HEALTH PLANNING SOURCE

May 31, 2012

Mr. Craig R. Smith, Chief
Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, North Carolina 27699-2704

Dear Mr. Smith:

In accordance with N.C. GEN. STAT. § 131E-185(a1)(1), Roberson Herring Enterprises, LLC, d/b/a AssistedCare of the Carolinas ("AssistedCare of the Carolinas") submits the following comments related to applications to establish a new home health agency in Wake County. AssistedCare of the Carolinas' comments include "discussion and argument regarding whether, in light of the material contained in the application and other relevant factual material, the application complies with the relevant review criteria, plans and standards." N.C. GEN. STAT. § 131E-185(a1)(1)(c). As such, AssistedCare's comments are organized by the general CON statutory review criteria and specific regulatory criteria and standards, as they relate to the following applications:

- **Hillcrest Home Health of the Triangle, LLC (Hillcrest), Project ID# J-8813-12**
- **HKZ Group, LLC (HealthKeeperz), Project ID # J-8814-12**
- **Maxim Healthcare Services, Inc. (Maxim), Project ID# J-8819-12**
- **Oakland Home Care NC, LLC, (Oakland), Project ID # J-8821-12**
- **AssistedCare of the Carolinas (AssistedCare), Project ID # J-8817-12**

Based on AssistedCare of the Carolinas' review of the applications, and as demonstrated in detail in the attached comments, each application, with the exception of AssistedCare of the Carolinas' application, is non-conforming with various review criteria and should not be approved. We appreciate your consideration of these comments. Also attached are three additional support letters for AssistedCare of the Carolinas' proposal that were received following the submission of the application.

Sincerely,

Emily Cromer

Emily Cromer
Consultant to AssistedCare of the Carolinas

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Competitive Comments on Wake County Home Health Agency Applications

submitted by

Roberson Herring Enterprises, LLC, d/b/a AssistedCare of the Carolinas

In accordance with N.C. GEN. STAT. § 131E-185(a1)(1), Roberson Herring Enterprises, LLC, d/b/a AssistedCare of the Carolinas (AssistedCare of the Carolinas) submits the following comments related to competing applications to develop a home health agency in Wake County to meet a need identified in the *2012 State Medical Facilities Plan* (*SMFP*). AssistedCare of the Carolinas' comments include "*discussion and argument regarding whether, in light of the material contained in the application and other relevant factual material, the application complies with the relevant review criteria, plans and standards.*" See N.C. GEN. STAT. § 131E-185(a1)(1)(c). As such, AssistedCare of the Carolinas' comments are organized by the general CON statutory review criteria and specific regulatory criteria and standards, as they relate to the following applications:

- **Hillcrest Home Health of the Triangle, LLC (Hillcrest), Project ID# J-8813-12**
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Hillcrest Home Health

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

The need determination in the *2012 State Medical Facilities Plan* indicates a need for **one additional** Medicare-certified home health agency in Wake County to serve 464 patients **by 2013**. On pages 79 and 80 of its application, Hillcrest indicates it will not begin serving patients until 2014 and will only serve 121 patients that year. It is not until 2015, two years after the determined need date, that Hillcrest proposes to meet the need of serving at least 464 patients in Wake County. Hillcrest does not provide any reasonable rationale for the lengthy delay in becoming operational.

In its response to III.2 (GEN-3) Hillcrest simply refers to II.7 (quality response), VI.3. (service to underserved) and VI.12 (proposed payor mix in Year 2). However, those responses, particularly the response to VI.3, do not specifically address how this project will "promote safety and quality in the delivery of health care services while providing equitable access and maximizing healthcare value for resources expended" as required by GEN-3. Furthermore, the policy requires that the applicant "document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services." In its response to VI.3, Hillcrest states simply, "Low income persons needing care will have access to HHH services." That basic response is duplicated in each response in VI.3. However, this does not satisfy the required response to GEN-3 as it is unclear specifically how Hillcrest's proposed project will ensure access to services for patients with limited financial resources.

For these reasons, Hillcrest is not conforming with Criterion 1.

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

Hillcrest provides utilization projections that are overstated and based on unreasonable and unsubstantiated assumptions. First, according to its methodology and projections in Section IV, Hillcrest projects to provide 1,548 visits to 121 unduplicated patients in its first year of operation followed by 9,303 visits to 538 unduplicated patients in the second year. This represents a 501 percent increase in visits and 345 percent increase in patients over the course of one year. More importantly, Hillcrest's projected volume of unduplicated patients in the second year of operation is 16 percent higher than the deficit of 464 identified in the *SMFP* for 2013, and Hillcrest fails to demonstrate that the growth in Wake County residents in need of home health care services will actually grow by that magnitude, particularly when the SMFP need methodology projects only an eight percent compound annual growth rate in Wake County home health patients served between 2010 and 2013. Further, nowhere does Hillcrest provide any assumptions or methodology for how it derived its unduplicated patient count, which is then the basis for projecting duplicated patients and visits. Similarly, Hillcrest provides no assumption or rationale for projecting a 25/75 percent mix of skilled nursing and physical therapy admissions in Year 1, but a 50/50 percent mix in Year 2.

There are several flaws in Hillcrest's projections of episodes and visits. First, on page 84, Hillcrest assumes 1.51 episodes per Medicare patient while the actual Wake County average in 2011 (based on 2012 license renewal applications) was only 1.35 episodes per Medicare patient. Further, on page 86 of its application, Hillcrest provides the following total visits per patient by payor, which as shown in the table below, differ significantly from the actual experience of existing Wake County home health providers according to data reported on 2012 license renewal applications:

Payor	*Visits per Patient Proposed by Hillcrest*	*2011 Wake County Average Visits per Patient*
Full Episode w/o Outliers	16.16	17.59
Full Episode w/ Outliers	32.32	
LUPAs	2.60	
PEPs	2.69	
Medicaid	16.16	10.69
Commercial	12.12	13.45
Indigent	12.12	7.23
Other	12.12	9.98

Hillcrest states that its projected visits per Medicare Full Episode w/out Outliers patient and per Medicare LUPA patient are based on the North Carolina Home Health database. Hillcrest then applies arbitrary percentages to these two visits per patient statistics to derive visits per patient for the remaining Medicare patient types and for all other payors, and provides no rationale for these assumptions. However, as shown in the table above, Hillcrest's arbitrary method of deriving visits per patient by payor result in significantly overstated figures for Medicaid, Indigent, and Other payors. Hillcrest also distributes these total visits per patient by discipline, but again does not provide clear assumptions for that distribution, making it difficult to determine the reasonableness of its visit per patient by discipline projections.

With regard to access to the underserved, on page 101, Hillcrest states, "HHH will not require any financial payment or verification of credit status upon admission." However, Hillcrest's admission criteria provided in Exhibit R states, "the agency will verify coverage with the insurance company prior to the provision of care." [Emphasis added.] So while it is not clear whether the agency will require payment prior to care, it appears that it will verify coverage prior to providing care in spite of its response to VI.5. Further, on page 78 of its application, Hillcrest states that in its first year of operation, "Indigent patients will be minimized until HHH is accredited." For broader context, Hillcrest explains immediately prior to that statement that it cannot receive any Medicare reimbursement during the first year of operation. According to the tables provided on page 79 of its application, which indicate that they will admit no indigent patients in

Year One, Hillcrest in fact intends to outright deny access to indigent patients in the first year rather than "minimize" indigent admissions. It also states that in the second year of operation, "Indigent patients will be admitted to HHH." In this context, it appears as though Hillcrest plans to intentionally deny access to indigent patients during the first year, until such time as its Medicare reimbursement makes providing care to indigent patients less of a financial burden on the agency. As such, it is questionable to what degree underserved groups will have access to the services proposed by Hillcrest.

It should also be noted that Hillcrest projects a completely different payor mix from one year to the next, neither of which is consistent with the actual Wake County average payor mix calculated from 2012 license renewal applications, as shown below.

Payor	*Hillcrest Year 1 (Patients)*	*Hillcrest Year 2 (Patients)*	*Wake County 2011 (Patients)*
Medicare	11.6%	53.6%	65.4%
Medicaid	0.0%	14.3%	10.2%
Commercial	85.1%	28.5%	21.5%
Indigent	0.0%	1.5%	0.3%
Self Pay/Other	3.3%	2.2%	2.6%

Hillcrest also provides projected payor mix by visits in Section VI of its application, and as shown in the table below, the percentage provided in its application sum to greater than 100.

Payor	*Hillcrest Year 2 (Visits)*
Medicare	67.4%
Medicaid	13.1%
Commercial	19.6%
Indigent	1.0%
Self Pay/Other	1.5%
Total	102.6%

The exclusion of Indigent and Self Pay/Other from the sum results in a total of 100 percent, calling into question the validity of Hillcrest's payor mix projections and its provision of access to the underserved.

For these reasons, Hillcrest's application is not conforming with 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.*

Section I. 11. (d) in the application states: "Describe the specific experience of the applicant in providing the proposed ***home health*** services." Hillcrest responds by describing its nursing facility services, not home health experience. Therefore, there is no evidence that the applicant is qualified to provide home health services. Lacking any experience or any support from an experienced home health provider, Hillcrest would not be the most effective alternative to provide home health services in Wake County.

Additionally, on page 78 of its application, Hillcrest states that it will apply for licensure "soon after being awarded the Certificate of Need" and expects to be licensed by October 2013, nearly one year after the CON application has been approved. Hillcrest does not explain why it believes it will take a year to become a licensed agency, when the *SMFP* clearly states that the need for an additional home health agency to serve Wake County residents is for 2013. Of all the applicants, Hillcrest is the only one to propose to serve its first patients in 2014 rather than 2013. Because of the lengthy delay in initiating operations of the agency, it is not the best alternative for the new Wake County home health agency.

For these reasons, Hillcrest has not proposed the most effective alternative and is not conforming with Criterion 4.

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

As discussed under Criterion 3, Hillcrest's utilization projections and payor mix projections are unreasonable and unsubstantiated, therefore

calling into question the reasonableness of its financial projections, which are directly related to projected utilization and payor mix. Further, Hillcrest's projected contractual deductions in Year 2 are questionable. Hillcrest projects gross revenue of $202,811 and total deductions of $70,629 in Year 1 followed by gross revenue of $1,438,903 and total deductions of $74,620 in Year 2. In other words, Hillcrest projects total deductions to represent 34.8 percent of gross revenue in Year 1, but only 5.2 percent of gross revenue in Year 2. As such, it appears that Hillcrest has overstated its net revenue projections substantially in Year 2. Hillcrest also projects an 18.1 percent increase in gross revenue per visit from Year 1 to Year 2, further suggesting a potential overstatement of revenue in Hillcrest's financial proformas.

For these reasons, Hillcrest is not conforming with Criterion 5.

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

Hillcrest's response to III.2, GEN-3 simply refers to II.7 (quality response), VI.3 (service to underserved) and VI.12 (proposed payor mix in Year 2). However, those responses, particularly the response to VI.3, do not specifically address how this project will "promote safety and quality in the delivery of health care services while providing equitable access and maximizing healthcare value for resources expended" as required by GEN-3. Furthermore, the policy requires that the applicant "document is plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services." In its response to VI.3, Hillcrest states simply, "Low income persons needing care will have access to HHH services." That basic response is duplicated in each response to VI.3. However, these statements do not satisfy the required response to GEN-3 as it is unclear specifically how Hillcrest's proposed project will ensure access to services for patients with limited financial resources.

Furthermore, on page 101 of its application, Hillcrest states, "HHH will not require any financial payment or verification of credit status upon

admission." However, Hillcrest's admission criteria provided in Exhibit R state, "the agency will verify coverage with the insurance company prior to the provision of care."[emphasis added] So while it is not clear whether the agency will require payment prior to care, it appears that it will verify coverage prior to providing care in spite of its response to VI.5. This pre-care verification of coverage questions whether Hillcrest will provide care for those whose coverage is limited or absent.

For these reasons, Hillcrest is non-conforming with Criterion 18a.

HKZ Group, LLC (HealthKeeperz)

(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.*

HealthKeeperz provides overstated visit projections based on an assumed visits per patient statistic that is higher than the actual experience of Wake County providers. On page 50 of its application, HealthKeeperz states that it projects its visits based on the experience of its existing agencies in Robeson, Scotland, and Cumberland Counties, which average 16.3 visits per unduplicated patient, which is higher than the actual average experience of all Wake County providers, 15.8 visits per unduplicated patient.

HealthKeeperz also chose to base its projected payor mix on the experience of its Robeson, Scotland, and Cumberland County agencies rather than using the actual experience of Wake County providers. This results in a proposed payor mix that is significantly different than actual Wake County experience as shown below. Of particular note is that HealthKeeperz does not include Indigent in its proposed payor mix at all.

Payor	*HealthKeeperz Year 2 (Patients)*	*Wake County 2011 (Patients)*
Medicare	69.7%	65.4%
Medicaid	14.8%	10.2%
Commercial	8.6%	21.5%
VA	1.3%	--

Payor	*HealthKeeperz Year 2 (Patients)*	*Wake County 2011 (Patients)*
Tricare	1.3%	--
Indigent	--	0.3%
Others (not specified)	4.3%	2.6%

Given the vast demographic differences between the counties, it is completely unreasonable to assume that the payor mix experienced in Robeson, Scotland, or Cumberland Counties would be accurately representative of the payor mix expected in Wake County. Wake County is one of the most affluent counties in the state while Robeson, Scotland, and Cumberland are among the poorest. To demonstrate this point, the following table provides the median household income and percent of the population below the poverty level for each of these counties.

County	*Median Household Income*	*% Below Poverty Level*
Wake	$63,770	9.7%
Robeson	$29,667	30.2%
Scotland	$29,368	29.5%
Cumberland	$46,834	16.6%

Source: www.census.gov

For these reasons, HealthKeeperz failed to base its utilization projections on reasonable assumptions and failed to adequately demonstrate its provision of services to the underserved, and therefore is not conforming with Criterion 3.

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

As discussed under Criterion 3, HealthKeeperz's utilization projections and payor mix projections are unreasonable and unsubstantiated, therefore calling into question the reasonableness of its financial

projections, which are directly related to projected utilization and payor mix. Also, as discussed under Criterion 7, HealthKeeperz did not project sufficient FTEs for physical therapy to provide the number of visits projected, and as such has understated its salary expenses.

The deductions from gross revenue on HealthKeeperz's Form B are also suspect. On a comparative basis, HealthKeeperz projects a combined charity care and bad debt percentage in its proformas that is significantly lower than all other applicants (0.7 percent), making it questionable whether or not it actually accounted for a reasonable and sufficient amount of charity care and bad debt and as a result whether or not its net revenue projections are overstated. Additionally, HealthKeeperz shows a negative contractual adjustment for Medicare in both years, which results in the addition, rather than deduction, of $156,330 and $221,663 in Medicare revenue in Years 1 and 2, respectively.

Also of significance, HealthKeeperz appears to have made over-arching errors in its reporting of expenses on Form B in Year 1. At first glance, one observes RN salaries of only $47,000 in Year 1 and $200,850 in Year 2; Nursing Travel Expenses of $41,010 in Year 1 and only $19,350 in Year 2; no Nursing Other Supplies expense in Year 1, but $3,870 in Year 2; no salary expense at all for Physical Therapist in Year 1, but $154,500 in Year 2; no Physical Therapy Travel Expenses in Year 1, but $10,090 in Year 2, allocated expenses for Occupational Therapy and Speech Therapy Other Supplies in Year 1, but none in Year 2, etc. Based on these inconsistencies and many more, it appears that HealthKeeperz erroneously omitted various expenses in each of the two project years. As such, its financial projections are completely unreliable.

For these reasons, HealthKeeperz is not conforming with 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.*

HealthKeeperz did not project sufficient staff to provide the services proposed for physical therapy. Specifically, HealthKeeperz did not project enough FTEs to perform the projected number of visits for this discipline in Year 2 as outlined in the table below.

Discipline	*Projected Year 2 Visits*	*Visits per FTE per Day*	*FTEs Needed for Projected Visits**	*Projected Year 2 FTEs*	*Difference*
Physical Therapy	2,695	5.4	1.92	1.50	(0.42)

*Calculation: Projected visits / visits per FTE per day / 260 days per year

The deficit in projected FTEs equates to a total of 589 visits that HealthKeeperz projects, but will not have the ability to provide in Year 2. Given the underestimation of staff required to provide the level of services proposed in Table IV.2 of its application, HealthKeeperz is not conforming with 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;

As discussed under Criterion 3, HealthKeeperz does not identify any allocation for indigent patients in its payor mix projections and as such is not conforming with Criterion 13(c).

Maxim Healthcare Services

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

On page 8 of its application, Maxim states, "Maxim's Raleigh agency currently maintains over 240 clients. Maxim estimates that out of its 240+ patients, it would be able to provide at least 100 of them with additional therapy (via Medicare certification). Furthermore, Maxim estimates that it refers over 150 patients to other Medicare-certified home health agencies

each year (in addition to the patients it currently serves) because its lack of Medicare certification prevents it from providing needed services."

The need determination in the *2012 State Medical Facilities Plan* indicates a need for **one additional** Medicare-certified home health agency in Wake County to serve 464 patients by 2013. Because Maxim is already a provider of home health services to Wake County patients, albeit a non-Medicare certified provider, it proposes to simply shift patients it now refers to other Wake County providers to its proposed Wake County agency; its proposal does not fulfill the need determination in the *2012 SMFP* to serve 464 ***additional*** patients in Wake County. Furthermore, Maxim proposes to serve only 439 unduplicated patients in 2013 rather than 464 unduplicated patients as indicated by the need methodology. If approximately 100 of those patients are patients it traditionally has referred to existing home health agencies, Maxim will only serve approximately 339 new patients rather than 439 as proposed in Table IV.1 of its application, or the 464 patient deficit identified in the *SMFP*.

Therefore, the total 464 **additional** patients in Wake County that will need home health care in 2013 would not be served by Maxim in Wake County.

(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.*

Maxim provides utilization projections that are overstated and based on unreasonable and unsubstantiated assumptions. First, according to its methodology and projections in Section IV, Maxim projects to provide 8,537 visits to 439 unduplicated patients in its first year of operation followed by 11,013 visits to 516 unduplicated patients in the second year. This represents a 29 percent increase in visits and 17.5 percent increase in patients over the course of one year. More importantly, Maxim's projected volume of unduplicated patients in the second year of operation is 11 percent higher than the deficit of 464 identified in the *SMFP* for 2013, and Maxim fails to demonstrate that the growth in Wake County residents in need of home health care services will actually grow by that magnitude, particularly when the SMFP need methodology projects only an eight percent compound annual growth rate in Wake County home health patients served between 2010 and 2013.

Maxim states that its projected visits per Medicare Full Episode w/out Outliers patient are based on the experience of existing Wake County home health providers as reported on 2012 license renewal applications, and that its visits per patient for LUPA and Medicare PEP patients are based on its corporate experience. Maxim then applies arbitrary percentages to the Wake County Medicare visit per patient statistic to derive visits per patient for all other payors, and provides no rationale for these assumptions. However, as shown in the table below, Maxim's arbitrary method of deriving visits per patient by payor result in overstated figures for Indigent and Other payors.

Payor	*Visits per Patient Proposed by Maxim*	*2011 Wake County Average Visits per Patient*
Full Episode w/o Outliers	17.96	17.59
Full Episode w/ Outliers	NA	
LUPAs	3.82	
PEPs	12.00	
Medicaid	10.77	10.69
Commercial	13.47	13.45
Indigent	8.98	7.23
Private Pay/Other	13.47	9.98

As a result of overstating visit projections, Maxim's utilization projections are unreliable and its application is not conforming with Criterion 3.

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

As discussed under Criterion 3, Maxim's utilization projections are unreasonable and unsubstantiated, therefore calling into question the reasonableness of its financial projections, which are directly related to projected utilization. Additionally, there appears to be a disconnect between the charity care and bad debt projected in Form B and Maxim's proposed payor mix. Specifically, Maxim projects in Form B a combined

charity care and bad debt deduction of 2.6 percent of gross revenue, which is the highest of all the applicants. However, Indigent and Self Pay/Other account for only 0.4 percent of total visits, which other than HealthKeeperz (which identified no Indigent or Self Pay in its payor mix), is by far the lowest of the applicants. This inconsistency calls into question the reliability of Maxim's payor mix and/or charity care and bad debt deductions.

Maxim also provides insufficient information to determine the reasonableness of its revenue projections given that it provides no detail for its gross revenue and reimbursement projections. Finally, Maxim did not include any start-up expenses nor did it include initial operating expenses. However, the funding letter (Exhibit 15), states, "The total capital and working capital cost of the project is estimated at less than $500,000." Because the capital costs are only $50,000, one would assume that the additional $450,000 is for initial operating costs. Furthermore, while they are a licensed and operational agency, they must hire additional staff (PT/OT/ST) and train staff to provide additional services required for a Medicare-certified home health agency. For example, OASIS training, as required by Medicare, requires three to six months, at a minimum, to master the skills required. As noted in the tables in Section VII (pages 92 and 94), Maxim does not now have therapy staff or a social worker. These individuals must be hired prior to initial operation and existing staff will require training, which would require an initial operating period, which is not included in Maxim's Section IX of its application. As such, it is unclear Maxim's intent with regard to an initial operating period; however, based on the funding letter, it appears that Maxim might have erroneously omitted either additional capital expenditures or working capital costs in the financials.

For these reasons, Maxim is not conforming with Criterion 5.

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

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

On page 90 of its application (Table VI.11), Maxim indicates that its existing Wake County home care agency provided no indigent or charity care during FY 2011. So, while it proposes to provide 0.4 percent self-pay/indigent/charity care in CY 2014 through the new Medicare-certified home health agency, based on its historical performance in providing care to medically underserved populations, it is questionable whether it will actually provide indigent care for patients being treated through its proposed Wake County home health agency.

(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;*

Page 90 of Maxim's application includes a payor mix table for its existing home care agency indicating zero percent self pay/indigent/charity care during FY 2011. Page 91 includes a payor mix table for its proposed home health agency indicating that it will provide 0.4 percent self-pay/indigent/charity care during CY 2014. Since Maxim does not provide any self-pay/indigent/charity care through its existing agency, it is not reasonable to assume Maxim will provide such care with the new home health agency it proposes to develop in Wake County.

Oakland Home Care

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

On page 87, Oakland indicates that Wake County is its "primary" service area but it also proposes to serve Chatham, Durham and Johnston counties, which indicate no need for additional home health services in 2013. Table III.23 on page 89 of the application indicates that Oakland will only serve 335 Wake County patients in Year 1 (2013) rather than 464 patients as projected in the *2012 SMFP*; therefore, Oakland is not conforming with Criterion 1.

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

Oakland provides utilization projections that are overstated and based on unreasonable and unsubstantiated assumptions. First, according to its methodology and projections in Section IV, Oakland projects to provide 6,712 visits to 372 unduplicated patients in its first year of operation followed by 11,331 visits to 573 unduplicated patients in the second year. This represents a 69 percent increase in visits and 54 percent increase in patients over the course of one year. More importantly, Oakland's projected volume of unduplicated patients in the second year of operation is 23 percent higher than the deficit of 464 identified in the *SMFP* for 2013, and Oakland fails to demonstrate that the growth in Wake County residents in need of home health care services will actually grow by that magnitude, particularly when the SMFP need methodology projects only an eight percent compound annual growth rate in Wake County home health patients served between 2010 and 2013.

Oakland proposes to serve not only Wake County patients but also patients in Chatham, Durham and Johnston counties. However, the identified need is for Wake County and not for Chatham, Durham or Johnston counties by 2013. Oakland states on page 87 of its application, "Chatham, Durham, and Johnston Counties are all counties located in home health planning Region J

that have an unmet need for home health services according to the 2012 home health methodology." To the contrary, according to Table 12-C in the *2012 SMFP*, which shows the need projections for Medicare-certified home health agencies or offices, the only county with a significant deficit is Johnston County (-140) while Chatham County shows a ***surplus*** for 2013 and Durham County shows a deficit of only three patients. Finally, Table 12-D in the *SMFP* indicates a need in 2013 for two Medicare-certified home health agencies in Mecklenburg County and one in Wake County but does not indicate a need for any additional Medicare-certified home health agencies in Durham, Chatham or Johnston counties for 2013.

For these reasons, Oakland is not conforming with 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.*

As discussed under Criterion 3, Oakland proposes Wake County as its "primary" service area but proposes to serve Chatham, Durham and Johnston county patients as well. However, on page 89, Table III.23, Oakland indicates that they will only serve 335 Wake County patients in Year 1 (2013); therefore, they will not meet the need for 464 patients in 2013 as required by the *2012 SMFP*. As such, they are not the most effective alternative to meet the need for 464 patients in 2013 and are not conforming with Criterion 4.

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

As discussed under Criterion 3, Oakland's utilization projections are unreasonable and unsubstantiated, therefore calling into question the reasonableness of its financial projections, which are directly related to projected utilization. Also as discussed under Criterion 7, it appears as though Oakland has not demonstrated adequate availability of medical social work services and therefore has understated related expenses.

As such, Oakland is also not conforming with 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.*

On page 24 of its application, Oakland proposes to hire a contract MSW rather than a staff MSW. Table VII.3 (year 1) indicates that the MSW will make 86 contract visits per year (0.2 average per day). However, this position will be assigned multiple roles in addition to intake evaluations, needs assessments, referral coordination, supportive care coordination, insurance coverage assistance (page 24). Additional roles include case management (page 25) as well as health literacy and education (page 27). It appears highly unlikely that this person will be able to accomplish these responsibilities on 86 contract visits per year.

For this reason, Oakland is not conforming with Criterion 7.

GENERAL COMPARATIVE COMMENTS

The AssistedCare, Hillcrest, HealthKeeperz, Maxim, and Oakland applications each propose to develop one home health agency in response to the *2012 SMFP* need determination for Wake County. Pursuant to N.C. GEN. STAT. § 131E-183(a)(1) and the *2012 SMFP*, no more than one new home health agency may be approved for Wake County in this review. Because each of the five applicants proposes to develop a new home health agency in Wake County, all of the applications cannot be approved. AssistedCare acknowledges that each review is different and, therefore, that the comparative review factors employed by the Project Analyst in any given review may be different depending upon the relevant factors at issue. Given the nature of the review, the Analyst must decide which comparative factors are most appropriate in assessing the applications.

In order to determine the most effective alternative to meet the identified need for one additional home health agency in Wake County, AssistedCare reviewed and compared the following factors in each application:

- Access by Medicaid Recipients
- Visits per Unduplicated Patient
- Average Direct Cost per Visit
- Average Administrative Cost per Visit
- Total Cost per Visit
- Net Revenue per Visit
- Net Revenue per Unduplicated Patient

- Ratio of Net Revenue per Visit to Cost per Visit
- Nursing and Home Health Aide Salaries
- Provision of Specialized Services

AssistedCare believes these factors are appropriate and/or have been used in previous competitive home health agency findings.[1]

Projected Access by Medicaid Recipients

The following table compares the percentage of visits provided to Medicaid patients, demonstrating the applicants' proposed access to this medically underserved population.

Applicant	*Proposed Medicaid % by Visit-Yr. 2*
AssistedCare	6.9%
Hillcrest	13.1%
HealthKeeperz	14.8%
Maxim	7.4%
Oakland	13.0%
Current Wake County Average	***6.9%***

While all other applicants project a higher percentage of Medicaid visits, AssistedCare's projected percentage is the only one that is consistent with the actual historical experience of existing home health agencies in Wake County. Given the actual Wake County average of 6.9 percent Medicaid visits, it is questionable whether applicants

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1 Please note that in developing comparative review factors, AssistedCare looked to previous home health reviews for guidance, such as: the 2007 Wake County Home Health Review, the 2009 Mecklenburg County Home Health Review, and the 2010 Wake County Home Health Review. Where appropriate, AssistedCare has included relevant comparative factors used in those reviews. See, e.g., the 2007 Wake County Home Health Review (using the following comparative factors: projected access by Medicaid recipients; visits per unduplicated patient; total administrative cost; net revenue per unduplicated patient; net revenue per visit; ratio of net revenue per visit to cost per visit; and nursing salaries in year two); the 2009 Mecklenburg County Home Health Review (using the following comparative factors: projected access by Medicaid recipients; provision of services to the non-English speaking, non-Hispanic population; visits per patient; administrative cost per visit; net revenue per visit; net revenue per patient; ratio of net revenue per visit to cost per visit; and nursing and home health aide salaries in year two); and the 2010 Wake County Home Health Review (using the following comparative factors: projected access by Medicaid recipients; visits per unduplicated patient; net revenue per visit; net revenue per unduplicated patient; total operating cost per visit; average direct cost per visit; average administrative cost per visit; ratio of net revenue to total operating cost per visit; and nursing and home health aide salaries in year two.

projecting significantly higher than this will actually achieve their projections. Moreover, none of the other applications demonstrated why the Medicaid need in Wake County will be higher than that experienced by existing Wake County agencies. As previously discussed, Wake County is one of the most affluent counties in the state. Therefore, AssistedCare represents the most realistic and effective applicant in terms of providing access to home health services to Medicaid recipients.

Visits per Unduplicated Patient

In order to assess the number of proposed visits per patient, AssistedCare divided the total number of proposed visits in Year 2 (IV.2) by the total number of unduplicated patients proposed in Year 2 (IV.1). The resulting visits per patient for each applicant are provided in the table below.

Applicant	*Visits per Patient- Yr. 2*
AssistedCare	15.8
Hillcrest	17.3
HealthKeeperz	16.3
Maxim	21.3
Oakland	19.8
Wake County Average	*15.8*

Maxim proposes the highest number of visits per patient at 21.3 visits, and therefore might appear to be the most effective alternative. However, as discussed previously, Hillcrest, HealthKeeperz, Maxim, and Oakland all overestimated projected visits and failed to demonstrate that their utilization projections are based on reasonable assumptions. In addition, none of these applicants' visit projections are consistent with the Wake County average. In contrast, AssistedCare's projected visits per patient are consistent with the actual experience of existing home health agencies in Wake County. Therefore, AssistedCare is the best representation of the experience of Wake County home health agencies and is the most effective alternative.

Average Direct Cost per Visit

The average direct care cost per visit in the second operating year was calculated by dividing projected direct care expenses from Form B by the total number of projected visits from Section IV, as shown in the table below.

Applicant	*Projected Visits Year Two*	*Direct Care Costs Year Two*	*Average Direct Care Cost per Visit Year 2*
AssistedCare	7,885	$731,757	$92.80
Hillcrest	9,303	$776,267	$83.44
HealthKeeperz	8,028	$704,054	$87.70
Maxim	11,013	$843,041	$76.55
Oakland	11,331	$996,556	$87.95

As discussed under Criterion 3, Hillcrest, HealthKeeperz, Maxim, and Oakland's utilization projections are unreasonable and unsubstantiated, therefore calling into question the reasonableness of their financial projections, which rely directly on projected utilization. Furthermore, as discussed under Criterion 5, Hillcrest, HealthKeeperz, Maxim, and Oakland all failed to demonstrate the reasonableness of their financial projections based on projected revenues and expenses. As a result, AssistedCare is the most effective alternative with regard to average direct care cost per visit, based on reasonable assumptions.

Average Administrative Cost per Visit

The average administrative cost per visit in the second operating year was calculated by dividing projected administrative expenses from Form B by the total number of projected visits from Section IV, as shown in the table below.

Applicant	*Projected Visits Year Two*	*Administrative Costs Year Two*	*Average Administrative Cost per Visit Year 2*
AssistedCare	7,885	$350,858	$44.50
Hillcrest	9,303	$513,851	$55.23
HealthKeeperz	8,028	$586,535	$73.06
Maxim	11,013	$329,334	$29.90
Oakland	11,331	$619,658	$54.69

As discussed under Criterion 3, Maxim's utilization projections are unreasonable and unsubstantiated, therefore calling into question the reasonableness of their financial projections, which rely directly on projected utilization. Furthermore, as discussed under Criterion 5, Maxim failed to demonstrate the reasonableness of its financial

projections based on projected revenues and expenses. As a result, AssistedCare is the most effective alternative with regard to average administrative cost per visit, based on reasonable assumptions.

Total Cost per Visit

The following table is a comparison of the total cost per visit proposed by each applicant (total operating costs in each applicant's proforma financial statements divided by total visits in IV.2).

Applicant	*Total Cost per Visit- Yr. 2*
AssistedCare	$137.30
Hillcrest	$138.68
HealthKeeperz	$160.76
Maxim	$106.45
Oakland	$142.64

As discussed under Criterion 3, Maxim's utilization projections are unreasonable and unsubstantiated, therefore calling into question the reasonableness of its financial projections, which rely directly on projected utilization. Furthermore, as discussed under Criterion 5, Maxim failed to demonstrate the reasonableness of its financial projections based on projected revenues and expenses. As a result, AssistedCare is the most effective alternative with regard to total cost per visit, based on reasonable assumptions.

Net Revenue per Visit

Net revenue per visit was calculated by dividing the projected patient net revenue from Form B by the projected number of visits from Section IV, as shown in the table below.

Applicant	*Projected Visits Year Two*	*Net Revenue Year Two*	*Net Revenue Per Visit*
AssistedCare	7,885	$1,216,030	$154.22
Hillcrest	9,303	$1,364,283	$146.65
HealthKeeperz	8,028	$1,315,621	$163.88
Maxim	11,013	$1,553,615	$141.07
Oakland	11,331	$1,639,141	$144.66

As discussed under Criterion 3, Hillcrest, Maxim, and Oakland's utilization projections are unreasonable and unsubstantiated, therefore calling into question the reasonableness of their financial projections, which rely directly on projected utilization. Furthermore, as discussed under Criterion 5, Hillcrest, Maxim, and Oakland all failed to demonstrate the reasonableness of their financial projections based on projected revenues and expenses. As a result, AssistedCare is the most effective alternative with regard to net revenue per visit, based on reasonable assumptions.

Net Revenue per Patient

Net revenue per unduplicated patient was calculated by dividing the net patient revenue by the number of unduplicated patients projected by the applicant in Section IV.1. The following table shows the net revenue per unduplicated patient based on projected revenues in Form B of the proformas and the number of projected unduplicated patients in the second operating year.

Applicant	*Projected Patients Year Two*	*Net Revenue Year Two*	*Net Revenue Per Patient*
AssistedCare	500	$1,216,030	$2,432.06
Hillcrest	538	$1,364,283	$2,535.84
HealthKeeperz	493	$1,315,621	$2,668.60
Maxim	516	$1,553,615	$3,010.88
Oakland	573	$1,639,141	$2,860.63

AssistedCare projects the lowest net revenue per patient of all applicants. Therefore, AssistedCare is the most effective alternative.

Ratio of Net Revenue per Visit to Cost per Visit

Applicant	*Visits Year Two*	*Net Revenue/Visit Year Two*	*Total Cost/Visit Year Two*	*Ratio of Net Revenue/Visit to Cost/Visit*
AssistedCare	7,885	$154.22	$137.30	112%
Hillcrest	9,303	$146.65	$138.68	106%
HealthKeeperz	8,028	$163.88	$160.76	102%
Maxim	11,013	$141.07	$106.45	133%
Oakland	11,331	$144.66	$142.64	101%

As discussed under Criterion 3, Hillcrest, HealthKeeperz, and Oakland's utilization projections are unreasonable and unsubstantiated, therefore calling into question the reasonableness of their financial projections, which rely directly on projected utilization. Furthermore, as discussed under Criterion 5, Hillcrest, HealthKeeperz, and Oakland all failed to demonstrate the reasonableness of their financial projections based on projected revenues and expenses. As a result, AssistedCare is the most effective alternative, based on reasonable assumptions.

Nursing and Home Health Aide Salaries

All five applicants propose to provide nursing and home health aide services with staff that are employees of the proposed home health agency. The tables below compare the proposed annual salary for nurses and home health aides in the second operating year, as reported in Section VII of each application.

Applicant	*Registered Nurse Annual Salary Year Two*
AssistedCare	$71,070
Hillcrest	$68,690
HealthKeeperz	$66,950
Maxim	$67,650
Oakland	$69,360

Applicant	*Home Health Aide Annual Salary Year Two*
AssistedCare	$29,870
Hillcrest	$24,426
HealthKeeperz	$30,900
Maxim	$32,800
Oakland	$30,090

Salaries are a significant contributing factor in recruitment and retention of staff. As shown in the table above, AssistedCare projects the highest annual salary for a registered nurse and an annual salary for home health aides that is generally consistent with other applicants. As a result, AssistedCare is the most effective alternative with regard to nursing and home health aide salaries.

Specialized Services

AssistedCare is the only applicant that demonstrated a web-based quality and data collection system already in place and operational. AssistedCare also appears to be the only applicant that has electronic medical records which also include web-based software that allows physicians to view patient records remotely and to make changes to the orders and sign off in real time. No other applicant even proposes to have this capability. On page 29 of its application, Maxim states it "is investing in health care technology..." for the new agency. However, AssistedCare has sophisticated systems in place and in use in Brunswick County and can add Wake County agency to the system immediately upon opening the agency. As such, it is a better alternative to Maxim. Finally, AssistedCare is the only applicant to comprehensively propose to combine behavioral health care with its medical care of home health patients through existing structures and relationships. On page 39 Oakland states it will provide behavioral and mental health care. However, in a comparative analysis with AssistedCare, they will not have ***comprehensive*** behavioral health services such as the services proposed by AssistedCare.

SUMMARY

In summary, based on both its comparative analysis and the comments on the competing applications, as well as the analysis presented in its application, AssistedCare believes that its application represents the most effective alternative for meeting the need identified in the 2012 *SMFP* for an additional home health agency in Wake County.

THE BONE JOINT
SURGERY CLINIC

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April 13, 2012

Mr. Craig R. Smith, Chief
Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

Dear Mr. Smith:

I wish to inform you of my support of the CON application filed by Roberson Herring Enterprises, LLC d/b/a AssistedCare of the Carolinas to develop a home health agency in Wake County. As an orthopaedic surgeon practicing in Wake County, it is extremely important to me that other providers in the continuum of care maintain a high standard of quality in caring for my patients. Follow-up care for orthopaedic patients must be provided by a competent, experienced, high-quality home health agency in order to ensure optimal outcomes. It is my firm belief that AssistedCare of the Carolinas will deliver such care as AssistedCare and its affiliated agencies are well-respected in southeastern North Carolina by both patients and physicians for its patient-focused, quality services. AssistedCare's home health agency, the model for the proposed Wake County agency, has received The Joint Commission's Gold Seal of Approval for high quality care. This is indicative of the exceptional level of care provided by this home health group and is what I expect when I refer my patients. As such, I believe AssistedCare of the Carolinas would be an excellent choice for a new home health agency in Wake County.

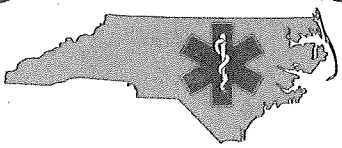
In an effort to enable me to focus on patient care, this letter may resemble the format of those signed by my colleagues; however, that should not detract from the fact that I fully support AssistedCare of the Carolinas' proposal to develop a home health agency in Wake County. Following the development of this agency, I intend to refer patients needing home health care to AssistedCare of the Carolinas, as clinically appropriate, and I urge the approval of this project to enable my patients to receive care in the best possible setting.

Please let me know if I can be of further assistance.

Sincerely,

Michael M. Fajgenbaum, M.D.

NORTH STATE



MEDICAL TRANSPORT

C. Saunders Roberson, Jr.
AssistedCare of the Carolinas
800 Tiffany Boulevard, Suite 201
Rocky Mount, NC 27804

Dear Mr. Roberson,

I fully support your agency's intent to submit a Certificate of Need to establish a new home health office in Wake County. It is my opinion that a new home health office in Wake County will improve access to quality health care in this area.

I am familiar with this agency's quality of work and I would definitely refer my patients to them.

Sincerely,

Janice B. Pearce
Director of Marketing/Development
North State Medical Transport

William D. Lee, M.D.
Family Practice

April 18, 2012

Mr. Craig Smith, Chief

Certificate of Need Section

2704 Mail Service Center

Raleigh, North Carolina 27699-2704

Dear Mr. Smith:

I am writing to support the application of AssistedCare Home Health to establish a home health agency in Wake County. There is currently a delay with certain of the existing home health agencies in responding to referrals; and with continued growth in Wake County, there will be a greater need for home health care. Home Health care has been very successful in decreasing the time of hospitalizations and stays in rehabilitation facilities, both for surgical and medical patients. Most patients prefer to be at home with convenient, reliable, and high quality service to help with their conditions.

As a primary care physician in Wake County, I have referred several patients each month to Home Health Agencies. The Assisted Care Home Health Agency has been serving patients in eastern North Carolina since 1997, and has received the Joint Commission's Gold Seal of Approval for their high quality care. I have personally referred patients to Community Home Care and Hospice, and have been very impressed with their response time and outcomes. I believe that both companies will work together to form a new Home Health Agency with a goal of providing the same high level of care that they have provided in the past.

Therefore, I would like to support their application to establish a new home health agency in Wake County, and would anticipate that I would use their service regularly. Please let me know if I can provide further information to you.

Sincerely,

William D. Lee MD

William D. Lee, M.D.

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