WRITTEN COMMENTS ON CLEVELAND COUNTY

2024 MEDICARE-CERTIFIED HOME HEALTH AGENCY NEED DETERMINATION

SUBMITTED BY WELL CARE HOME HEALTH OF CLEVELAND, INC. / PROJECT ID C-012490-24

Well Care Home Health of Cleveland, Inc. (Well Care) proposes to develop a home health agency in Cleveland County (Project ID C-012490-24). Two additional applications were submitted in response to the need determination in the 2024 State Medical Facilities Plan ("SMFP") for one new Medicare-certified home health agency in Cleveland County:

Applicant / Project ID	Well Care Written Comments Begin on Page #
CaroMont Partners (CaroMont) Project I.D. C-012472-24	11
PHC Home Health-Cleveland (PHC) Project I.D. C-012487-24	19

These comments are submitted by Well Care in accordance with N.C. Gen. Stat. § 131E-185(a1)(1) to address the representations in the applications, including a comparative analysis and a discussion of the most significant issues regarding the applicants' conformity with the statutory and regulatory review criteria ("the Criteria") in N.C. Gen. Stat. §131E-183(a) and (b). Other non-conformities in the competing applications may exist. Nothing in these Comments is intended to amend the Well Care Application and nothing contained here should be considered an amendment to the Well Care Application as submitted.

COMMENTS REGARDING COMPARATIVE REVIEW

The following factors are suggested for all reviews regardless of the type of services or equipment proposed:

- Conformity with Statutory and Regulatory Review Criteria
- Scope of Services
- Historical Utilization
- Geographic Accessibility (Location within the Service Area)
- Access by Service Area Residents
- Access by Underserved Groups: Medicaid
- Access by Underserved Groups: Medicare
- Competition (Access to a New or Alternate Provider)
- Projected Average Net Revenue per Patient, Procedure, Case, or Visit
- Projected Average Total Operating Cost per Patient, Procedure, Case, or Visit

The following additional factor is suggested for home health proposals:

- Average Number of Visits per Patient

Project Analysts have the discretion to apply additional factors based on the type of proposal.

Conformity to CON Review Criteria

Three CON applications have been submitted seeking one home health agency in Cleveland County. Based on the 2024 SMFP's need determination for one additional home health agency, only one application can be approved. Only applicants demonstrating conformity with all applicable Criteria can be approved, and only the application submitted by Well Care demonstrates conformity to all Criteria:

Conformity of Competing Applications

Applicant	Project I.D.	Conforming/ Non-Conforming
CaroMont	C-012472-24	No
PHC	C-012487-24	No
Well Care	**C-012490-24**	**Yes**

The Well Care application for a new home health agency is based on reasonable and supported volume projections and adequate projections of cost and revenues. As discussed separately in this document, the competing applications contain errors and flaws which result in one or more non-conformities with statutory and regulatory review Criteria. Therefore, **Well Care** is the most effective alternative regarding conformity with the review criteria.

Scope of Services

Generally, the application proposing to provide the broadest scope of services is the more effective alternative regarding this comparative factor. With regard to scope of services, all of the applications submitted are in response to the 2024 SMFP which includes a need determination for one Medicare-certified home health agency in Cleveland County. All the applicants propose to develop one Medicare-certified home health agency in Cleveland County. Regarding this comparative factor, the competing applications are equally effective alternatives.

Geographic Accessibility (Location within the Service Area)

Since a home health agency serves patients in their place of residence, the Agency has historically determined the geographic location of the home health office is not a deciding factor. Additionally, all three applicants propose to develop a new home health agency in Shelby. Therefore, the applications are equally effective regarding geographic access.

Projected Charges Per Visit by Staff Discipline

Form F.5 provides the appropriate information for the Agency to evaluate potential costs to patients and third-party payors. Generally speaking, commercial insurance and private pay patients reimburse home health providers on a per visit basis. Thus, lower charges per visit may indicate comparatively lower cost to patients and third-party payors. Medicare and Medicaid have set payments for home health reimbursement that do not vary depending on the provider of the service; therefore, Medicare and Medicaid will not incur higher costs for the services proposed.

The following table compares charges per visit by staff discipline in the third full fiscal year following project completion for all applicants in the review. Projected charges were obtained from Form F.5 of the respective applications.

Charges per Visit by Staff Discipline, Project Year 3

Rank		Nursing	Physical Therapy	Speech Therapy	Occupational Therapy	Social Worker	Home Health Aide
1	Well Care	**$135**	**$135**	**$135**	**$135**	$350	$70
2	PHC	$139	$171	$171	$171	$204	**$64**
3	CaroMont	$225	$225	$225	$225	**$225**	$100

Source: Form F.5 from each application

Well Care projects the lowest charges per visit for nursing, physical therapy, speech therapy, and occupational therapy. Therefore, **Well Care** is the most effective alternative regarding costs to patients and third-party payors.

Projected Average Net Revenue Per Visit

The following table compares the projected average net revenue per visit for the third year of operation following project completion for all the applicants, based on the information provided in the applicants' pro forma financial statements (Section Q).

Rank	Applicant	Net Revenue	# of Visits	Net Revenue per Visit
1	Well Care	$3,437,629	30,211	**$113.79**
2	PHC	$2,242,159	19,585	$114.48
3	CaroMont	$2,489,398	19,293	$129.03

Source: Form C.5 and Form F.2 from each application

Well Care projects the lowest net revenue per unduplicated visit in the third full fiscal year following project completion. Therefore, regarding this comparative factor, the application submitted by **Well Care** is the most effective alternative.

Projected Average Net Revenue Per Unduplicated Patient

The following table compares the projected average net revenue per patient for the third year of operation following project completion for all applicants, based on the information provided in the applicants' pro forma financial statements (Section Q).

Rank	Applicant	# of Unduplicated Patients	Net Revenue	Net Revenue per Unduplicated Patient
3	Well Care	1,131	$3,437,629	$3,039
2	PHC	794	$2,242,159	$2,824
1	CaroMont	912	$2,489,398	$2,730

Source: Form C.5 and Form F.2 from each application

Regarding this factor, historically the Agency has generally considered the application proposing the lowest average net revenue as the more effective alternative citing the rationale that "a lower average may indicate a lower cost to the patient or third-party payor." Both PHC and CaroMont are not approvable; therefore, the respective applications cannot be effective alternatives. Well Care is an effective alternative because its application is based on reasonable and supported patient and revenue projections.

Average Operating Expense Per Visit

The following table compares the projected average operating expense per visit for the third year of operation following project completion for all applicants, based on the information provided in the applicants' pro forma financial statements (Section Q).

Average Total Operating Cost Per Visit

Rank	Applicant	Total Visits	Total Operating Costs	Average Total Operating Cost per Visit
1	Well Care	30,211	$3,078,502	**$102**
2	PHC	19,585	$2,011,730	$103
3	CaroMont	19,293	$2,415,836	$125

Source: Form C.5 and Form F.2 from each application

Regarding this factor, historically the Agency has considered the application proposing the lowest average operating expense as the more effective alternative citing the rationale that "a lower average cost may indicate a lower cost to the patient or third-party payor or a more cost-effective service."

Well Care proposes the lowest total operating cost per visit and the lowest operating cost per patient. Therefore, the application submitted by **Well Care** is the most effective alternative regarding this comparative factor.

Access By Underserved Groups

Underserved groups are defined in G.S. 131E-183(a)(13) as follows:

"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."

The metrics used by the Agency are determined by whether the applications included in the review provide data that can be compared and whether such a comparison would be of value in evaluating the alternative factors. Due to the vast differences in defining charity care among healthcare providers, comparisons of charity care are typically inconclusive. Based on a review of the charity care/financial assistance policies of the competing applications, there is no consistent definition of charity care that would enable a conclusive comparison of access by charity care patients. Therefore, for access by underserved groups, the following section compares access for Medicare and Medicaid patients.

Projected Medicare Access

The following table compares the total number of duplicated patients in the third full fiscal year of operation, the number of duplicated Medicare patients in third full fiscal year of operation, and duplicated Medicare patients as a percentage of total duplicated patients for each application. Generally, the application proposing the highest number of Medicare patients is the more effective alternative on this comparative factor. This is the approach used by the Agency in the 2023 New Hanover County Home Health Agency Review (pp. 100-101).

In this 2024 Cleveland County Home Health Agency Review, for CaroMont, as discussed separately, the duplicated Medicare patients in the third full fiscal year of operation cannot be reliably compared because CaroMont did not properly complete Form C.5 in its application.

Projected Medicare Duplicated Patients – 3rd Full Fiscal Year

Rank	Applicant	Total # of Dup. Patients	Total # of Dup. Medicare Patients	Dup. Medicare Patients as a % of Total Dup. Patients
1	Well Care	4,388	1,634	37.23%
2	PHC	3,074	941	30.61%
--	CaroMont	2,472	---	---

Source: Form C.5 of each application

As shown in the table above, Well Care projects to serve the highest number of duplicated Medicare patients in the third full fiscal year of operation and the highest percentage of duplicated Medicare patients as a percentage of total duplicated patients. Therefore, as to projected access by Medicare recipients, the application submitted by Well Care is the most effective alternative.

Projected Medicaid Access

The following table compares the total number of unduplicated patients in the third full fiscal year of operation, the number of unduplicated Medicaid patients in third full fiscal year of operation, and unduplicated Medicaid patients as a percentage of total duplicated patients for each application in this review Generally, the application proposing the highest number of Medicaid patients is the more effective alternative on this comparative factor. This is the approach used by the Agency in the 2023 New Hanover County Home Health Agency Review (pp. 101-102).

Projected Medicaid Duplicated Patients – 3rd Full Fiscal Year

Rank	Applicant	Total # of Dup. Patients	Total # of Dup. Medicaid Patients	Dup. Medicaid Patients as a % of Total Dup. Patients
1	Well Care	4,388	658	15%
2	PHC	3,074	461	15%
3	CaroMont	2,472	183	7.4%

Source: The total number of unduplicated patients is from Form C.5 of each application and the Medicaid percentage is from Section L.3 of each application. The number of unduplicated Medicaid patients was calculated by applying the Medicaid percentage from the table in Section L.3 to the applicant's projections of total unduplicated patients in the third full fiscal year of operation from Form C.5.

As shown in the table above, Well Care projects to serve the highest number of unduplicated Medicaid patients in the third full fiscal year of operation. Well Care and PHC project the same percentage of unduplicated Medicaid patients as a percentage of total unduplicated patients. Therefore, as to projected access by Medicaid recipients, the application submitted by Well Care is the most effective alternative.

In the 2023 New Hanover Home Health Agency Review, Well Care projected to serve the highest number of unduplicated Medicaid patients in the third full fiscal year of operation. A competing applicant (Interim HealthCare) projected to serve a higher percentage of unduplicated Medicaid patients as a percentage of total unduplicated patients but a lower number of unduplicated Medicaid patients.

In the 2023 New Hanover Home Health Agency Review, the Agency found that, regarding projected access by Medicaid recipients, the application submitted by Well Care was the more effective alternative and the application submitted by Interim HealthCare was a less effective alternative. In other words, since Well Care had the highest number of Medicaid patients, even though it projected a lower percentage than Interim, Well Care was found more effective on the projected access by Medicaid recipients factor.

Likewise, in this 2024 Cleveland County Home Health Agency Review, because Well Care projects the highest number of unduplicated Medicaid patients, notwithstanding the "tie" as between the percentages proposed by Well Care and PHC, Well Care is appropriately found more effective on the projected access by Medicaid recipients factor.

Salaries for Direct Care Staff

In recruitment and retention of personnel, salaries are a significant factor. The applicants provide the following information in Section Q, Form H.2. The following table compares the proposed salaries for direct-care staff. Generally, the application proposing the highest annual salary for direct care staff is the more effective alternative regarding this comparative factor.

Direct Care Staff	Well Care	PHC	CaroMont
Registered Nurse	**$113,075**	$109,304	$93,058
LPN	**$73,999**	$72,162	$61,456
Home Health Aide	$50,746	**$50,938**	$43,392
Social Worker	**$87,790**	$68,979	$75,417
Physical Therapist	**$134,843**	$106,121	$110,865
Occupational Therapist	**$129,105**	$106,121	$101,714
Rank	1	2	3

Source: Form H

As shown in the table above, Well Care projects the highest annual salaries in Project Year 3 for registered nurses, licensed practical nurses, social workers, physical therapists, and occupational therapists. Well Care projects the highest salaries for five direct care staff positions, which is the highest of the competing applications. Well Care projects the second highest home health aide salary. Therefore, with regard to the salaries of direct care staff, the application submitted by **Well Care** is the most effective alternative.

Access By Service Area Residents

Chapter 12 of the 2024 SMFP states, "*A Medicare-certified home health agency or office's service area is the county in which the agency or office is located. Each of the 100 counties in the state is a separate service area*." Therefore, for the purpose of this review, Cleveland County is the service area. Facilities may also serve residents of counties not included in the service area.

The following table illustrates access by service area residents during the third full fiscal year following project completion.

Access By Service Area Residents

	Well Care	PHC	CaroMont
Projected Cleveland County Residents Served in Project Year 3	**643**	601	912
Rank	2	3	1

As shown in the table above, CaroMont projects to serve the highest number of Cleveland County residents (912). As discussed separately in these comments, CaroMont does not conform to all applicable statutory and regulatory criteria, and therefore the application is not approvable. Therefore, **Well Care** is the most effective alternative with respect to access by service area residents.

Average Number of Visits per Unduplicated Patient

The following table shows the average number of visits per unduplicated patient projected by each applicant in Project Year 3.

Average Visits per Unduplicated Patient – 3rd Full FY

Rank	Applicant	Unduplicated Patients	Total Visits	Average Visits per Unduplicated Patient
1	Well Care	1,131	30,211	**26.7**
2	PHC	794	19,585	24.7
3	CaroMont	912	19,293	21.2

Source: Form C.5

Well Care projects the highest number of average visits per unduplicated patient (26.7). The Well Care application for a new home health agency is based on reasonable and supported volume projections and adequate projections of cost and revenues. Therefore, **Well Care** is the most effective alternative regarding the average number of visits per unduplicated patient.

Summary

The following table lists the comparative factors and indicates the relative effectiveness of each applicant for each metric. The following table makes no assumptions on the factor "Conformity with Review Criteria."

Comparative Factor	Well Care	PHC	CaroMont
Scope of Services	Equally Effective	Equally Effective	Equally Effective
Access by Service Area Residents	Less Effective	Less Effective	**Most Effective**
Competition (Access to a New or Alternate Provider)	Equally Effective	Equally Effective	Equally Effective
Access by Medicare Patients	Less Effective	Less Effective	**Most Effective**
Access by Medicaid Patients	**More Effective**	Less Effective	Less Effective
Average Number of Visits per Unduplicated Patient	**Most Effective**	Less Effective	Less Effective
Average Net Revenue Per Visit	**Most Effective**	Less Effective	Less Effective
Average Net Revenue per Unduplicated Patient	Less Effective	Less Effective	**Most Effective**
Average Operating Expense per Visit	**Most Effective**	Less Effective	Less Effective
Ratio of Average Net Revenue per Visit to Average Operating Expense Per Visit	Less Effective	Less Effective	**Most Effective**
Direct Care Salaries	**Most Effective**	Less Effective	Less Effective
Charges per Visit by Staff Discipline, Project Year 3	**Most Effective**	Less Effective	Less Effective

Well Care is determined to be the most effective alternative for the following factors:

- Access by Medicare Recipients
- Access by Medicaid Recipients
- Average Number of Visits per Unduplicated Patient
- Average Net Revenue Per Visit
- Average Operating Expense per Visit
- Charges per Visit by Staff Discipline, Project Year 3
- Direct Care Salaries

Well Care is a most effective alternative for seven factors, which is the most of any applicant in this Review. Therefore, the Well Care application is the most effective alternative in this competitive review.

COMMENTS SPECIFIC TO CAROMONT HOME HEALTH CARE INC. (CaroMont) PROJECT I.D. C-012472-24

Comments regarding CaroMont's Assumptions of CMS Certification

CaroMont erroneously assumes that it will secure Medicare certification on the same day in which it obtains its licensure from DHSR.

	Licensure Obtained	Services Offered	CMS Certification Obtained
CaroMont	07/01/2025	**07/01/2025**	**07/01/2025**

Source: CaroMont application, Section P, page 119

This is not a reasonable assumption, and it impacts CaroMont's conformity with multiple criteria. *See* Discussion under Criteria (3) and (5).

An organization cannot legally begin seeing patients until it has been issued a license for home health services by the state. According to Section P, page 119, CaroMont projects that its license will be issued on 7/1/2025. CMS requires that before any organization is eligible for an initial survey, they must have an active census of seven (7) patients and have served 10 total patients. In addition, the minimum number of days that an initial survey must last is two days per the State Operations Manual. Thus, because CaroMont will not be able to begin admitting patients to their service until the license is obtained (7/1/25), it is unreasonable that CaroMont could meet the 10 total patients served threshold on the same day, and have the initial survey completed on the same day. Notwithstanding the additional delays noted below:

- Medicare has a time-consuming, six-step approval process for home health agencies.

- After obtaining a license, an agency must complete an initial onsite survey to determine compliance with the health and safety conditions of participation (CoP) by the State Survey Agency (SA) or by a CMS-approved Accreditation Organization (AO). The agency is required to have provided skilled home health services to a minimum of 10 patients before a survey is conducted, with at least seven of the 10 patients should be receiving care from the home health agency at the time of the initial Medicare Survey.

- Licensed home health agencies must apply to enroll in the Medicare program using a Medicare Enrollment Application commonly known as the CMS-855A form.

- These forms are submitted in the system referred to as PECOS (the Provider Enrollment, Chain, and Ownership System).

- After a licensed HHA submits its application through PECOS, the Application will go to Palmetto GBA (the Palmetto Government Benefits Administration).

- Palmetto GBA then has up to six months to review, approve or deny a Medicare Enrollment Application.

- Only after Palmetto GBA completes his stage of the process will it begin the enrollment process.

- CMS then requires an accredited organization or state agency to then survey the HHA to determine its conformity with the Medicare Conditions of Participation which operate as the federal certification standards.

- CMS will then send what is commonly referred to as a tie-in notice letter with the home health agency's Medicare provider number.

- Reimbursement is generally allowable from the date that the certification recommendation is made by the surveying body (either state agency or accredited organization), but funds will not be transferred until the "tie in" notice has been completed.

Not only will CMS not reimburse a provider before it is Medicare-certified, during this period, reimbursements from other payor sources can also be expected to be impacted.

CaroMont improperly assumes Medicare certification will occur immediately upon licensure, meaning that CaroMont's projected Year One utilization is based on the improper premise that its patient load and visits would not be impacted by the typical pre-certification period. Moreover, CaroMont then built on these faulty Year One projections to improperly project more patients and visits in Years Two and Three. Because Year One is based on the erroneous assumption of nearly immediate full utilization, Year One patient visits are overstated and projections in Years Two and Three. It is also important to note that these improper projections also cascade to poison other important factors in the application, such as net revenue projections, providing a significant and unfair advantage to CaroMont's application relative to other applicants with reasonable and realistic timeline assumptions.

In its application as filed, Well Care properly took into consideration the timeframe associated with the Medicare certification process.[1] CaroMont did not.

Comments Regarding Criterion 1

CaroMont does not adequately demonstrate how its projected volumes incorporate the concept of maximizing healthcare value for resources expended. CaroMont does not adequately demonstrate the need to develop a new Medicare-certified HHA and does not adequately demonstrate that developing a new Medicare-certified HHA would not be an unnecessary duplication of existing and approved services. CaroMont does not demonstrate the need for the proposed project and does not demonstrate that the proposed project is not an unnecessary duplication of existing and approved health care services in the service area and thus, cannot demonstrate that it will maximize healthcare value for resources expended in meeting the need identified in the 2024 SMFP. Thus, the CaroMont application is not consistent with Policy GEN-3.

[1] As described in Well Care's assumptions for Form F.2b, "*Year One revenues reflect the time associated with initial certification for the new agency. Well Care conservatively projects no Medicare or Medicaid reimbursement during the first six months of Project Year 1 until the agency is certified*."

Comments Regarding Criterion 3

CaroMont's assumptions and methodology for projecting home health patients are unreasonable and not supported.

The CaroMont "Admits per Month" Assumptions are Not Reasonably Supported

Much like HealthView in the 2023 New Hanover County Home Health Agency Review, CaroMont relies on projections for "admits per month," or, in other words, a "fill-up rate" that is not reasonably or adequately supported by any stated assumptions.

In the 2023 New Hanover County Home Health Agency Review, HealthView stated:

"The assumptions made for the total number of patients in total are based on a fill-up rate average of 3 unduplicated patients per month during years one and two, and 1 unduplicated patient per month during year three … While this fill-up rate is conservative, it is consistent with previous CON applications for new Home Health Agencies offering similar services and is also consistent with the recent trend of transition from institutional / congregate living to in-home patient care."

As explained below, the 2023 New Hanover County Home Health Agency Findings indicated that HealthView failed to provide adequate support for its fill-up rate assumptions.

The Agency explained that none of the recently filed Home Health Agency applications used similar assumptions. The Agency Findings examined multiple prior Review and found no support for the approach used by HealthView: "None of the 10 applications involved assumptions and methodology similar to the ones used by the applicant in the current application." (2023 New Hanover County Home Health Agency Findings, p. 16).

The Agency Findings questioned this "fill-up rate" approach used by HealthView in the 2023 New Hanover County Home Health Agency Review because it was not adequately supported nor based on prior Reviews. The Agency found HealthView non-conforming.

CaroMont has used the same approach and, consistent with its New Hanover Findings, the Agency should likewise find CaroMont non-conforming to Criterion (3).

Notwithstanding differences in the two Reviews, it is also notable that the CaroMont fill-up rate averages by month for unduplicated patients differ markedly from those the Agency questioned when proposed by HealthView in 2023.

In the 2023 New Hanover County Home Health Agency Review, HealthView assumed only 3 unduplicated patient admissions per month in years one and two, followed by only 1 unduplicated patient admission per month in its third year.

In this 2024 Cleveland County Home Health Agency Review, CaroMont assumes an average of 12 unduplicated patient admissions per month. (Step 3, CaroMont Need Methodology). CaroMont assumes 15 unduplicated patient admissions per month in year two and 20 unduplicated patient admissions per month in year three. These assumptions are much more aggressive than the same types of assumptions

relied upon by HealthView (3 unduplicated patient admissions per month in year two and only 1 unduplicated patient admission per month in year three).

Unreasonable Assumptions for Capture of 100% of Hospital Home Health Discharges

After projecting an average of 12 unduplicated patient admissions per month, CaroMont further assumes it will *additionally* capture 100% of the inpatient and outpatient discharges to home health historically served at CaroMont Regional Medical Center in Gastonia.

In Section Q, Step 3 of its methodology, CaroMont assumes that 100 percent of Cleveland County inpatients and outpatients treated at CaroMont Regional Medical Center in Gastonia and discharged to home health will choose the proposed CaroMont home health agency. Such an assumption is highly problematic for a multitude of reasons.

First, this assumption seems inconsistent with well-established regulations that ensure patients have a choice in the post-acute provider that delivers their care. Generally, as part of the discharge planning process, hospitals must provide patients with a need for home health services a "choice list" of available home health providers in the area that can meet their care needs. Moreover, hospitals may not specify or limit qualified providers from selection, and must notify patients if a particular home health provider is affiliated with the hospital.

Second, this assumption represents a radical change in CaroMont's historical home health referral patterns. Indeed, the patients historically discharged from CaroMont Regional Medical Center to home health have been served by 15 different home health agencies.[2]

Third, this assumption leads to major questions as to its operational feasibility in a health care operating environment that entails frequent staffing challenges, widespread workforce shortages, and high-acuity patient care needs.

Accordingly, as suggested by the data contained in the State Medical Facilities Plan, in no North Carolina county does any singular home health provider service all (or close to all) of an area's referred home health volume, even in situations where a home health provider is affiliated with the local hospital. Normally, a multitude of home health providers come together to serve a hospital's home health referral needs.

CaroMont believes it is reasonable "that a majority of patients will select CaroMont Partners for the following reasons identified in the response to Section N.2.a, on pages 109-112 in the CON application." *Emphasis added*. However, CaroMont's response to Section N.2.a merely describes the manner in which CaroMont believes its proposal will have a positive impact on cost-effectiveness, quality, and access of home health services. There is no explanation to support CaroMont's assumption that it will serve 100 percent of Cleveland County inpatients and outpatients treated at CaroMont Regional Medical Center in Gastonia and discharged to home health.

CaroMont annualizes FY2024 patient discharges to home health and calculated the 1-year change in inpatient and outpatient discharges to home health. CaroMont then projected the number of inpatient

[2] *See* 2024 SMFP, Chapter 12: Home Health Data by County of Patient Origin - 2022 Data https://info.ncdhhs.gov/dhsr/mfp/pdf/por/2023/Chapter12PatientOrigin_final.pdf

and outpatient discharges to home health for FY2025 through FY2028 by multiplying the previous year's discharges by 50% of the calculated 1-year change. These assumptions result in an annual growth rate of over 10%.

Discharges	FY2023	Annualized FY2024	Annual Change	50% of the Annual Change
Inpatient	289	352	21.8%	**10.9%**
Outpatient	130	156	20.0%	**10.0%**
Total	**419**	**508**		

Calculations: Annual Change = (Annualized FY2024 – FY2023) / FY2023
50% of Annual Change = Annual Change x 0.50

Source: CaroMont application, Section Q, Step 3

CaroMont failed to provide any explanation to support the reasonableness of the projected annual growth rates of 10.9% and 10.1%, respectively. The annualized FY2024 projections are based on only six months of data. CaroMont failed to provide any historical data prior to FY2023 to demonstrate its ability to sustain the assumed growth rates. Absent this information, the projected home health discharges are unreasonable and not supported. Consequently, CaroMont's unduplicated home health patient projection are grossly overstated and not achievable.

CaroMont's projections of duplicated Medicare patients in From C.5 are erroneous and not supported by the information contained in the application as submitted. Specifically, Form C.5 requires the applicant to provide projected duplicated Medicare clients and visits for each of the Medicare payor categories. See highlighted sections of the following table.

Form C.5 Home Health Utilization	1st Full FY		2nd Full FY		3rd Full FY	
	F: T:		F: T:		F: T:	
	# of Clients	# of Visits	# of Clients	# of Visits	# of Clients	# of Visits
Duplicated Medicare Clients & Visits Full Episodes without Period Outliers Full Episodes with Period Outliers Patient Episodes With Partial Period Payments Patient Episodes With Low-Utilization Payment Adjustments (LUPAs) **Total Medicare Clients and Visits**						

CaroMont provides the assumptions and methodology used to project duplicated Medicare clients by reimbursement type in Section Q, PDF pages 139-141. See also the table below, which is excerpted from Step 9 of the CaroMont methodology.

The Medicare Episode Reimbursement type breakout is highlighted in the following table:

Medicare Episode	FY2026	FY2027	FY2028	Reimbursement Type %
Full w/o Outliers	228	630	990	91.5%
Full w Outliers	1	3	5	0.5%
PEPs	1	3	5	0.5%
LUPAs	19	52	81	7.5%
Total	**250**	**689**	**1,082**	**100.0%**

Calculation: Full w/o Outliers = (Total Medicare Episodes x Reimbursement Type Percentage)
Full w Outliers = (Total Medicare Episodes x Reimbursement Type Percentage)
PEPs = (Total Medicare Episodes x Reimbursement Type Percentage)
LUPAs = (Total Medicare Episodes x Reimbursement Type Percentage)

As shown in the previous table, CaroMont projects to serve 1,082 duplicated Medicare patients during the third project year. As described in the CaroMont methodology, the projected Medicare patients in Step 9 represent duplicated patients because they reflect 1) 25% readmitted Medicare patients (Step 7) and 2) a Medicare episode ratio of 1.35 per duplicated patient (Step 8 = 1.35 x Step 7). Therefore, CaroMont's projection of 1,082 duplicated Medicare patients should have been included in Table C.5 of the CaroMont application.

It should be noted that the CaroMont methodology is similar to Well Care's methodology. Well Care included duplicated Medicare patients based on a similar methodology to CaroMont's projected Medicare patients reflected in Step 9 of its application. However, CaroMont did not include the duplicated Medicare patients from Step 9 of its methodology in Form C.5 of its application. Instead, CaroMont attempted to calculate duplicated Medicare patients by dividing Medicare visits by Service Discipline in Step 11 by Average Visits per Patient in Step 12. The Medicare patients calculated in Step 12 reflect Medicare patients that receive home health services across multiple disciplines, which artificially inflates CaroMont's calculation of duplicated Medicare patients. In other words, CaroMont may count one Medicare patient four times if the patient is projected to receive home health services across multiple service disciplines.

In home health parlance, "duplicated clients" refers to patients that 1) receive more than one episode of care and/or 2) admitted to home health more than once during a given fiscal year.

The definition of "unduplicated clients" in the CON application form states: *For home health agency proposals, the term "unduplicated clients" means the total number of home health clients served or projected to be served during a given fiscal year. Each home health client should be counted only once regardless of the number of times the clients are admitted during the given fiscal year.*

The definition of "duplicated clients" in the CON application form states: *For home health agency proposals, the term "duplicated clients" means the total number of home health clients served or projected to be served during a given fiscal year by each staff discipline. If the client is seen by more than one discipline, the related client visits should be counted under each staff discipline*. The definition of "duplicated clients" does not state the client should be counted under each staff discipline, rather, the definition states the related client visits should be counted under each staff discipline. Thus, based on the definitions included in the CON application, CaroMont's projection of 2,012 duplicated Medicare patients

in Form C.5 is overstated and should not be considered in a comparative analysis because it is not an apples-to-apples comparison to Well Care's projections of duplicated Medicare patients in Form C.5. Therefore, a comparison of duplicated Medicare patients as reported by applicants in Form C.5 is inconclusive.

Comments Regarding Criterion 4

CaroMont does not adequately demonstrate that the alternative proposed in this application is the most effective alternative to meet the need based on the following:

- CaroMont does not adequately demonstrate the need it has for the proposed project and does not demonstrate that projected utilization is based on reasonable and adequately supported assumptions. A proposal that is not needed by the population proposed to be served cannot be an effective alternative to meet the need.

- CaroMont does not demonstrate sufficient funds for the operating needs of the proposal and that the financial feasibility of the proposal is based upon reasonable projections of revenues and operating expenses. A proposal that cannot demonstrate it will be financially feasible cannot be an effective alternative to meet the need.

- CaroMont does not demonstrate that the proposed project is not an unnecessary duplication of existing and approved services in Cleveland County. A proposal that cannot demonstrate it is not an unnecessary duplication of existing and approved services in the service area cannot be an effective alternative to meet the need.

- CaroMont does not demonstrate that any enhanced competition from the proposed project will have a positive impact on cost-effectiveness. A proposal that cannot demonstrate how any enhanced competition will have a positive impact on cost-effectiveness cannot be an effective alternative to meet the need.

- The application is not conforming to all other statutory and regulatory review criteria. An application that cannot be approved cannot be an effective alternative to meet the need.

Comments Regarding Criterion 5

CaroMont does not adequately demonstrate that the financial feasibility of the proposal is reasonable and adequately supported because projected utilization is not based on reasonable and adequately supported assumptions. Therefore, projected revenues and operating expenses, which are based in part on projected utilization, are also questionable.

Comments Regarding Criterion 6

CaroMont does not adequately demonstrate that the proposal would not result in an unnecessary duplication of existing or approved services in the service area because CaroMont does not demonstrate the need the population proposed to be served has for the proposed services or that projected utilization

is based on reasonable and adequately supported assumptions. CaroMont cannot demonstrate that the population proposed to be served needs the proposed services and thus cannot demonstrate that its project will not be an unnecessary duplication of existing or approved services.

Comments Regarding Criterion 18a

CaroMont does not adequately demonstrate the proposal would have a positive impact on cost-effectiveness because CaroMont did not adequately demonstrate: a) the need the population to be served has for the proposal; b) that projected revenues and operating costs are reasonable; and c) that the proposal would not result in an unnecessary duplication of existing and approved health services.

A proposal that cannot demonstrate need, cannot demonstrate that projected revenues and operating costs are based on reasonable and adequately supported assumptions, and cannot demonstrate that the proposed project is not an unnecessary duplication cannot have a positive impact on cost-effectiveness.

COMMENTS SPECIFIC TO PHC HOME HEALTH - CLEVELAND (PHC)
PROJECT I.D. C-012487-24

Comments Regarding Criterion 3

PHC does not adequately demonstrate the need the patients projected to be served have for the proposed office because projected utilization is not based on reasonable and adequately supported assumptions.

PHC's projections of total unmet home health patient need for Cleveland County (Section Q, Table 5) result in unreasonable utilization projections. Specifically, PHC subtracts the number of Cleveland County patients served by existing agencies (Section Q, Table 5) from the projected number of Cleveland home health patient need (Section Q, Table 3) to calculate what it refers to as projected "total unmet need." *See* the following table calculated from projections in the PHC application.

PHC Source	Description	FFY2025	FFY2026	FFY2027
Table 5a	Cleveland Home Health Patient Need	4,517	4,574	4,642
Table 4	Cleveland County Patients Served by Home Health Agencies	4,016	4,039	4,062
Table 5	Total Unmet Need	501	535	580

Source: PHC application pages 140-141

PHC failed to provide sufficient information to support its projection that the patient need deficit in Cleveland County will increase nearly 40 percent from 359 home health patients in FFY2025 (2024 SMFP, Table 12D) to 501 home health patients in FFY2025 (PHC application, page 141, Table 5).

PHC's methodology for projecting home health patients is premised on unreasonable and unrealistic market share assumptions. PHC projects it will serve 100% of its identified "unmet need" in Cleveland County during the third project year, which would equate to 12.5% of PHC's projected Cleveland County home health patient market (508/4,642).[3] There is no rationale or justification in the application to support PHC's projection of market share assumptions. In fact, **PHC provided zero letters of support in its application from Cleveland County providers**. In comparison, Well Care provided an abundant number of letters of support from local providers in the Cleveland County and surrounding area that refer Cleveland County residents for home health services.

The market share projections are the foundation of PHC's methodology and the means by which annual unduplicated home health patients are determined. Therefore, because the market share assumptions are unreasonable and not adequately supported, the patient utilization projections are likewise unreasonable. Consequently, the application does not conform to Criterion 3.

Impact on Other Review Criteria

PHC does not adequately demonstrate the need the patients projected to be served have for the proposed office because projected utilization is not based on reasonable and adequately supported assumptions.

[3] PHC Application, Section Q Table 5: 2027 580 / Table 5a: 2027 4,642

Based on the previously described facts which render the PHC application non-conforming to criterion 3, the application is also **non-conforming to criteria 1 (Policy GEN-3), 4, 5, 6, and 18a and 10A NCAC 14C .2003**.

Comments Regarding Criterion 5

Form F.2b and F.3b reflect projected revenues, net income, and expenses for "**PHC Home Health – Onslow**," which is not an applicant for the proposed PHC project. See Section Q, pages 160-163. PHC failed to project revenues, net income, and expenses for PHC Home Health-Cleveland. Consequently, the PHC application does not conform to criterion 5.