduce Medicaid fraud. Perhaps we should consider more stringent punishments for companies which systematically defraud Medicaid, as Mr. West suggests in his testimony, or consider harsher penalties for the management of such companies. Thank you again for holding this hearing and to the witnesses for their attendance.

HHS OIG (Gary Cantrell) Responses to Questions for the Record
"A Medicaid Fraud Victim Speaks Out: What's Not Working and Why?"
12/7/11

Q: How many states was Maxim committing fraud in?

A: The Department of Justice (DOJ) entered into a Deferred Prosecution Agreement (DPA) with Maxim; therefore, fraud was not adjudicated against the corporate entity and thus there is not a list of States in which fraudulent conduct can be attributed. To date, nine individuals--eight former Maxim employees, including three senior managers, and the parent of a former Maxim patient--have pleaded guilty to felony charges and been sentenced for conduct arising out of the submission of fraudulent billings to government health care programs, the creation of fraudulent documentation associated with government program billings, or false statements to government health care program officials regarding Maxim's activities. The charges involved conduct in the States of Arizona, Florida, Georgia, New Jersey, Texas, and South Carolina. The Committee may find helpful the DPA, available at http://www.justice.gov/usao/nj/Press/files/pdffiles/2011/Maxim%20DPA.pdf, and the settlement agreement, available at http://www.justice.gov/usao/nj/Press/files/pdffiles/2011/Maxim%20SA.pdf.

Q: What was the total amount of fraudulent claims from Maxim that OIG found in its investigation?

A: DOJ entered into a DPA with Maxim; therefore, fraud was not adjudicated and thus there is not a dollar amount that can be attributed to fraudulent claims. However, the DPA, available at http://www.justice.gov/usao/nj/Press/files/pdffiles/2011/Maxim%20DPA.pdf, notes that "[Maxim] received more than $61 million to which the Company was not entitled as a result of its conduct as described in the Criminal Complaint and the Statement of Facts." The Committee may also find helpful the Maxim settlement agreement, available at http://www.justice.gov/usao/nj/Press/files/pdffiles/2011/Maxim%20SA.pdf.

Q: Are victims allowed to make recommendations or negotiate in whistleblower cases in order to help arrange damages in a settlement?

A: DOJ administers the False Claims Act (FCA) and is responsible for all aspects of the Government's coordination with whistleblowers. In OIG's experience, whistleblowers often provide information that may be used, along with other information gathered during the Government's investigation, to determine the damages in the case.

Q: Were Mr. West and/or his attorney, Robin Page West, involved in the settlement negotiations with Maxim?

A: As described above, DOJ takes the lead with respect to any negotiations involving whistleblowers. In OIG's experience, whistleblowers are often involved in the settlement negotiations and typically sign the civil settlement agreement, as Mr. West and his counsel did in this case.

Q: How often does the government file a motion for upward departure when prosecuting health care fraud cases?

A: OIG does not have record of this information, as DOJ is responsible for filing motions for upward departure. We contacted DOJ in an effort to collect this information but they do not track the number of times the government files a motion for upward departure. If, however, the Subcommittees are interested in the number of times defendants actually received upward departures, DOJ has advised that it can provide this information through DOJ's Office of Policy and Legislation.

Angela Brice-Smith
"A Medicaid Victim Speaks Out: What's Not Working and Why?"
Hearing on December 7, 2011

Questions from Rep. Todd Rusell Platts, Chairman,
Subcommittee on Government Organization, Efficiency and Financial Management

Lead-In
In 2004, Richard West filed a whistleblower lawsuit resulting in an investigation of Maxim Healthcare Services, Inc., which found that Maxim was submitting fraudulent claims to the Centers for Medicare and Medicaid Services (CMS). In September 2011, Maxim reached a $150 million settlement for committing Medicaid fraud.

1. How much money has Maxim received from CMS since the investigation of Maxim began? How much money has Maxim received since Maxim reached a settlement?

Answer: CMS continues to work with the committee to identify the claims associated with billings from Maxim, and will respond to that request accordingly.

2. How did New Jersey and other states where Maxim had been committing fraud address this failure in oversight? Did CMS issue any recommendations, and if so, what were they?

Answer: Frauds such as the one perpetrated by Maxim are often inordinately hard to detect because the underlying fraud schemes are meant to operate covertly, with submitted claims intended to look clean and subvert claims processing systems' edits and fraud analytics. Nevertheless, continually improving automated fraud analytics that CMS (with respect to Medicare) and the States (with respect to Medicaid) are increasingly deploying are better able to discern, in real time, aberrancies that should enable such conduct to be detected earlier.

CMS has been a leader in piloting the use of predictive analytics to detect aberrancies in Medicare claims. CMS intends to rigorously scrutinize this emerging technology, subject it to continuous quality improvement cycles, ensure it delivers the best value for the taxpayers, and actively engage in technology transfer to share lessons learned and help diffuse this technology to the States. Further, CMS is aware that the HHS/OIG has proposed a rule to enable State Medicaid Fraud Control Units (MFCUs) to engage in data mining to further enhance the States' ability to detect potential fraud as early as possible. (With respect to Maxim in particular, we are fortunate that a beneficiary—who only incidentally hails from NJ, which is why the enforcement action arose there —had carefully compared his services received against his statements and discerned and reported the fraud.)

Moreover, CMS' Medicaid Integrity Group (MIG) has a proactive agenda to continually analyze and recommend improvement to State Medicaid program integrity (PI) operations. CMS conducts triennial reviews of State program PI operations to identify areas of non-compliance and program vulnerabilities as well as highlight effective PI practices by States. Because the

reviews are broad in scope, they do not probe down to an analysis of individual provider billing behavior. CMS requires States to submit corrective action plans (CAPs) in response to findings and other vulnerabilities identified through the review process, and staff reviews the CAPs with the States. Likewise, CMS reviews and evaluate the CAPs that States submit in response to findings in CMS' Payment Error Rate Measurement program. Through both of these processes, States have instituted significant quality improvement initiatives.

CMS also issued Fraud Referral Performance Standards in September 2008 that set minimum standards for adequacy of information that State PI units provide in making referrals to MFCUs. Since the issuance of the Standards, MFCUs have reported substantial improvements in the quality of referrals from States' PI units and both the PI Units and the MFCUs report better collaboration. Under provider screening regulations promulgated February 2, 2011 to implement provisions of the Affordable Care Act, these Standards are now required for all referrals to MFCUs.

3. Has CMS worked with New Jersey and other states where Maxim had committed fraud? If so, what did CMS do to strengthen oversight in those states?

Answer: CMS sponsors ongoing training at MIG's Medicaid Integrity Institute (MII), which is based at the Department of Justice's National Advocacy Center in Columbia, South Carolina. Since its establishment in 2008, the MII has provided training to over 2,600 State Medicaid employees through a variety of courses. New Jersey has had 44 staff attend training courses at the MII. This training includes:

- PI fundamentals;
- emerging trends in home health care and durable medical equipment;
- emerging trends in managed care, investigative techniques, and data analysis;
- correct coding, with training leading to coder certification to ensure that State Medicaid program staff that conduct claims reviews are well qualified; and,
- interactions between MFCUs and PI Units Symposium designed to foster better PI unit/MFCU collaboration and coordination, and where PI and MFCU representatives from each State paired and worked together throughout the course.

All costs associated with MII training, including transportation, lodging, and tuition, are provided free of charge. As a result of the work accomplished by the MII, we believe that many fraud schemes such as that perpetrated by Maxim would now be identified more rapidly at the State level. CMS has also established a secure website through the MII which allows States to exchange best practices as well as to share sensitive information confidentially. This tool has allowed the level and degree of communication across State Medicaid programs to increase significantly in the last few years.

CMS has also engaged several States in discussions about undertaking joint field investigations of problem providers in home and community based care programs. Since October 2011, CMS has jointly undertaken two such investigations with Florida and participated in test site visits to selected facilities in New York, and we expect to expand such activities significantly over the next two fiscal years. By spreading an awareness of how to prevent and detect fraud and abuse across the full range of Medicaid-funded programs, CMS is strengthening its oversight capabilities and making it less likely that future Maxim-style fraud schemes will go unnoticed.

Lead-In
States have some freedom in creating and implementing plans to administer and oversee Medicaid. However, not all states are reporting all required data to CMS.

4. Are there reporting requirements that states *must* follow in order to participate in the Medicaid program, and if so, what are those requirements?

Answer: States are required to submit Medicaid Statistical Information System (MSIS) data to CMS on a quarterly schedule. The MSIS is an automated reporting database system that is used to maintain information about enrollment, utilization, and expenditures. It provides program utilization and expenditure forecasts, analysis of policy alternatives, and program management support at both the Federal and State levels. Once the State files are received, CMS submits the MSIS data through a review and validation process before it is made available to our PI staff.

5. Why are some states not reporting all required data to CMS, and what is CMS doing to address that problem?

Answer: As noted above, States submit MSIS data to CMS on a quarterly schedule. However, there are challenges associated with bringing together data from 56 independent Medicaid programs, and the accuracy, timeliness, and availability of the data, as well as the data standardizations among State programs can be improved. We are working with the States to improve the timeliness of their reporting as well as the consistency of the data across States.

CMS is actively working to improve the quality and accuracy of data reported by States to CMS. In order to do so, CMS established the Medicaid and CHIP Business Information Solutions (MACBIS) Council to provide leadership for the development and deployment of enterprise-wide improvements in the accuracy, timeliness and availability of data. The MACBIS Council has proposed an expansion of the MSIS data set, called Transformed-MSIS (T-MSIS), including additional data elements useful for the detection of fraud, waste, and abuse.

CMS is currently introducing the expanded T-MSIS data set for testing in a pilot project involving Medicaid data from 10 States, representing approximately 40 percent of the nation's Medicaid expenditures. Those ten States are California, Oregon, Washington, Texas, New Mexico, Arizona, Arkansas, Tennessee, North Carolina, and New Jersey. After intensive analysis and assessment is conducted to verify and validate the data and framework to ensure standardization and quality of data of the T-MSIS data set, we hope to use the results and lessons learned from these 10 States as the basis for national implementation.

Additionally, in the more near term, CMS will continue working to improve access to better quality Medicaid data by leveraging the data available through the Medicare/Medicaid Data Match Expansion Project (Medi/Medi) and its participating States, as well as working directly with States to obtain Medicaid data for specific collaborative projects.

Lead-In
The federal and state Medicaid partnership makes program integrity more challenging than for most federal programs. States have disparate programs to maintain program integrity, and poor data quality is a key problem in many States.

6. Which states have the highest rates of improper payments? Which states have the lowest?

Answer: The Payment Error Rate Measurement (PERM) program methodology is designed to use statically valid estimates of improper payments in the States to estimate a national Medicaid improper payment error rate. CMS does not publish the State-by-State rates, but works closely with States with high PERM rates to identify the causes for errors and to determine if the errors were caused by conflicting State policies or operational problems. Under CMS regulations, States are required to submit and implement CAPS no later than 90 days from the date the State receives its error rates. CMS monitors States' implemented corrective actions to determine whether the actions are effective and whether milestones are being reached.

7. Why does CMS not publicize Medicaid improper payment rates by state?

Answer: The PERM program methodology is designed to use statically valid estimates of improper payments in the States to estimate a national Medicaid improper payment error rate. PERM's underlying purpose is not to show State-by-State error rates.

8. Which states have the worst information technology systems and program integrity? Which states have the best?

Answer: States have made varying investments in their information systems based on available State dollars, the availability of Federal resources, and program requirements. As the States' partner, CMS works diligently to ensure States have the resources they need to improve their information systems.

CMS continues to work with all States to ensure their information systems are able to meet Medicaid program obligations.

9. Are any states using advanced analytics to detect fraud and improper payments?

Answer: States are in varying stages, ranging from those that are investigating feasibility for predictive analytics to those that are currently developing and implementing advanced analytics technologies. Illinois is an example of a State taking action on this front. Using a CMS grant

from 2007, Illinois is partnering with two universities to begin implementing predictive modeling analytics, including assessing provider risk scores. The project is currently in the validation stage with plans to expand the program once fully operational. CMS brought together States to discuss their progress, challenges and successes in implementing predictive analytics at the MII this year. Moreover, as we indicated in response to Question 2, CMS has deployed this technology in the Medicare program and intends to rigorously scrutinize it, subject it to continuous quality improvement cycles, ensure it delivers the best value for taxpayers, and to actively engage in technology transfer to share lessons learned and help diffuse it to the States.

10. What are states and CMS doing to increase prepayment review?

Answer: States have responsibility for paying claims in the Medicaid program. As part of this responsibility, States are obligated to comply with Federal regulations. Under current regulation (42 CFR §447.45), States are required to conduct prepayment claims review in order to verify such items as beneficiary eligibility, provider eligibility, third party liability, and duplicate or conflicting claims.

As required by the Small Business Jobs Act, CMS is exploring the use of predictive analytic technologies for identifying and preventing improper payments under Medicaid and CHIP. CMS is working with the States to identify the most effective ways to implement additional prepayment controls. In order to meet these requirements, CMS is currently working on developing advanced analytics techniques including predictive analytics, linkage analysis, outlier analysis, network analysis, behavioral analysis, and other statistical techniques that will generate alerts and triangulate the results to identify claims and providers most likely to be engaged in fraudulent or wasteful behavior.

11. What are the problems with MSIS data that arise from Medicaid managed care? Does CMS consider Medicaid managed care data in MSIS reliable?

Answer: CMS strives to continually improve the quality, reliability, and consistency of data reported by the States. Two years ago, CMS established the MACBIS Council to bring an enterprise focus to Medicaid and CHIP data and information needs and to bring about improvements overall to Medicaid and CHIP data capabilities, including those for PI. Substantial improvements in current capabilities have resulted, including improved analytic capabilities and timeliness of the data.

There are some substantial challenges that States face in providing data to CMS. These include the need for proprietary formats and State MMIS modernization efforts. Part of our MACBIS effort is aimed at addressing these challenges and improving the timeliness, completeness and reliability of Medicaid and CHIP program data. Our initial 10-state pilot should provide results later in 2012.

The Affordable Care Act made an important addition to the data reporting requirements by including a requirement that Medicaid managed care encounter data be reported to CMS. CMS, with the implementation of this provision and efforts under way to improve data reporting, is

working to ensure that all State Medicaid data are readily available to support program objectives and PI goals. While some States do report encounter data, and those that do generally provide complete and accurate data, we plan to use this new authority to ensure that we are able to obtain complete data from all State managed care programs.

Questions from Rep. Trey Gowdy, Chairman
Subcommittee on Health Care, District of Columbia, Census & the National Archives

Lead-In
In a 2006 article in the City Journal, Steve Malanga wrote that at least half of the states spend less than one-tenth of one percent of their Medicaid budget on combating fraud.

1. How much of each state's Medicaid budget is spent on combating Medicaid fraud?

Answer: Medicaid's financing structure encourages robust State program integrity (PI) activities. Medicaid is a Federal-State partnership supported by both Federal and State funds, and States have an incentive to ensure program requirements are in place that safeguard the program and protect vital State resources.

States must fulfill the PI requirements of the Medicaid statute and receive financial participation from the Federal government for these efforts.

CMS also provides oversight over State programs through Medicaid State Plan Amendments, as well as through the State Program Integrity Assessment (SPIA), which annually collects standardized, national data on State Medicaid PI activities. According to the SPIA data, States reported spending approximately $393 million collectively on PI efforts during FY 2009. CMS also conducts triennial comprehensive reviews of each State's PI activities as part of the Medicaid error rate calculation.

2. Has any state successfully incentivized Medicaid beneficiaries to report fraud? Where do these beneficiaries go to report fraud?

Answer: Beneficiary involvement is a key component of all of CMS' anti-fraud efforts. CMS believes that alert and vigilant beneficiaries are among the most valuable tools in our efforts to stop fraudulent activity, and we seek to inform and educate our beneficiaries, including those dually eligible for Medicare and Medicaid, to report fraud.

CMS works to enlist beneficiaries in our fight against fraud in several ways. For example, our Education Medicaid Integrity Contractor (MIC) provides informational materials that give examples of common types of fraud, waste, and abuse and informs beneficiaries on how they can report Medicaid fraud. The Education MIC also created easily disseminated postcards that explain how beneficiaries can report fraud, waste, and abuse, and it is working on a public service announcement that conveys the same message. Further, the MIC is developing all-purpose fraud reporting forms for both a beneficiary and a provider audience. In addition, the Education MIC is expanding its use of social media and "news blasts" to give wider circulation to anti-fraud and abuse messages and information about preventing and reporting Medicaid fraud.

There are a variety of ways in which Medicare and Medicaid fraud tips can be reported. In March of 2011, the Medicaid Integrity Program posted a list of Medicaid fraud reporting contacts on the CMS website: http://www.cms.gov/FraudAbuseforConsumers/.

This page includes:

- State-by-State contact information for reporting suspected Medicaid fraud or abuse. Generally there are two contacts provided for each State (State Medicaid agency & MFCU).
- HHS OIG National Fraud Hotline number (1-800-HHS-TIPS)
- Information to have ready when reporting suspected fraud
- Common Medicaid fraud schemes
- Tips to help prevent fraud

The fraud reporting contact list is updated quarterly.

As of July 2011, 28 States (including the District of Columbia) had State false claims act laws with *qui tam* provisions. These provisions provide an opportunity for individuals with knowledge of high dollar Medicaid offenses to collect part of the recovery amount if a successful court action against the fraudulent party occurs. In addition, six States (Arkansas, Florida, Louisiana, Missouri, New Jersey, and Tennessee) have regulations that provide for rewards for the reporting of Medicaid fraud without filing a *qui tam* lawsuit. The rewards in these programs vary from $50 to $500,000, depending on the State, the amount recovered, and the severity of the offense.

Lead-In
According to the recent reports, very little of the information that individuals place on their Medicaid applications is verified.

3. How do states verify individual information in order to accurately assess program eligibility?

Answer: States are required to maintain eligibility systems to accurately assess an individual's eligibility for Medicaid benefits. States use their Mechanized Claims Processing and Information Retrieval Systems to assess an individual's eligibility.

4. What is CMS doing to address this problem of eligibility verification in many parts of the country?

Answer: We recognize that Medicaid eligibility workers play an important role in ensuring that Federal and State Medicaid dollars are spent providing health care to eligible individuals and protected against abusers. State Medicaid programs periodically remind employees about the ethical and legal obligations they have when speaking to and advising a potential applicant. CMS also directly supports eligibility workers with free training for State eligibility workers at the Medicaid Integrity Institute (MII). Since its inception, the MII has trained more than 2,600 State PI staff from all 50 States, DC, and Puerto Rico.

Further, CMS recently finalized the regulation, CMS-2346-F, which supports State efforts to ensure appropriate expenditures in the Medicaid program. The [Final Rule] provides for enhanced Federal funds, at 90 percent match rate through calendar year 2015, for State investments in the design, development, installation or enhancement of eligibility determination and enrollment activities, as long as they meet certain requirements.

THE SUCCESS OF THE FALSE CLAIMS ACT

The government's partnership with private citizens in the fight against fraud was cemented in 1986, when Congress amended the False Claims Act, the United States' primary tool against government fraud.

— Tony West, Assistant Attorney General of the United States

The False Claims Act is the most successful fraud-fighting tool ever developed. Its success is due to the efficiency of law enforcement, made possible by the public-private partnership that exists between whistleblowers, their attorneys, and the United States Government.

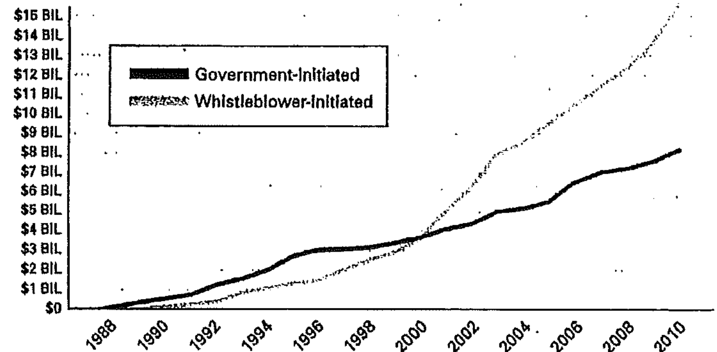
Since the 1986 Amendments were passed, with bipartisan support in both houses of Congress, fraud recoveries have risen dramatically. Today, whistleblower actions under the False Claims Act are the primary vehicle for fraud recoveries for both federal and state governments.

An analysis of recoveries in the health arena finds that the U.S. Government gets back $15 for every $1 invested in False Claims Act investigations and prosecutions.

In Fiscal Year 2010, over $3 billion was recovered under the False Claims Act—twice as much as was recovered in FY 2000. Of this amount, nearly 80% was recovered as a direct result of whistleblower lawsuits—a total of $2.39 billion.

Since the 1986 amendments to the False Claims Act, more than $30 billion has been recovered in judgments and settlements.

Amounts Recovered in Government-Initiated FCA Suits Versus Whistleblower-Initiated FCA Suits



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

Tony West
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515
District of New Jersey

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

DATED:_________ BY: ____________________
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: [signature]
RICHARD WEST

DATED: 9-8-11 BY: [signature]
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.

STATE SETTLEMENT AGREEMENT

I. PARTIES

This Settlement Agreement ("Agreement") is entered into between the State of North Carolina ("the State") and 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, including the entities listed in Exhibit A, (collectively "Maxim") collectively referred to as "the Parties".

II. PREAMBLE

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

A. At all relevant times, Maxim, a Maryland corporation with its principal place of business in Columbia, Maryland, provided in-home health and nursing services in the "State".

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. On October 8, 2004 Richard W. West filed a qui tam action in the United States District Court for the District of New Jersey captioned United States of America ex rel. Richard W. West v. Maxim Healthcare Services, Inc., Civil Action No. 04-4906 (AET).

D. On March 3, 2009, Richard W. West filed an Amended Complaint, adding twenty-three states and the District of Columbia as plaintiffs.

E. The *qui tam* action identified in Paragraphs B, and C. will be referred to collectively as the "Civil Action."

F. Maxim has entered or will enter into a Deferred Prosecution Agreement (DPA) with the United States Attorney for the District of New Jersey. The United States Attorney for the District of New Jersey will file a criminal complaint in the United States District Court for the District of New Jersey charging Maxim with conspiracy to commit violations of the Healthcare Fraud Statute, contrary to Title 18, United States Code, Section 1347, in violation of Title 18, United States Code, Section 1349, (the "Federal Criminal Action").

G. Maxim has entered into a separate civil settlement agreement (the "Federal Settlement Agreement") with the United States (as that term is defined in the Federal Settlement Agreement).

H. The State contends that Maxim submitted claims for payment to the State's Medicaid Program (Medicaid), 42 U.S.C. §§ 1396-1396(v).

I. The State contends that it has certain civil and administrative causes of action against Maxim for engaging in the following conduct (the "Covered Conduct"):

a. during the period from October 1, 1998 to May 31, 2009, submitting or causing to be submitted false claims to the state Medicaid program for services not rendered;
b. during the period from October 1, 1998 to May 31, 2009, submitting or causing to be submitted false claims to the state Medicaid program, for services not reimbursable by the state Medicaid program because Maxim lacked adequate documentation to support the services purported to have be performed; and
c. for the following offices, during the following periods, submitting or causing to be submitted false or fraudulent claims to the state Medicaid program for services not reimbursable by the state Medicaid programs because the offices were unlicensed:

i. Trenton, New Jersey (January 2003 to February 2004)
ii. Egg Harbor, New Jersey (July 2003 to February 2004)
iii. Gainesville, Georgia (October 2007 to February 2008)
iv. Brunswick, Georgia (December 2007 to February 2008)
v. Cartersville (Northwest), Georgia (December 2007 to February 2008)
vi. East Houston Texas (November 2005 to November 2006)
vii. East Tampa, Florida (April 2008 to November 2008)
viii. Orlando South, Florida (May 2008 to October 2008)
ix. The Villages, Florida (July 2008 to October 2008)
x. Treasure Coast, Florida (June 2008 to October 2008)
xi. New London, Connecticut (January 2009 to June 2009)
xii. Stamford, Connecticut (June 2007 to June 2009)
xiii. Middletown, Connecticut (March 2009 to June 2009)

J. This Agreement is neither an admission of facts or liability by Maxim nor a concession by the State that its allegations are not well founded. Except for the specific conduct which Maxim is acknowledging, as described in the Deferred Prosecution Agreement filed in the Federal Criminal Action, Maxim expressly denies the allegations of the State as set forth herein and in the Civil Actions.

K. To avoid the delay, expense, inconvenience and uncertainty of protracted litigation of these causes of action, the Parties mutually desire to reach a full and final settlement as set forth below.

III. TERMS AND CONDITIONS

NOW, THEREFORE, in reliance on the representations contained herein and in consideration of the mutual promises, covenants and obligations set forth in this Agreement, 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, (as defined herein) collectively, the sum of one hundred and twenty-one million and five hundred and fourteen thousand and one hundred and ninety-nine dollars and eight cents ($121,514,199.08), plus

interest accrued thereon at a rate of 1.25% per annum from June 24, 2010 and continuing until and including the day before complete payment is made (the "Settlement Amount"). The Settlement Amount shall be paid as follows:

a. Maxim shall pay to the United States the sum of sixty- five million, five hundred and fifty-four thousand, four hundred eighty-four dollars and forty-five cents ($65,554,484.45), plus interest accrued thereon at a rate of 1.25% per annum from June 24, 2010, and continuing until and including the day before complete payment is made (the "Federal Settlement Amount"), in accordance with the payment schedule ("Federal 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 according to the Federal Payment Schedule. Maxim agrees to pay the Initial Payment to the United States by electronic funds transfer pursuant to written instructions agreed to by the United States and Maxim no later than ten (10) business days after the Federal Settlement Agreement is fully executed by the parties and delivered to Maxim's attorneys.

b. Maxim shall pay to the Medicaid Participating States the principal sum of fifty-five million and nine hundred and fifty-nine thousand and seven hundred and fourteen dollars and sixty-three cents ($55,959,714.63), 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 State Payment Schedule (Exhibit B). Within 10 days after the Effective Date of this Agreement, Maxim shall set aside $23,057,523.54, ("Initial State Amount") plus any interest that has accrued on the Initial State Amount in an interest-bearing money market

or bank account held in the name of Maxim, but segregated from other Maxim accounts (the "State Settlement Account"). Upon reaching agreements with, and obtaining releases from, each of the Medicaid Participating States and upon receipt of written payment instructions from the State Team, Maxim shall pay the initial payment of the Medicaid State Settlement Amount ("Initial State Payment") by electronic funds transfer to the New York State Attorney General's National Global Settlement Account ("NY State Account"). The Initial State Payment shall be the portion of the Initial State Amount attributable to the recoveries of the Medicaid Participating States plus the *pro rata* of interest that has accrued thereon. If all eligible states become Medicaid Participating States, the Initial State Payment will be equal to the Initial State Amount. Maxim shall thereafter make fixed pro rata payments according to the Payment Schedule for each settling Medicaid Participating State by electronic funds transfer to the NY State Account. 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.

(i) Maxim shall execute a State Settlement Agreement in the form to which Maxim and the State Team have agreed, or in a form otherwise agreed to by Maxim and an individual state, with any State that executes such an Agreement within 60 days of the the State's receipt of this Settlement Agreement. Those states with which Maxim executes a State Settlement Agreement during this time period shall be defined as "Medicaid Participating States." Within 10 days after the 60th day following the State's receipt of this Settlement Agreement or five business days after Maxim's attorneys receive written wire instructions provided by the State Team, whichever is later, Maxim shall pay to the NY State Account the Initial State Amount. This payment shall consist of each Medicaid Participating State's share of the Initial Amount (as set forth in a communication transmitted from the State Team to Maxim's attorneys) (the "Individual State Share") plus that

State's *pro rata* share of interest accrued from June 24, 2010. After making the payment to the NY State Account, in accordance with the terms of this paragraph, Maxim shall have no continuing obligations with respect to any payment pursuant to this agreement to any Medicaid Participating States except as to payments set forth in the State Payment Schedule (Exhibit B), which will also be electronically transferred on the appropriate dates to the NY State Account.

(ii) Maxim may, at its sole discretion, waive any rights that it has reserved in sub-paragraph III. 1b(ii) with respect to payment of any Individual State Share.

(iii) Except as otherwise provided in this sub-paragraph, absent Maxim's consent, no State may become a Medicaid Participating State if it has not executed a Medicaid State Settlement Agreement within 60 days following the State's receipt of this Settlement Agreement. (A Medicaid Participating State shall be deemed to have become a Medicaid Participating State on the date on which it executed a State Settlement Agreement.) If Maxim is obligated pursuant to the terms of sub-paragraph III.1(b)(ii) to pay to the NY State Account an aggregate amount less than the Medicaid State Settlement Amount, Maxim shall be entitled to retain any such difference and no State shall be entitled to any portion of that difference pursuant to the terms of this Agreement.

c. The total portion of the Settlement Amount paid by Maxim in settlement for the Covered Conduct to the State is $11,767,271.00, consisting of a portion paid to the State under this Agreement and another portion paid to the Federal Government as part of the Federal Settlement Agreement. The individual portion of the Medicaid State Settlement Amount allocated to the State under this Agreement is the sum of $3,741,292.00, plus applicable interest.

(i) The Medicaid Participating States whose False Claims Act(s) had been properly pled by the relator, Richard W. West, agree that as soon as feasible after receipt of the Medicaid State Settlement amount described in para III b. above, the State Team will disburse agreed upon amounts, pursuant to the Relator's Payment Schedule attached as Exhibit C, the relators share, as set forth in a side letter with Robin Page West, Esq, counsel for relator Richard W. West.

(ii) The State agrees to dismiss with prejudice any supplemental state law claims asserted in the Civil Action against Maxim for the Covered Conduct.

d. 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 Medicaid Participating States acknowledge 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(d) as long as the ownership of the ultimate parent company of the Maxim legal entities described above remains the same as the ownership of Maxim Healthcare Services, Inc. as of January 1, 2011, as set forth in a April 28, 2011 letter from Laura Laemmle-Weidenfeld to Joyce R. Branda. For purposes of this Paragraph 1(d), "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 per cent (2%), 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(d).

e. In no event will Maxim pay, or cause to be paid by any affiliate or other entity, to Maxim's shareholders 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 provision shall prevent Maxim from making tax distributions to its shareholders 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(e) shall prevent Maxim from repurchasing shares of common stock from, or making payments with respect to incentive compensation agreements 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 provision shall prevent Maxim from paying reasonable remuneration to any Maxim shareholder for the fair market value of services rendered to Maxim or its agents, provided that any such remuneration must be reported, 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 the Settlement Amount and any interest owing on the Settlement Amount are paid in full.

iv. Any report required in this paragraph shall be sent to Assistant Attorney General John Kraynisk, New Jersey Division of Criminal Justice-Medicaid Fraud Control Unit, 25 Market Street, PO Box 085, Trenton, New Jersey 08625-0085 and marked "Pursuant to States v. Maxim Healthcare, Inc., Settlement, New Jersey case number 200703957, or to any other representative designated by the State Team.

2. In the event that Maxim fails to remit at least the total amount due to the United States and/or the Medicaid Participating 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, Esq., 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 State 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 State 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 Medicaid Participating States may at their option:

a) rescind their releases;

b) offset the remaining unpaid balance from any amounts due and owing to Maxim by any state Medicaid program, at the time of the Default; and/or

c) re-institute an action or actions against Maxim.

Maxim agrees not to contest any offset imposed and not to contest any collection action undertaken by the Medicaid Participating States pursuant to this Paragraph, either administratively or in any state or federal court. Maxim shall pay the Medicaid Participating States all reasonable costs of collection and enforcement under this Paragraph, including attorney's fees and expenses (collection costs). In the event one or more of the Medicaid Participating States re-institutes 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 Medicaid Participating 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, the State may, at its sole discretion, exclude Maxim from participating in all state health care programs until Maxim pays the State Settlement Amount, any interest owing as of the date of payment pursuant to the State Payment

Schedule, and collection costs. Exclusion for Default shall have statewide effect and shall also apply to all other state procurement and non-procurement programs. State 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 provides 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 state 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 State health care programs, and all 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. The state 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 the State in accordance with the provisions of 42 C.F.R. §§ 1001.3001-.3005 and applicable state regulations. Maxim will not be reinstated unless and until the state approves such request for reinstatement.

4. Subject to the exceptions in Paragraph 5 below, and in consideration of the obligations of Maxim set forth in this Agreement, conditioned upon payment by Maxim of the State's share of the Medicaid State Settlement Amount, and subject to Paragraph 13 below (concerning bankruptcy proceedings commenced within 91 days of the Effective Date of this Agreement or any payment under this Agreement), the State agrees to release Maxim, together with its predecessors; and current and former parents, divisions, subsidiaries, successors, transferees, heirs and assigns, and their current and former directors, officers, employees and agents individually and collectively (collectively, the "Maxim Released Entities"), from any civil or administrative monetary cause of action that the State has for any claims submitted or caused to be submitted to the State Medicaid Program as a result of the Covered Conduct.

5. Notwithstanding any term of this Agreement, the State specifically does not release any person or entity from any of the following liabilities:

(a) any criminal, civil, or administrative liability arising under state revenue codes;

(b) any criminal liability;

(c) any civil or administrative liability that any person or entity, including any Released Entities, has or may have to the State or to individual consumers or state program payors under any statute, regulation or rule not expressly covered by the release in paragraph 4 above, including but not limited to, any and all of the following claims: (i) State or federal antitrust violations; (ii) Claims involving unfair and/or deceptive acts and practices and/or violations of consumer protection laws;

(d) any liability to the State for any conduct other than the Covered Conduct;

(e) any liability which may be asserted on behalf of any other payors or insurers, including those that are paid by the State's Medicaid program on a capitated basis;

(f) any liability based upon obligations created by this Agreement;

(g) except as explicitly stated in this Agreement, any administrative liability, including mandatory exclusions from the State's Medicaid program;

(h) any express or implied warranty claims or other liability for defective or deficient products and services provided by Maxim; or

(i) any liability for personal injury or property damage or for other consequential damages arising from the Covered Conduct.

6. This Agreement is expressly conditioned upon resolution of the Federal Criminal Action by means of the Deferred Prosecution Agreement identified in paragraph II.F. of this Agreement.

7. In consideration of the obligations of Maxim set forth in this Agreement, and the Corporate Integrity Agreement ("CIA") that Maxim has entered into or will enter into with the Office of the Inspector General of the United States Department of Health and Human Services ("HHS-OIG") in connection with this matter, and conditioned on receipt by the State of its share of the State Medicaid Settlement Amount, except as reserved in Paragraph 4 above and subject to Paragraph 15 below (concerning bankruptcy proceedings commenced within 91 days of the Effective Date of this Agreement or any payment under this Agreement), the State agrees to release and refrain from instituting, recommending, directing or maintaining any administrative action seeking exclusion from the State's Medicaid program against the Maxim for the Covered Conduct or for the conduct set forth in the Federal Criminal Action. Nothing in this Agreement precludes

the State from taking action against Maxim in the event that Maxim is excluded by the federal government, or for conduct and practices other than the Covered Conduct.

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

9. In consideration of the obligations of the State set forth in this Agreement, Maxim waives and discharges the State, its agencies, political subdivisions, employees, servants, and agents from any causes of actions (including attorneys' fees, costs and expenses of every kind and however denominated) which Maxim has asserted, could have asserted, or may assert in the future against the State, its agencies, political subdivisions, employees, servants and agents, arising from the State's investigation and prosecution of the Covered Conduct.

10. The amount that Maxim must pay to the State pursuant to Paragraph 1 above will not be decreased as a result of the denial of claims for payment now being withheld from payment by the State's Medicaid program, or any other state payer, for the Covered Conduct; and, if applicable, Maxim agrees not to resubmit to the State's Medicaid program or any other state payer, any previously denied claims, which denials were based on the Covered Conduct, and agrees not to appeal or cause the appeal of any such denials of claims.

11. Maxim shall not seek payment for any of the claims for reimbursement to Medicaid covered by this Agreement from any health care beneficiaries or their parents, sponsors, legally responsible individuals or third party payors.

12. Maxim expressly warrants that it has reviewed its financial condition and that it is currently solvent within the meaning of 11 U.S.C. §§ 547(b)(3) and 548(a)(B)(ii)(I), and expects to remain solvent following payment of the State Settlement Amount and compliance with sub-paragraphs III.1.b(i), (ii), and (iv) of the State Settlement Agreement. Further, the Parties expressly warrant that, in evaluating whether to execute this Agreement, the Parties (a) have intended that the mutual promises, covenants and obligations set forth herein constitute a contemporaneous exchange for new value given to Maxim within the meaning of 11 U.S.C. § 547(c)(1), and (b) have concluded that these mutual promises, covenants and obligations do, in fact, constitute such a contemporaneous exchange.

13. In the event Maxim commences, or another party commences, within 91 days of the Effective Date of this Agreement or any payment made hereunder, 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 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 assets, Maxim agree(s) as follows, to the extent consistent with applicable law:

a. Maxim's obligations under this Agreement may not be avoided pursuant to 11 U.S.C. §§ 547 or 548, 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 or 548; (ii) Maxim was insolvent at the time this Agreement was entered into, or became insolvent as a result of the payment made to the State hereunder; 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 State, at its sole option, may rescind the releases provided in this Agreement, and bring any civil and/or administrative action or proceeding against Maxim for the liability that would otherwise be covered by the releases provided in this Agreement. If the State chooses to do so, Maxim agrees that for purposes only of any actions or proceedings referenced in the first clause of this Paragraph, any such actions or proceedings brought by the State (including any proceedings to exclude Maxim from participation in the State's Medicaid program) are not subject to an "automatic stay" pursuant to 11 U.S.C. § 362(a) as a result of the action, case or proceeding described in the first clause of this Paragraph, and that Maxim shall not argue or otherwise contend that the State's actions or proceedings are subject to an automatic stay; 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 actions or proceedings which are brought by the State within 120 calendar days of written notification to Maxim that the releases herein have been rescinded pursuant to this Paragraph, except to the extent such defenses were available before October 8, 2004; and the State has a valid demand against Maxim in the amount of its share of the Medicaid State Settlement Amount plus applicable multipliers and penalties and it may pursue its demand *inter alia*, in the case, action, or proceeding referenced in the first clause of this Paragraph, as well as in any other case, action or proceeding; and Maxim acknowledges that its agreements in this Paragraph are provided in exchange for valuable consideration provided in this Agreement.

14. The Parties each represent that this Agreement is freely and voluntarily entered into without any degree of duress or compulsion whatsoever.

15. Maxim agrees to cooperate fully and truthfully with any State investigation of individuals or entities not released in this Agreement stemming from the Covered Conduct. Upon reasonable notice, Maxim shall facilitate, and agree not to impair, the cooperation of their directors, officers, employees or agents, for interviews and testimony, consistent with the rights and privileges of such individuals and of Maxim. Upon request, Maxim agrees to furnish to the State complete and unredacted copies of all non-privileged documents, reports, memoranda of interviews, and records in their possession, custody or control, concerning the Covered Conduct. Maxim shall be responsible for all costs it may incur in complying with this paragraph.

16. 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.

17. Except as otherwise stated in this Agreement, this Agreement is intended to be for the benefit of the Parties only; and by this instrument the Parties do not release any liability against any other person or entity.

18. Nothing in this Agreement constitutes an agreement by the State concerning the characterization of the amounts paid hereunder for purposes of State or Federal revenue codes.

19. In addition to all other payments and responsibilities under this Agreement, Maxim agrees to pay all reasonable expenses and travel costs of the State Team. Maxim will pay this amount by separate check made payable to the National Association of Medicaid Fraud Control Units, after the Medicaid Participating States execute their respective Agreements, or as otherwise agreed by the Parties.

20. This Agreement is governed by the laws of the State.

21. The undersigned Maxim signatories represent and warrant that they are authorized as a result of appropriate corporate action to execute this Agreement. The undersigned State signatories represent that they are signing this Agreement in their official capacities and that they are authorized to execute this Agreement on behalf of the State through their respective agencies and departments.

22. The "Effective Date" of this Agreement shall be the date of signature of the last signatory to this Agreement. Facsimiles of signatures shall constitute acceptable binding signatures for purposes of this Agreement.

23. This Agreement shall be binding on all successors, transferees, heirs and assigns of the Parties.

24. This Settlement Agreement constitutes the complete agreement between the Parties with respect to this matter and shall not be amended except by written consent of the Parties.

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

STATE OF NORTH CAROLINA

By: *Charles H. Hobgood* Dated: *7/6/2011*

CHARLES H. HOBGOOD
Director, Medicaid Investigations Unit
Office of the Attorney General

By: *Craigan Gray* Dated: *6/30/2011*

DR. CRAIGAN L. GRAY
Director, Division of Medical Assistance

MAXIM HEALTHCARE SERVICES, INC.

By: ______________________ Dated: 9/6/11

W. BRADLEY BENNETT
Chief Executive Officer

By: ______________________ Dated: 9/6/11

TONI-JEAN LISA
General Counsel

By: ______________________ Dated: ________

LAURA LAEMMLE-WEIDENFELD, Esq.
Patton Boggs LLP
Counsel for Maxim Healthcare Services, Inc.

MAXIM HEALTHCARE SERVICES, INC.

By: ______________________________ Dated: ________

W. BRADLEY BENNETT
Chief Executive Officer

By: ______________________________ Dated: ________

TONI-JEAN LISA
General Counsel

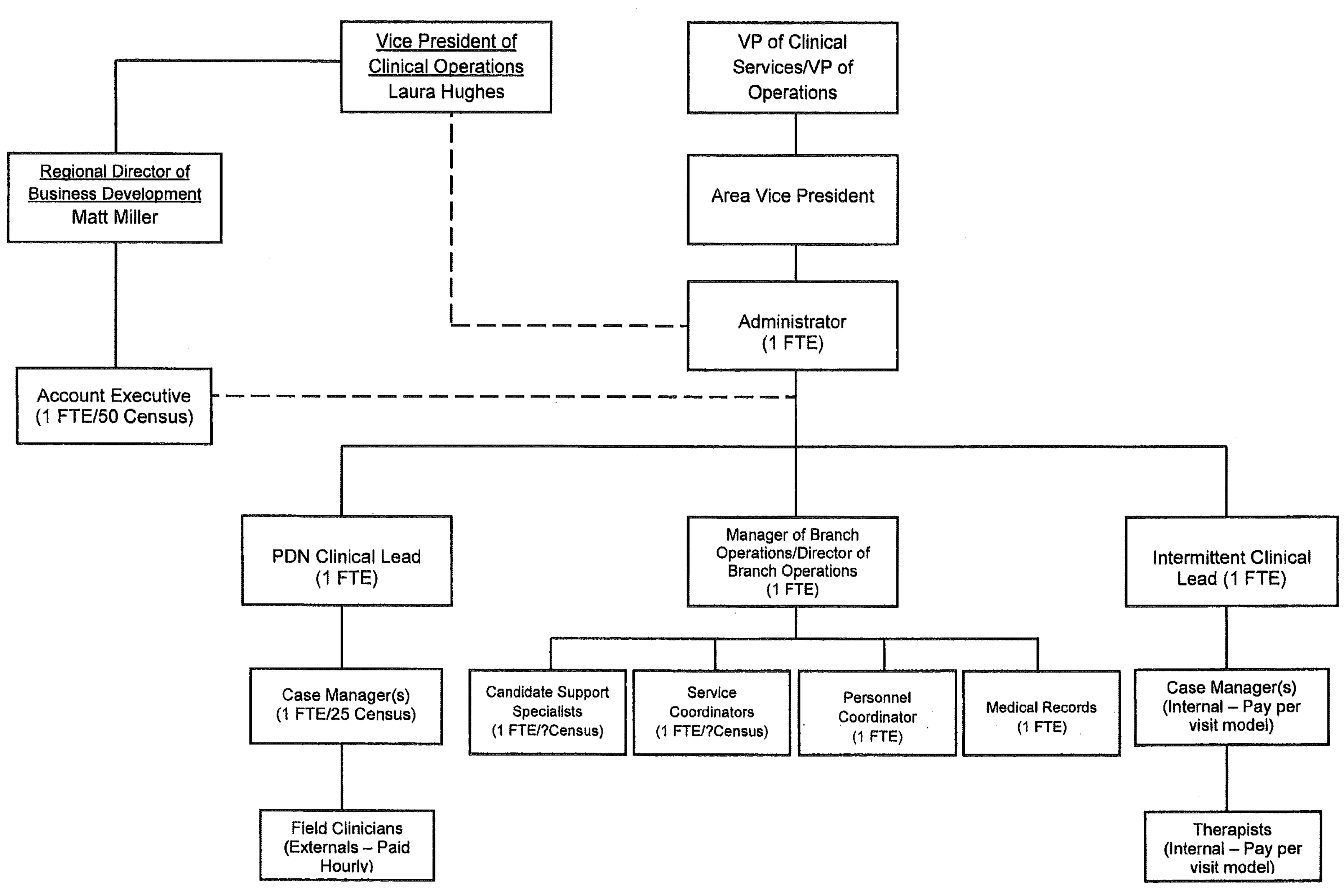
By: [signature] Dated: 9/16/2011

LAURA LAEMMLE-WEIDENFELD, Esq.
Patton Boggs LLP
Counsel for Maxim Healthcare Services, Inc.

Attachment H

Maxim Medicare Home Health Agency Organization Chart, Exhibit 3, Project No. F-10003-12

Medicare Agency Organizational Chart



Source: Maxim Mecklenburg CON Application F-10003-12 Exhibit 3