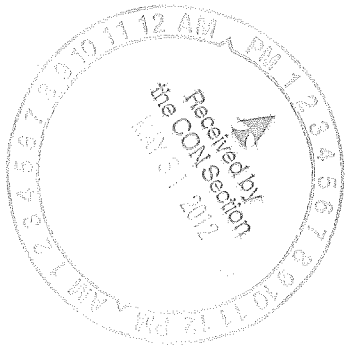

Competitive Comments
Submitted by Hillcrest Home Health of the Triangle, LLC
May 31, 2012

J-8814-12
HealthKeeperz of Wake ("HealthKeeperz")
Develop a Medicare-certified home health agency in Wake County.

J-8817-12
Assisted Care of the Carolinas ("Assisted Care")
Develop a Medicare-certified home health agency in Wake County.

J-8819-12
Maxim Healthcare Services, Inc. ("Maxim")
Develop a Medicare-certified home health agency in Wake County.

J-8821-12
Oakland Home Care NC, LLC ("Oakland")
Develop a Medicare-certified home health agency in Wake County.

Pursuant to N.C.G.S. § 131E-185, Hillcrest Home Health of the Triangle, LLC submits these comments in opposition to the above-referenced CON applications for a Medicare-certified home health agency in Wake County.

Overview
The *2012 State Medical Facilities Plan* identifies a need for one (1) Medicare-certified home health agency in Wake County. The term "Medicare-certified" is important because the need determination is for a "Medicare-certified" home health agency, not a "North Carolina licensed" home health agency; as such, the Agency must take into consideration the issues regarding the process to become "Medicare-certified." Hillcrest Home Health engaged the services of a nationally-respected, Medicare-certified home health agency consultant, who provided Hillcrest Home Health with the most accurate picture of how a home health agency operates prior to becoming Medicare-certified. Hillcrest Home Health's projections, staffing, and revenues are based on the "reality" of developing a Medicare-certified home health agency. It would appear that in the past the Agency may have been unfamiliar with the actual requirements and/or the actual process and time requirements to become a Medicare-certified home health agency.

Competitive Comments
Submitted by Hillcrest Home Health of the Triangle, LLC
May 31, 2012

The following comments are pertinent to all of the four identified Medicare-certified home health agency CON applications included in the CON review batch with Hillcrest Home Health of the Triangle. The errors each of the competing Medicare-certified home health agency CON applicants made in these areas makes each of the CON applications UNAPPROVABLE and the associated pro forma statements unfeasible. The errors made by the competing Medicare-certified home health agency CON applicants in each of these areas indicates that the applicants are not familiar with the requirements of becoming a Medicare-certified home health agency and/or did not engage an expert in the development of a Medicare-certified home health agency during the preparation of the CON application and/or the applicants felt that no applicant would make "real/actual" assumptions in the development and operation of a Medicare-certified home health agency in this review.

1. The North Carolina licensure process for a home health agency can be between six (6) to twelve (12) months. One of the four competing Medicare-certified home health agency CON applications, Oakland, proposes to receive initial North Carolina "licensure" as a home health agency in less than six (6) months. This is not a reasonable assumption.
2. A North Carolina-licensed home health agency must receive accreditation through one of several accreditation agencies, including:
    i. JCAHO (Joint Commission)
    ii. The Community Health Accreditation Program (CHAP)
    iii. Accreditation Commission for Health Care, Inc. (ACHC)

   All of the four competing Medicare-certified home health agency CON applications propose to receive accreditation through an approved Medicare accreditation agency. This is a reasonable assumption.
3. The on-site survey, which is a single part of the accreditation process, is scheduled from six (6) to nine (9) months after a licensed home health agency has initiated services and contracted with one of the accreditation agencies. The remaining activities of the accreditation agency takes two (2) to three (3) weeks to complete before the home health agency can become accredited, which then makes the home health agency a Medicare-certified home health agency. Each of the four competing Medicare-certified home health agency CON applications proposes to receive Medicare-certification within six (6) months of initiation of services. This is an unreasonable assumption.
4. A Medicaid patient cannot receive home health services from a non-Medicare-certified home health agency. Each of the four competing Medicare-certified home health agency CON applications proposes to begin serving Medicaid patients from the initial "licensure" of the home health agency. This is an unreasonable assumption.
5. The need determination in the 2012 State Medical Facilities Plan is for a Medicare-certified home health agency, not merely a North Carolina-licensed home health agency; as such, neither Medicare nor Medicaid will make any financial payments to a home health agency until it becomes a "Medicare-certified" home health agency. Each of the four competing Medicare-certified home health agency CON applications proposes to receive reimbursements from the initial "licensure" of the home health agency from both Medicare and Medicaid. This is an unreasonable assumption.
6. Combining all five of the previous comments, it is unreasonable for any applicant to assume that it will obtain Medicare-certification within twelve (12) months of operation; as such, no revenue can be projected for any Medicare or Medicaid patients projected in the first year of operation.

Each of these general comments is detailed in the following points:

1. The North Carolina licensure process for a home health agency is between six (6) to twelve (12) months. The licensure process requires the meeting between the Licensure Section and the staff of the proposed licensed home health agency; as such, the proposed licensed home health agency must have staff to meet with the Licensure Section.

    - Two of the four competing Medicare-certified home health agency CON applicants (Healthkeeperz and Oakland) propose to receive North Carolina "licensure" as a home health agency in two months or less after recruiting their core staff. This is as unreasonable assumption.
    - Oakland proposes to receive North Carolina "licensure" as a home health agency in less than two months after receiving the Certificate of Need. This is an unreasonable assumption.
    - Assisted Care proposes to become a Medicare-certified home health agency (7/1/2013) prior to becoming a North Carolina licensed home health agency (12/1/2013). This is impossible and is an unreasonable assumption. However, if Assisted Care of the Carolinas actually expected to become a North Carolina licensed home health agency on 12/01/2012; an assumption that the Agency CANNOT make in its review of the CON application, Assisted Care of the Carolinas would still project to become licensed just one (1) month after receiving the Certificate of Need and just 15 days after hiring its core staff. These would still be unreasonable assumptions.

	Issuance of Certificate of Need	Recruitment of Core Staff	Licensure Date	Months from Issuance of Certificate of Need to Licensure Date	Months from Recruitment of Core Staff to Licensure Date
Hillcrest Home Health	10/29/2012	04/01/2013	10/1/2013	11	6
Assisted Care of the Carolinas	10/29/2012	11/15/2012	12/1/2013	13	12.5
HealthKeeperz of Wake	10/30/2012	05/01/2013	7/1/2013	8	2
Maxim Healthcare Services	10/28/2012	NA	NA	NA	NA
Oakland Home Care NC	10/29/2012	12/01/2012	1/1/2013	2	1

2. A North Carolina-licensed home health agency must receive accreditation through one of several accreditation agencies, including:
    i. JCAHO (Joint Commission)
    ii. The Community Health Accreditation Program (CHAP)
    iii. Accreditation Commission for Health Care, Inc. (ACHC)

   All of the four competing Medicare-certified home health agency CON applications propose to receive accreditation through an approved Medicare accreditation agency. This is a reasonable assumption.

	Accreditation Agency
Hillcrest Home Health	ACHC
Assisted Care of the Carolinas	Joint Commission
HealthKeeperz of Wake	Joint Commission
Maxim Healthcare Services	ACHC
Oakland Home Care NC	Joint Commission

3. The on-site survey, which is a single part of the accreditation process, is scheduled from six (6) to nine (9) months after a licensed home health agency has initiated services and contracted with one of the accreditation agencies. The remaining activities of the accreditation agency take two (2) to three (3) weeks to complete before the home health agency can become accredited, which then makes the home health agency a Medicare-certified home health agency. The initial operating period before the scheduled on-site survey and the additional activities required of the accreditation agency results in an accreditation process of between twelve (12) months and eighteen (18) months.

    - Three of the competing Medicare-certified home health agency CON applicants (Healthkeeperz of Wake, Maxim Healthcare Services and Oakland Home Care) propose to receive "Medicare-certification" in less time than it is currently taking to just schedule an on-site survey with an accreditation agency. This is as unreasonable assumption.
    - Three of the competing Medicare-certified home health agency CON applicants (Healthkeeperz of Wake, Maxim Healthcare Services and Oakland Home Care) propose to receive "Medicare-certification" in less than twelve (12) months. This is as unreasonable assumption.
    - Assisted Care of the Carolinas proposes to become a Medicare-certified home health agency (7/1/2013) prior to becoming a North Carolina licensed home health agency (12/1/2013). This is impossible and is an unreasonable assumption.

	Licensure Date	Medicare Certification Date	Months from Li censure to Certification Date
Hillcrest Home Health	10/1/2013	10/1/2014	12
Assisted Care of the Carolinas	12/1/2013	7/1/2013	NA
HealthKeeperz of Wake	7/1/2013	10/1/2013	3
Maxim Healthcare Services	10/28/2012[1]	4/1/2013	5
Oakland Home Care NC	1/1/2013	7/1/2013	6

[1] Maxim already has a home health license. It proposes in its application that the current license will be sufficient.

4. A Medicaid patient cannot receive home health services from a non-Medicare-certified home health agency. Each of the four competing Medicare-certified home health agency CON applications proposes to begin serving Medicaid patients prior to becoming a Medicare-certified home health agency. This is an unreasonable assumption.

A North Carolina requirement for the delivery of home health services (not to be mistaken for home care services) to a Medicaid patient is that the service must be provided by a Medicare-certified home health agency; as such, no Medicaid patients can be included in any volume projections until the home health agency has become "Medicare-certified".

*See DMA Provider Enrollment Instructions ("P*roviders are not guaranteed a retroactive effective date and are strongly encouraged to provide services only after they are enrolled as a Medicaid provider.") (http://www.ncdhhs.gov/dma/provenroll/index.htm)

See *"Basic Medicaid and NC Choice Billing Guide"* ("Retroactive enrollment will not be granted.")

If a Medicaid patient is projected in the CON application prior to "Medicare-certification," the home health agency WILL NOT be reimbursed by Medicaid for the services provided.

At a minimum, none of the four (4) competing Medicare-certified home health agency CON applications can include reimbursement from Medicaid prior to the home health agency becoming "Medicare-certified." As previously discussed all four (4) competing Medicare-certified home health agency CON applications propose to receive Medicare-certification before it is reasonably possible for them to complete any accreditation process with any accreditation agency. However, for the sole purpose of discussing the impact that proposing to serve Medicaid patients prior to becoming Medicare-certified has on the financial feasibility of the project, the following table was developed. This table shows the Medicaid revenue lost in Year 1 because it was proposed to be received prior to becoming Medicare-certified. It should be noted that no reimbursement will be received by the proposed Medicare-certified home health agencies for Medicaid patients receiving care prior to the home health agency becoming "Medicare-certified." Medicare-certification and thus reimbursement is NOT retroactive.

- Assisted Care of the Carolinas proposes to become a Medicare-certified home health agency (7/1/2013) prior to becoming a North Carolina licensed home health agency (12/1/2013); as such, the pro forma financial statements provided are completely in error and unreliable.

	Operational/Licensure Date	Medicare Certification Date	Months Prior to Certification	Lost Revenue per Pro Forma Statements
Hillcrest Home Health	10/1/2013	10/1/2014	12	0
Assisted Care of the Carolinas	12/1/2013	7/1/2013	NA	NA
HealthKeeperz of Wake	7/1/2013	10/1/2013	3	$17,547
Maxim Healthcare Services	10/28/2012	4/1/2013	5	$19,125
Oakland Home Care NC	1/1/2013	7/1/2013	6	$34,275

5. The need determination in the 2012 State Medical Facilities Plan is for a Medicare-certified home health agency, not merely a North Carolina-licensed home health agency; as such, neither Medicare nor Medicaid will make any financial payments to a home health agency until it becomes a "Medicare-certified" home health agency. Each of the four competing Medicare-certified home health agency CON applications proposes to receive reimbursements from the initial "licensure" of the home health agency from both Medicare and Medicaid. This is an unreasonable assumption.

A requirement for the delivery of home health services (not to be mistaken for home care services) to a Medicare patient is that the service must be provided by a Medicare-certified home health agency to be reimbursed; as such, Medicare patients can be included in volume projections until the home health agency has become "Medicare-certified" but with the understanding that NO reimbursement will be received from Medicare. In fact, it is an accreditation requirement that some care be delivered to Medicare patients in order for the accreditation agency to survey the quality of services provided to the Medicare patients.

At a minimum, none of the four competing Medicare-certified home health agency CON applications can include reimbursement from Medicare prior to the home health agency becoming "Medicare-certified." For the sole purpose of discussing the impact that proposing to serve Medicare patients prior to becoming Medicare-certified has on the financial feasibility of the project, the following table was developed. This table shows the Medicare revenue lost in Year 1 because it was proposed to be received prior to becoming Medicare-certified. It should be noted that no reimbursement will be received by the proposed Medicare-certified home health agencies for Medicare patients receiving care prior to the home health agency becoming "Medicare-certified." Medicare-certification and thus reimbursement is NOT retroactive.

- Assisted Care of the Carolinas proposes to become a Medicare-certified home health agency (7/1/2013) prior to becoming a North Carolina licensed home health agency (12/1/2013); as such, the pro forma financial statements provided are completely in error and unreliable.

	Operational/Licensure Date	Medicare Certification Date	Months Prior to Certification	Lost Revenue per Pro Forma Statements
Hillcrest Home Health	10/1/2013	10/1/2014	12	0
Assisted Care of the Carolinas	12/1/2013	7/1/2013	NA	NA
HealthKeeperz of Wake	7/1/2013	10/1/2013	3	$107,385
Maxim Healthcare Services	1/1/2013	4/1/2013	3	$185,481
Oakland Home Care NC	1/1/2013	7/1/2013	6	$250,999

6. Combining all five of the previous comments, it is unreasonable for any applicant to assume that it will obtain Medicare-certification within twelve (12) months of operation; as such, no revenue can be projected for any Medicare or Medicare patients projected in the first year of operation.

A requirement for the delivery of home health services (not to be mistaken for home care services) to a Medicare or Medicaid patient is that the service must be provided by a Medicare-certified home health agency to be reimbursed; as such, Medicare and Medicaid patients can be included in volume projections until the home health agency has become "Medicare-certified" but with the understanding that NO reimbursement will be received from Medicare.

As previously discussed all four (4) competing Medicare-certified home health agency CON applications propose to receive Medicare-certification before it is reasonably possible for them to complete any accreditation process with any accreditation agency. To demonstrate the impact that proposing to serve Medicare and Medicaid patients prior to becoming Medicare-certified has on the financial feasibility of the project, the following table was developed. This table shows the Medicare and Medicaid revenue lost in Year 1 because the revenue was proposed to be received prior to becoming Medicare-certified and the loss in net income associated with not receiving Medicare or Medicaid reimbursements in the first year of operation. It should be noted that no reimbursement will be received by the proposed Medicare-certified home health agencies for Medicare or Medicaid patients receiving care prior to the home health agency becoming "Medicare-certified." Medicare-certification and thus reimbursement is NOT retroactive.

Year 1	Year 1 Revenue Lost			Year 1	
	Medicare	Medicaid	Total	Net Income	Revised Net Income
Hillcrest Home Health	$0	$0	$0	($168,435)	**($168,435)**
Assisted Care of the Carolinas	$900,460	$133,187	$1,033,647	$119,646	**($914,001)**
HealthKeeperz of Wake	$726,830	$93,218	$820,048	($46,891)	**($866,939)**
Maxim Healthcare Services	$799,491	$83,331	$882,822	$15,001	**($867,821)**
Oakland Home Care NC	$818,133	$96,448	$914,581	($214,673)	**($1,129,254)**

None of the competing Medicare-certified home health agency CON applications provides a letter for the revenue shortfall that would occur when Medicare and Medicaid revenues are eliminated from the pro forma statements due to the unreasonable assumptions that the applicants used in projecting when they would become Medicare-certified home health agencies.

Additional Issues Regarding Competitive Applications:

- None of the applications propose to use the MedMinder and Maya Med Management System proposed by Hillcrest to address a significant issue in patient care.

Maxim Application

- Maxim says it will provide 0.9% charity care but it shows no history of charity care. *See* Maxim application pp. 90 and 91.
- In response to Policy GEN:3 "Maximizing healthcare value", Maxim states "Maxim is experienced in operating cost-effective, quality home health services." However, last year Maxim settled allegations of home health care fraud by paying $150 million in restitution. See attached letter.

Oakland Application

- Oakland discusses providing an extremely wide range of services without corresponding increase in staffing.

Assisted Care

- Assisted Care appears to be stating that they will have better staffing during on-call hours (p. 127) but Hillcrest proposes more staff than Assisted Care.

- Assisted Care submitted an alternate proforma with no explanation regarding the same.

Department of Justice
Office of Public Affairs

FOR IMMEDIATE RELEASE

Monday, September 12, 2011

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

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

NEWARK, N.J. – Maxim Healthcare Services Inc., one of the nation's leading providers of home healthcare services, has entered into a settlement to resolve criminal and civil charges relating to a nationwide scheme to defraud Medicaid programs and the Veterans Affairs program of more than $61 million.

Today's announcement was made by Tony West, Assistant Attorney General of the Civil Division of the Department of Justice; J. Gilmore Childers, Acting U.S. Attorney for the District of New Jersey; Tom ODonnell, Special Agent in Charge of the Health and Human Services Office of Inspector General (HHS-OIG) region covering New Jersey; Michael B. Ward, Special Agent in Charge of the FBI's Newark, N.J., Field Office; and Jeffrey Hughes, Special Agent in Charge of the U.S. Department of Veterans Affairs, Office of the Inspector General (VA OIG), Northeast Field Office.

Maxim was charged today in a criminal complaint with conspiracy to commit health care fraud, and has entered into a deferred prosecution agreement (DPA) with the Department of Justice. The agreement will allow Maxim to avoid a health care fraud conviction on the charges if it complies with the DPA's requirements. As required by the DPA, which will expire in 24 months if the company meets all of its reform and compliance requirements, Maxim has agreed to pay a criminal penalty of $20 million and to pay approximately $130 million in civil settlements in the matter, including to federal False Claims Act claims.

To date, nine individuals – eight former Maxim employees, including three senior managers and the parent of a former Maxim patient – have pleaded guilty to felony charges arising out of the submission of fraudulent billings to government health care programs, the creation of fraudulent documentation associated with government program billings, or false statements to government health care program officials regarding Maxim's activities.

The criminal complaint accuses Maxim, a privately-held company based in Columbia, Md., with hundreds of offices throughout the United States, of submitting more than $61 million in fraudulent billings to government health care programs for services not rendered or otherwise not reimbursable. The investigation revealed that the submission of false bills to government health care programs was a common practice at Maxim from 2003 through 2009. During that time period, Maxim received more than $2 billion in reimbursements from government health care programs in 43 states based on billings submitted by Maxim.

"Fraudulent billing for services not rendered uses patients as pawns in a game of corporate greed that puts cash over care and wastes precious taxpayer dollars," said Assistant Attorney General West. "At a time when we're all looking for ways to reduce public expenditures, settlements like this one recapture taxpayer dollars lost to fraud and abuse, and help ensure that funds are available for the vital health care programs and services that people depend on day in and day out."

"Maxim, including senior executives, defrauded a system providing needed services to turn money meant for patient care into corporate profits," said Acting U.S. Attorney Childers. "We will continue to prove our commitment to investigating and prosecuting both companies and individuals whose misconduct robs our nation's health care programs and those who count on them. It is our hope that Maxim, in cleaning up its own house, will be a lighthouse influencing best practices across the industry."

"Companies scheming to profit by deceiving patients and defrauding taxpayer-funded government health care programs can expect close scrutiny and aggressive investigation," said HHS-OIG Special Agent in Charge ODonnell. "We will continue to carefully guard the nation's vital health programs against those who put greed over patient care."

"Health care fraud is a considerable problem in New Jersey with residents being victimized by an estimated $7.5 billion in care-related frauds in 2010," said FBI Special Agent in Charge Ward. "The criminal conduct by Maxim in this instance was significant and systemic, which resulted in both the company and individuals being liable for their actions. The Newark Division of the FBI is committed to its stance of being among the most aggressive offices in pursuit and ultimate prosecution of health care fraud offenders."

"Today's announcement demonstrates the Department of Veterans Affairs Office of Inspector General's commitment to focus investigative resources on companies that choose to pursue profit over the public's health," said VA OIG Special Agent in Charge Hughes. "VA OIG applauds the hard work of the Department of Justice and our law enforcement counterparts in bringing about this successful conclusion by aggressively pursuing and prosecuting those who committed fraud against our nation's federal healthcare programs, including VA's."

As part of the DPA, Maxim has stipulated to a statement of facts which mirrors the language of the criminal complaint. In the event that Maxim fails to comply with the provisions of the DPA, Maxim has agreed that the U.S. Attorney's Office may proceed with its prosecution of Maxim and use the agreed-upon statement of facts against it in the prosecution.

As detailed in the criminal complaint, Maxim, through its former officers and employees, falsely and fraudulently submitted billings to government health care programs for services not rendered or otherwise not reimbursable by government health care programs from 2003 through 2009. In order to conceal the fraud, Maxim's former officers and employees engaged in various conduct during that time period, including creating or modifying time sheets to support billings to government health care programs for services not rendered. They also submitted billings through licensed offices for care actually supervised by offices which operated without licenses and whose existence was concealed from government health care program auditors and investigators. Additionally, they created or modified documentation relating to required administrative functions associated with billings submitted to government health care programs, including documentation reflecting required training and qualifications of caregivers.

The DPA obliges Maxim to continue cooperating in the government's ongoing federal and state criminal investigation of former Maxim executives and employees responsible for the alleged conduct at issue, and to develop and operate an effective corporate compliance and governance program that includes adequate internal controls to prevent the recurrence of any improper or illegal activities.

The DPA requires Maxim's acceptance and acknowledgment of full responsibility for the conduct that led to the government's investigation.

The settlement requires payment of approximately $130 million to Medicaid programs and the Veterans Affairs program to resolve False Claims Act liability for false home healthcare billings to Medicaid programs and the Veterans Administration under civil agreements relating to this matter. The settlement resolves allegations that Maxim billed for services that were not rendered, services that were not properly documented, and services performed by 13 unlicensed offices. Maxim has agreed to pay approximately $70 million to the federal government and approximately $60 million to 42.

Also included in the settlement is a corporate integrity agreement with HHS-OIG, which requires additional reforms and monitoring under HHS-OIG supervision.

In addition, the company must also retain and pay an independent monitor, who will review Maxim's business operations and regularly report concerning the company's compliance with all federal and state health care laws, regulations, and programs. The monitor was selected by the U.S. Attorney's Office, consistent with U.S. Department of Justice guidelines, after a review of monitor candidates and in consultation with the company. Maxim will be monitored by Peter Keith of the law firm Gallagher, Evelius & Jones, which is headquartered in Baltimore.

Prosecution of Individuals

According to documents filed in these cases and statements made in Trenton, N.J., federal court: Gregory Munzel, 35, of Charleston, S.C., was employed as a regional account manager, reporting directly to a vice president, responsible for Maxim offices throughout the southeastern United States. He pleaded guilty on Dec. 4, 2009, to one count of making false statements relating to health care fraud matters. During his plea hearing, Munzel admitted that he was aware individuals he supervised were submitting time cards for work that had not actually been done – a practice Munzel said was in response to pressure from Maxim superiors to increase revenue. Munzel also acknowledged forging caregiver credentials such as CPR cards throughout his time at Maxim, in order to make it appear that the caregivers were properly credentialed, when they were not. Munzel indicated he learned the practice from his supervisors when he first joined Maxim, and that those under him engaged in the practice when he took on a leadership role with the company. Munzel is currently scheduled to be sentenced Sept. 29, 2011.

Bryan Lee Shipman, 38, of Athens, Ga., worked for Maxim for 13 years, the last eight as a regional account manager, reporting directly to a vice president. He pleaded guilty on June 17, 2010, to one count of health care fraud. During his plea hearing, Shipman acknowledged that Maxim's Gainesville, Ga., office operated without a license from 2008 through 2009, and that he and others directed billings from that office to be submitted as if they were from another, licensed office to be approved for reimbursement by the Medicaid program. At one point, when Maxim employees believed a state regulator would be visiting the office, lower-level employees were directed to provide false information to the state regulator in an effort to prevent the Medicaid program from learning about the unlicensed operation of the office. Shipman said his superiors demanded levels of growth based "not on any market analysis, but simply on a belief that dramatic growth was necessary regardless of market conditions." Shipman is currently scheduled to be sentenced Nov. 16, 2011.

Matthew Skaggs, 39, was employed as a regional account manager, reporting directly to a vice president, responsible for Maxim's offices in Texas. He pleaded guilty on Sept. 23, 2010, to making false statements relating to health care fraud matters. During his plea hearing, Skaggs acknowledged having knowingly made false statements to a surveyor from Texas' Medicaid Program, who was investigating the operation of an unlicensed Maxim office in Houston. Skaggs was sentenced on June 10, 2011, to a three-year term of probation and ordered to pay a $4,000 fine.

Andrew Sabbaghzadeh, 29, of Clay, N.Y., was employed as an account manager; and Jason Bouche, 27, of Paradise Valley, Ariz., was employed as a recruiter at Maxim's Tempe, Ariz., office. They pleaded guilty to health care fraud on Nov. 4, 2009, and April 23, 2010, respectively. During their plea hearings, Sabbaghzadeh and Bouche acknowledged creating fraudulent time cards in order to bill government programs. They acknowledged that in some instances, Maxim employees cut signatures from legitimate time cards and pasted them onto forged time cards in order to submit them for reimbursement. Sabbaghzadeh is currently scheduled to be sentenced on Sept. 26, 2011; Bouche is currently scheduled to be sentenced on Nov. 17, 2011.

Donna Ocansey, 49, of Medford, N.J., was employed as a director of clinical services (supervising nurse) in Maxim's Cherry Hill, N.J., office. She pleaded guilty on May 28, 2010, to making false statements relating to health care fraud matters. Ocansey, a registered nurse, had responsibility for, among other things, ensuring that Medicaid-required supervisory visits of patients were conducted periodically – meaning that a registered nurse periodically visited each patient to check each patient's condition and the care the patient was receiving from Maxim Home Health Aides, who lack the skills and training of registered nurses. During her plea hearing, Ocansey acknowledged that she fabricated documentation in order to make it appear that other nurses had conducted Medicaid-mandated supervisory visits, when in fact they had not. Ocansey stated that she fabricated documentation in response to pressure from her superiors at Maxim, who expected her to make sure that all supervisory visits were completed without providing adequate resources for her to do so. Ocansey is currently scheduled to be sentenced Sept. 20, 2011.

Mary Shelly Janvier-Pierre, 42, of Lake Worth, Fla., and Sandy Cave, 39, of West Palm Beach, Fla., pleaded guilty to health care fraud on Feb. 1, 2010, and June 21, 2010, respectively. During their plea hearings, Janvier-Pierre, who had been employed by Maxim's West Palm Beach office as a licensed practical nurse; and Cave, the mother of a former pediatric patient of Maxim, admitted to their roles in a scheme to fraudulently bill Medicaid through Maxim for services that were not rendered. Janvier-Pierre and Cave acknowledged that they agreed to submit billings as if Janvier-Pierre was taking care of Cave's child, when in reality she was not. Janvier-Pierre and Cave then split the money Janvier-Pierre received for purportedly providing the care. As a result of the scheme, Maxim was paid more than $70,000 by Florida's Medicaid program. Janvier-Pierre and Cave are scheduled to be sentenced on Sept. 21, 2011, and Oct. 24, 2011, respectively.

Marion Morton, 45, of North Charleston, S.C., was employed as a home health aide and personal care assistant by Maxim's Charleston office. He pleaded guilty on May 3, 2010, to one count of making false statements relating to health care fraud matters. During his plea hearing, Morton acknowledged that, at the instruction of Maxim employees, he fabricated timecards reflecting work he had not done. On multiple occasions, Maxim submitted bills to Medicaid based on timecards which showed he worked more than 24 hours on certain days. Morton was sentenced on May 24, 2011, to a three-year term of probation and ordered to pay a $5,000 fine.

All of the defendants pleaded guilty before U.S. District Judge Anne E. Thompson in Trenton federal court.

The health care fraud charge to which Shipman, Sabbaghzadeh, Bouche, Janvier-Pierre and Cave pleaded guilty carries a maximum penalty of 10 years in prison and a maximum fine of $250,000, or twice the amount of loss caused by their offenses. The false statements relating to health care fraud matters charge to which defendants Munzel, Skaggs, Ocansey and Morton pleaded guilty carries a maximum penalty of five years in prison and a maximum fine of $250,000, or twice the amount of loss caused by their offenses.

Maxim's Remedial Actions

The government's willingness to enter into a DPA with Maxim is due, in significant part, to the company's cooperation and the reforms and remedial actions the company has taken – beginning particularly in May 2009 – including significant personnel changes: terminating senior executives and other employees the company identified as responsible for the misconduct; establishing and filling of positions of chief executive officer, chief compliance officer, chief operations officer/chief clinical officer, chief quality officer/chief medical officer, chief culture officer, chief financial and strategy officer, and vice president of human resources; and hiring a new general counsel.

The company has identified and disclosed to law enforcement the misconduct of former Maxim employees, including providing information which has been critical in obtaining the convictions of some of the individuals who have pleaded guilty to date. The company has also significantly increased the resources allocated to its compliance program.

The settlement arises from a lawsuit filed under the False Claims Act. Under the qui tam, or whistleblower, provisions of the act, private citizens may file actions on behalf of the United States and share in any recovery. The whistleblower will receive approximately $15.4 million as his share of the recoveries from the federal government and the states.

The criminal complaint, DPA, civil settlement agreement and guilty pleas are the culmination of a multi-year investigation conducted jointly by special agents and investigators from HHS-OIG, under the direction of Special Agent in Charge ODonnell; FBI, under the direction of Special Agent in Charge Ward; and VA OIG, under the direction of Special Agent in Charge Hughes. The National Association of Medicaid Fraud Control Units (NAMFCU) and the Medicaid Fraud Control Units of the New Jersey, Virginia and Massachusetts Attorney General's Offices also assisted in coordinating the settlements with the various states.

The government is represented in the prosecution of the criminal case by Assistant U.S. Attorney Jacob T. Elberg of the U.S. Attorney's Office Health Care and Government Fraud Unit in Newark; and in the civil agreement by Sara McLean of the Department of Justice's Commercial Litigation Branch, Frauds Section and Assistant U.S. Attorney Alex Kriegsman of the U.S. Attorney's Office's Civil Division.

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

11-1169 Civil Division