HAND DELIVERED

May 31, 2012

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

Re: Comments on Competing Wake County Home Health CON Proposals –
Hillcrest Home Health of the Triangle, LLC (Hillcrest), **J-8813-12**
HKZ Group, LLC (HKZ), **J-8814-12**
Roberson Herring Enterprises, LLC, d/b/a Assisted Care of the Carolinas (Assisted Care), **J-8817-12**
Maxim Healthcare Services, Inc. (Maxim), **J-8819-12**

Dear Mr. Yakaboski and Mr. Smith:

On behalf of Oakland Home Care NC, LLC (OHC), Project ID # **J-8821-12**, thank you for the opportunity to comment on the above referenced applications for development of a new Medicare-certified home health agency in Wake County. During your review of the projects, I trust that you will consider the comments presented herein.

We recognize that the State's Certificate of Need (CON) award for the proposed home health agency will be based upon the State's CON health planning objectives, as outlined in G.S. 131E-183. Specifically, we request that the CON Section give careful consideration to the extent to which each applicant:

1. Demonstrates the need the proposed service area population has for all types of home health services;
2. Demonstrates that the most effective alternative is proposed;
3. Demonstrates immediate and long-term financial feasibility;
4. Demonstrates the availability of adequate staff to provide all proposed services;
5. Demonstrates the ability to provide all necessary ancillary and support services;
6. Offers service accessibility to all service area residents; and
7. Demonstrates that the project will have a positive impact on cost effectiveness, quality, and access to the proposed services.

The application from OHC, Project ID # J-8821-12, is conforming to all the above-referenced planning objectives and is competitively superior to all other applicants.

WHY APPROVE OAKLAND HOME CARE NC, LLC

Overview

Wake County will benefit tremendously from OHC. OHC proposes:

- The only service program specifically tailored to Wake County area resident needs;
- The most comprehensive care management program;
- A program and staffing plan that can appropriately care for Wake County's diverse foreign-born population;
- A program that includes outreach to community health and advocacy programs;
- The highest percentage of Medicare and Medicaid access;
- The second most visits per unduplicated patient;
- The highest compensation for Licensed Practical Nurses (LPNs) and the second highest compensation for Registered Nurses (RNs) and Home Health Aides (HHAs);
- The lowest ratio of net revenue to total cost; and
- The second lowest net revenue per visit.

The following pages highlight the advantages of the OHC application in the context of the 2012 State Medical Facilities Plan (SMFP) Basic Principles: Quality, Access and Value.

Quality

Service Need

Wake County's current and future need for home health services, as a whole, is well documented by the applicants in this competitive batch. Most applicants make it clear that the sustained growth and aging of the population of Wake County will generate a need for home health services far greater than existing Wake County home health agencies can handle. However, only OHC truly determined and described in Section III.1.(a) what specific home health services are actually needed by this population. Thus, OHC is the only applicant conforming to Criterion (3). Please see Table 1 below.

Wake County is home to 12 Medicare-certified home health agencies, and a number of other agencies based outside of the county serve Wake County residents. Most existing agencies continue to expand capacity and reach more patients every year. It has been two years since a new agency was added to the county and it will likely be several years before another is added. Hence, with five agencies competing for the one new provider opportunity, it is important that the CON Section select a new provider that will fill service gaps in this large and diverse county.

To determine what home health services are truly needed in the Wake County area, only one applicant, OHC, conducted a comprehensive survey of Wake County area healthcare providers. HKZ did conduct a survey but it surveyed only the need for core home health services (intermittent skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, medical social work) and two additional services (pharmacy and dietary counseling). OHC surveyed 31 Wake County area healthcare providers, who represented a broad cross-section of the community. Collectively, they identified 28 different home health agency services that the county needs and that fall within the scope of services of a home health agency (Please see OHC Exhibit 4). The ten most needed services are shown below in Table 1. As seen in Table 1, OHC proposes the most comprehensive program to meet county needs.

Table 1 - Comparison of Response to Most Requested Wake County Home Health Agency Services

Applicant	Medication Mgmt.	Diabetes Mgmt.	Wound Care	Palliative Care	DME**	Case Mgmt.	Stroke	Pain	Nutrition Counseling	Respite ***	Documents Need of the Population to be Served for Services in III.1.(a).
AssistedCare	Yes*	Yes*	Yes	Yes	Yes	Yes*	Yes*	Yes*	Yes*	No	Some****
Hillcrest	Yes	Yes*	Yes	No	No	Yes*	No	No	Yes*	No	No
HKZ	Yes	Yes*	Yes	No	No	Yes*	Yes*	Yes*	Yes*	No	No
Maxim	Yes*	Yes*	Yes*	No	No	Yes*	Yes*	Yes*	Yes	Yes	No
OHC	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**

**Documents that the agency will have programming but provides no description of the program.*

***Service not directly provided by home health agency. Applicants received a no, if they did not provide a letter from a DME company.*

****Services are provided by home care company.*

*****AssistedCare documents the only need for behavioral health services. It should be noted that behavioral health services did not come up as one of the top 10 most needed services during OHC's survey process.*

Care Management

Medicare costs are significant part of the national budget deficit and a matter of concern to policy makers. One way lawmakers and the Center for Medicare and Medicaid Services (CMS) are looking to control health care costs is by decreasing hospital readmissions. Hospital stays are expensive and research studies have shown that approximately 75 percent of hospital readmissions by Medicare beneficiaries are preventable[1]. This is important to this review because patients served by home health agencies are a significant and growing source of readmissions. The number of patients who needed home health care after being discharged from hospitals surged by about 70 percent (2.3 million to 4 million) from 1997 to 2008, according to the latest *News and Numbers* from the Agency for Healthcare Research and Quality (AHRQ). In contrast, the number of patients routinely discharged to their homes without the need for additional care grew by less than 8 percent, from 27 million to 29 million patients, during the period[2].

Effective October 1, 2012, CMS will reduce Medicare payments to hospitals for "excessive re-hospitalizations" of patients who have been admitted with a diagnosis of congestive heart failure (CHF), acute myocardial infraction (AMI) or pneumonia. Cuts will begin at one percent and increase to three percent. Cuts will be applied to all Medicare payments received by a hospital, regardless of diagnosis. Currently, the best performing U.S. hospitals produce one to three percent net operating margins, while 20 percent of all U.S. hospitals have negative operating margins. With narrow to negative margins, a one percent Medicare reimbursement penalty could prove catastrophic for any hospital that is not able to rein in its avoidable readmission rate. As a result, hospitals will refer their patients to the most efficient agencies that are least likely to readmit the hospital's patients. Therefore, home health agencies need to move away from general, episodic care toward sustained coordinated care of all patient needs by becoming coordinated care management companies[3].

OHC is the only applicant to demonstrate that it can and will implement a comprehensive care management plan within a reasonable budget for its home health agency. OHC's plan includes telemonitoring, point-of-care technology, case management, medication management, home safety programming, health literacy/education, and social networks. OHC believes all components are necessary for a comprehensive care management plan. Please see Section II.1.(b) and III.1.(a) of OHC's application for program specifics and documentation on the importance of a care management program that includes the services listed in Table 2 below.

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[1] 2 MedPAC: June 2007 Report to the Congress: Promoting Greater Efficiency in Medicare pp 107-115.
[2] http://www.ahrq.gov/news/nn/nn030911.htm
[3] http://www.doctorsmakinghousecalls.com/wp-content/uploads/2011/09/Wyatt-Matas-White-Paper-How-Home-Healthcare-Thrives-with-Healthcare-Reform-Final.pdf

Table 2 - Comparison of Care Management Program

Applicant	Telehealth	Case Mgmt.	Medication Mgmt.	Home Safety	Point of Care	Health Literacy / Education	Social Networks
AssistedCare	Yes	Yes*	Yes*	Yes*	Yes	No	No
Hillcrest	No	Yes*	Yes	No	No	No	No
HKZ	No	Yes*	Yes	No	No	Yes*	No
Maxim	No	Yes*	Yes*	No	Yes*	No	No
OHC	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**

**Documents that the agency will have programming but provides no description of the program.*

Staffing

For an agency to offer a comprehensive service package that focuses on care management, it must recruit top caliber direct care employees. In a competitive market like Wake County, a high salary is one way to recruit and retain such talent.

OHC proposes the highest total compensation for Licensed Practical Nurse (LPN) employees and the second highest total compensation for Registered Nurse (RN) and Home Health Aide (HHA) employees.

Table 3 - Total Compensation (Salary and Benefits) Comparison – Project Year 2

Applicant	LPN
OHC	**$ 67,738.96**
HKZ	$ 57,123.83
Hillcrest	$ 54,331.55
AssistedCare	$ 51,837.48
Maxim	N/A

Applicant	RN
AssistedCare	$ 85,980.43
OHC	**$ 85,300.91**
Hillcrest	$ 83,801.90
HKZ	$ 79,001.05
Maxim	$ 78,474.11

Applicant	HHA
Maxim	$ 38,048.05
OHC	**$ 37,005.54**
HKZ	$ 36,462.02
AssistedCare	$ 36,136.70
Hillcrest	$ 29,799.76

Visits per Unduplicated Patient

The majority of home health visits are covered by Medicare and most are Medicare fee for service. Medicare fee for service does not reimburse on a per visit basis, but on a per episode basis. Thus, there is a financial disincentive to providing more visits per Medicare episode. OHC provides the second most visits per unduplicated patient.

Table 4 - Visits per Unduplicated Patient Comparison – Project Year 2

Applicant	Visits / Unduplicated
Maxim	21.3
OHC	**20.5**
Hillcrest	17.3
HKZ	16.3
AssistedCare	15.8

Access

OHC offers the most access to Medicare and Medicaid recipients.

Table 5 - Payor Mix Comparison – Project Year 2

Applicant	Projected Visits /Hours as % of Total Project Visits /Hours
OHC	**93.0%**
Maxim	92.2%
HKZ	84.5%
Hillcrest	80.5%
AssistedCare	79.9%

OHC is the only applicant that can appropriately care for Wake County's diverse foreign-born population. OHC is the only applicant to document and budget for coordination with persons capable of assisting OHC in hiring non-English speaking staff and is the only applicant to allocate funds for interpreter services.

OHC is the only applicant to coordinate care with Wake County community health care programs that focus on providing care to uninsured individuals.

Finally, OHC is the only applicant that documents sources of sufficient referrals to fill its utilization projections.

Table 6 - Referral Comparison

Applicant	Year 2 Unduplicated Census	Promised Referrals from Service Area	Deficit (-) Surplus(+)
AssistedCare	500	420*	-80
Hillcrest	538	0	-538
HKZ	492	138*	-216
Maxim	516	0	-516
OHC	**552**	**1,152**	**+630**

**Referral estimates are from Wake County providers only. AssistedCare and HKZ census projections are based on serving only Wake County residents.*

A provider's ability to demonstrate it can reasonably reach its census totals is of the utmost importance. Industry experts are concerned that agencies are going to find it increasingly difficult to make a profit in the face of decreasing Medicare and Medicaid reimbursement and increasing costs associated with the administrative burden of complex regulations, quality reporting requirements and increased compliance audits. In fact, based on these growing concerns, the State Health Coordinating Council's Long-Term Care and Behavioral Health Committee is recommending increasing the home health methodology need threshold from 275 to 325.

Value

Table 7 - Ratio of Net Revenue to Total Cost – Project Year 2

Applicant	Ratio of Net Revenue to Total Cost
OHC	**1.01**
HKZ	1.02
Hillcrest	1.06
AssistedCare	1.12
Maxim	1.27

Maxim and AssistedCare propose to take significant profit out of their proposed agencies. The high profits are attributed to both agencies offering fewer staff in functions that are not directly reimbursable. Unlike OHC, Maxim and AssistedCare provide no OASIS Coordinator or full time Nurse Supervisor / Clinical Coordinator. As a result of CMS's pressure to reduce hospital readmissions, it is likely that hospitals are going to try to keep sicker patients in the community as long as possible. This will require a patient's home health eligibility to be monitored closely and more coordination with community resources. The missing care coordination services in these agencies will make them less valuable to patients.

Table 8 - Net Revenue per Visit – Project Year 2

Applicant	Net Revenue Per Visit
Maxim	$ 139.24
OHC	**$ 144.66**
Hillcrest	$ 150.42
AssistedCare	$ 154.24
HKZ	$ 163.90

As explained above, because Medicare reimburses home health agencies by episode and a majority of an agency's patients will be Medicare, there is a financial disincentive to providing more visits. As Tables 4 and 8 show, OHC and Maxim sacrifice profit to provide more visits. It should be noted that Maxim does not have the referrals necessary to support its visit projections.

Conclusion

OHC believes that all applicants are interested in providing quality service. However, it is our opinion that among the projects under review, competing applications are non-conforming to the State's CON Review Criteria and offer less desirable alternatives.

The application from OHC is competitively superior for the following reasons. It:

- Provides programming for all home health services currently needed in Wake County;
- Provides a care management program that will make OHC an ideal partner for area health care providers focusing on decreasing readmissions;
- Increases accessibility to all service area residents;
- Offers salaries that will ensure high quality, well trained direct care staff are employed;
- Demonstrates a commitment to providing appropriate levels of care and not financial gain; and
- Conforms to all the State's Review Criteria and special rules (10A NCAC 14C .2000).

Attached is an analysis of the competing applications discussed within the framework of the State's CON Review Criteria and applicable home health rules (10A NCAC 14C .2000). For each applicant, we have addressed only those criteria which we believe the application is non-conforming. Please call me if you have any questions.

Sincerely,

Mike Kham, Vice-president
Singh Development, LLC
919-677-1700

Attachments:

A Noncompliance with CON Review Criteria and applicable home health rules: 10A NCAC 14C .2000

B U.S. English Foundation Statistics

C FFY 2011 Durham County Nursing Care Facility Payor Mix

D Hillcrest Medicare Revenue Calculation

E Psychiatric Nurse Regulations

F Healthkeeperz, Inc.'s FFY 2011 Payor Mix

G Medicare Reimbursement Articles

Attachment A

COMPETITIVE REVIEW OF –
Hillcrest Home Health of the Triangle, LLC (*Hillcrest*), J-8813-12

CON REVIEW CRITERIA

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

Need

Hillcrest does not demonstrate a need for each of the proposed services described in Section II.1. Section III.1.(a) instructs applicants to "*describe, in specific terms, the unmet need that necessitated the inclusion of each of the proposed services to be offered by the home health office as set forth in the description of the scope of services in Section II.1.*" As such, Hillcrest does not adequately demonstrate the need of the population to be served for the services proposed.

Access

Hillcrest does not adequately demonstrate 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 because it provides no plan, or funds, for care of non-English speaking residents. In a study by the US English Foundation, Wake County was found to be the most linguistically diverse county in the state of North Carolina, with 70 languages spoken. Please see Attachment B. Thus, to ensure access to all Wake County residents, applicants must demonstrate an ability to care for non-English speaking residents.

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

4. ***Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.***

The application is non-conforming to other applicable statutory and regulatory Review Criteria. Therefore, Hillcrest did not demonstrate the least costly or most effective alternative has been proposed. As a result, the application is non-conforming to this Review Criterion. Please see discussion in Criterion (3), (5), (6), (7), (8), (13c), and (18a).

It should also be noted that Hillcrest has no experience operating a home health agency and is the least prepared to operate an agency focused on care management. Hillcrest offers no point-of-care system, telehealth, health literacy, social networks, or home safety techniques. A home health agency will only provide value in today's market if it can offer services that focus on reducing readmissions.

Finally, a majority of Hillcrest's referrals originate from Durham County providers and Hillcrest's owners operate a nursing care facility in Durham County that has a high Medicare population. In Federal Fiscal Year (FFY) 2011, 34 percent of Hillcrest Convalescent Center's days of care were to Medicare recipients. The FFY 2011 Durham County nursing care facility Medicare days of care average was 20 percent. Please see Attachment C. Medicare beneficiaries in nursing care facilities are typically receiving short-term rehab care and are discharged home. Hillcrest's utilization projections in Section IV assume a high therapy volume. In Project Year 1, 75 percent of Hillcrest's unduplicated admissions will be for physical therapy services and in Project Year 2, 50 percent of Hillcrest's unduplicated admissions will be for physical therapy services. Based on Hillcrest's large number of Durham County referral's and its nursing care facility's case mix, it is reasonable to assume that Hillcrest will actually utilize the proposed agency to serve the needs of its nursing care facility before focusing on Wake County residents.

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

Operational Projections

The applicant's operational projections are unsupported and unreliable for the following reasons:

- On Hillcrest application page 77, Section IV.3, the applicant states that unduplicated patient projections are based in part on referral letters. However, Hillcrest failed to document that it will receive patient referrals sufficient to reach its projected number of patients. On Hillcrest application page 77, Section IV.3, the applicant states that it has 1,380-1,872 annual referrals. However, only 430 referrals are from Wake County providers. As such, annual referrals do not support the applicant's projected Project Year 2 patient total of 547. Having established referral relationships is important in a competitive market like Wake County. All three hospitals located in Wake County operate strong home health programs. Furthermore, according to a recent MedPAC report, depending on hospitals for referrals is insufficient. According to the report, approximately 65 percent of home health admissions are from non-hospital referral sources[4]. As such, it is important that new agencies have established relationships with area providers for referrals. As discussed in OHC's attached letter to CON, volume is critical to a home health agency's success in today's market.

[4] http://www.medpac.gov/documents/Mar12_EntireReport.pdf, page 220.

- The applicant's episode per patient ratio of 1.44 is very high compared to North Carolina and Wake County history. Please see Table 1 below. On Hillcrest application page 84, Section IV.3, the applicant states that its ratio is reasonable because the ratio for the six largest Wake County based non-hospital related home health agencies reported an average episode per patient ratio of 1.51 in FFY 2011. However, the applicant provides no rationale for excluding the other six home health agencies based in Wake County.

Table 1 - Medicare Episodes per Patient Comparison

a	b	c	d
Last Winning Wake County CON	**NC April 2011-June 2011 per Palmetto GBA**	**FFY 2010 Wake County Median (from Cost Reports)**	**FFY 2011 Wake County Average (from Licensure Reports)**
1.34	1.20	1.28	1.37

Notes:

a) J-8511-10

b) Palmetto GBA data. Please see OHC Exhibit 14, page 470.

c) 2010 Medicare home health cost report data from CMS. Please see OHC Exhibit 14, page 469.

d) 2012 Wake County home health licensure renewal applications. Please see OHC Exhibit 14, page 471-472.

Financial Projections

The applicant's financial projections are unsupported and unreliable for the following reasons:

- The applicant's projections for utilization are unsupported and unreliable. Please see discussion above. Consequently, costs and revenues that are based on the applicant's utilization projections are unreliable.
- The applicant's Full Episode without Outlier Medicare reimbursement projection is unsupported and incorrect. On Hillcrest application page 142, the applicant utilizes a case mix of 1.36. However, the applicant provides no justification for this number. Furthermore, the applicant does not apply the wage index factor for Wake County (0.9648) to its calculation. As such, the applicant overstated Medicare revenue by $27,777.79. Please see Attachment D.
- The applicant provides no source data for its projected Low Utilization Payment Adjustment (LUPA) payment.
- The applicant fails to budget adequate expenses for appropriate levels of health manpower. Please see discussion in Criterion (7).
- Medicaid revenue is based on inappropriate assumptions. On Hillcrest application page 143, Hillcrest provides Medicaid revenue assumptions that show its agency being paid for medical social work visits. Medicaid does not reimburse for medical social work visits[5].

[5] http://www.dhhs.state.nc.us/dma/services/homehealth.htm

- The applicant's medical supply reimbursement assumption is unsupported and unreasonable. On Hillcrest application page 144, the applicant projects a medical supply reimbursement rate of $51.91 and it is applied to all Medicare episodes and all Medicaid, commercial, indigent, and other patients. The applicant provides no assumption for the reimbursement rate. Additionally, OHC believes it is unreasonable to assume revenue collection from indigent patients when 100 percent of their visit revenue is written off.
- On Hillcrest application page 145, the applicant projects a 10 percent deduction from gross revenue collected from "Other". It is impossible to validate if this is a reasonable assumption. The applicant never specifies what "Other" includes.
- The applicant budgets no supply costs for physical therapy, occupational therapy, speech therapy, and medical social worker. The applicant provides no assumption(s) for why this is reasonable.
- On Hillcrest application page 20, Section II.1.(b), the applicant states that it will utilize MedMinder and Maya Medication management system for medication adherence. However, the applicant does not appear to budget for capital or operating expenses associated with the equipment.
- On Hillcrest application page 26, Section II.1.(c), the applicant states that a corporate team will coordinate contracted services and patient billing and will provide agency governance, strategic leadership, control, direction. The applicant budgets no money for these services.
- The applicant fails to budget funds for a physician to sit on its required advisory committee. Please see discussion in Criterion (8).
- The applicant's capital costs are under budgeted for the following reasons:
    - The applicant budgets four computers/monitors/keyboards. In Project Year 2 the applicant will employ seven office staff (Administrator, Scheduler, Billing Assistant, Marketing Liaison, DCS, Oasis Coordinator, and Medical Records Clerk). OHC believes it is unlikely that three of these staff will not utilize a computer. Additionally, this allows no computer for field staff to utilize.
    - The applicant budgets office furniture for five people. As stated above, in Project Year 2, the applicant will employ seven office staff. The agency will also employ approximately nine clinicians who will make home visits. These staff will need shared space for documentation work.
    - The applicant budget's two laptops. OHC assumes the laptops will be utilized by the clinicians in the field. As stated above, the applicant budgets approximately nine clinicians who will make home visits. It is common practice for only nurses and therapy staff to carry a laptop but nurses alone total 4.92 FTEs in Project Year 2.

Availability of Funds

The applicant provides insufficient data to demonstrate availability of funds necessary to operate the proposed project. On Hillcrest application page 116, Section VIII.1, the applicant estimates capital costs of $98,900. However, as discussed above, the applicant likely underestimated its capital costs by more than $1,100. This is important because Hillcrest's financing letter, in Hillcrest application Exhibit S, allocates only $100,000 for capital costs. Therefore, the applicant does not demonstrate the availability of funds necessary to operate the proposed project.

In conclusion, the applicant did not adequately demonstrate the availability of sufficient funds for capital and operating needs and the applicant's utilization and financial projections are unreliable. Thus, the application is non-conforming to Criterion (5).

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

The applicant does not describe the unmet need that necessitated the inclusion of each of the proposed project components. Therefore, the applicant fails to provide alternate information to demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities and the application is non-conforming with this Review Criterion. Please also see discussion of need in Criterion (3).

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

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

- Hillcrest does not budget for a registered nurse that can provide psychiatric home health services. On Hillcrest application page 48, Section II.2, Hillcrest proposes a psychiatric home health program. In order to get paid by Medicare for a direct psychiatric patient admission, an agency must utilize a registered nurse that meets certain psychiatric care standards. Please see Attachment E. Hillcrest does not propose such a staff person.
- Hillcrest does not provide the time considerations that were used to project visits per day for registered nurses, therapy staff, home health aides or medical social workers, as requested by application question VII.3. As such, it is impossible to verify if visit per day estimates are reasonable. As a result, it is impossible to determine if projected nursing, therapy, and medical social work staffing is accurate.

8. ***The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system***

The applicant does not demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services because it does not provide evidence of a physician that is willing to serve on the agency's required advisory committee. An advisory committee is a requirement of Medicare Conditions of Participation (42 CFR 484.16)[6]. Thus, the applicant is non-conforming to Criterion (8).

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

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

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

[6] http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/xml/CFR-2011-title42-vol5-part484.xml#seqnum484.16

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

The applicant's proposal will increase competition in the proposed service area but it will not have a have a positive impact upon the cost effectiveness, quality, and access to the services proposed for the following reasons:

- Hillcrest has no experience operating a home health agency and is the least prepared to operate an agency focused on care management. A home health agency will only provide value in today's market if it can offer services that focus on reducing readmissions. Please see discussion in Criterion (4).
- The applicant provides no plan, or funds, for care of non-English speaking residents. Please see discussion in Criterion (3).
- The applicant does not demonstrate a need for each of the proposed services described in Section II.1. Please see discussion in Criterion (3).
- It is reasonable to assume that the applicant will serve Durham County residents before Wake County residents. Please see discussion in Criterion (4).
- The applicant's projected costs are unreliable because they are based on unsupported and unreliable operational and financial projections. Please see discussion in Criterion (5).
- The applicant does not demonstrate the availability of funds necessary to operate the proposed project. Please see discussion in Criterion (5).
- The applicant does not show evidence of the availability of resources including health manpower and management personnel, for the provision of the services proposed. Please see discussion in Criterion (7).
- The applicant does not demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. Please see discussion in Criterion (8).

10A NCAC 14C .2000

CRITERIA AND STANDARDS FOR HOME HEALTH SERVICES

10A NCAC 14C .2002 INFORMATION REQUIRED OF APPLICANT

(a) An applicant shall identify:

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

Projections are based on undocumented assumptions. Please see discussion in Criterion (3) and (5) above.

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

Projections are based on flawed and undocumented assumptions. Please see discussion in Criterion (3) and (5) above.

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

Projections are based on flawed and undocumented assumptions. Please see discussion in Criterion (3) and (5) above.

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

As discussed in Criterion (7), the applicant does not provide the time considerations that were utilized to project visits per day for registered nurses, therapy staff, home health aides or medical social workers, as requested by application question VII.3. Please see discussion in Criterion (7) above.

(7) the projected average annual cost per visit for each service discipline;

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

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

Projections are based on flawed and undocumented assumptions. Please see discussion in Criterion (3) and (5) above.

10A NCAC 14C .2003 PERFORMANCE STANDARDS

An applicant shall project, in the third year of operation, an annual unduplicated patient caseload for the county in which the facility will be located that meets or exceeds the minimum need used in the applicable State Medical Facilities Plan to justify the establishment of a new home health agency office in that county. An applicant shall not be required to meet this performance standard if the home health agency office need determination in the applicable State Medical Facilities Plan was not based on application of the standard methodology for a Medicare-certified home health agency office.

Projections are based on flawed and undocumented assumptions. Please see discussion in Criterion (3) and (5) above.

10A NCAC 14C .2005 STAFFING AND STAFF TRAINING

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

The applicant does not provide copies of letters of interest, preliminary agreements, or executed contractual arrangements from a physician that is willing to serve on the agency's required advisory committee. An advisory committee is a requirement of Medicare Conditions of Participation (42 CFR 484.16). Please see discussion in Criterion (8) above.

COMPETITIVE REVIEW OF – HKZ Group, LLC (*HKZ*), J-8814-12

CON REVIEW CRITERIA

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

Need

HKZ does not adequately demonstrate the need of the population to be served for the services proposed:

- HKZ does not demonstrate a need for each of the proposed services described in Section II.1. Section III.1.(a) instructs applicants to "*describe, in specific terms, the unmet need that necessitated the inclusion of each of the proposed services to be offered by the home health office as set forth in the description of the scope of services in Section II.1.*"
- HKZ does not provide an independent assessment of Wake County's projected home health need for each project year. On HKZ application page 45, Section IV.3, HKZ states that existing provider volume will increase by 6.1 percent; however, HKZ provides no statistical methodology projecting the population's need for the home health services.

Access

HKZ does not adequately demonstrate 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 because it provides no plan, or funds, for care of non-English speaking residents. In a study by the US English Foundation, Wake County was found to be the most linguistically diverse county in the state of North Carolina, with 70 languages spoken. Please see Attachment B. Thus, to ensure access to all Wake County residents, applicants must demonstrate an ability to care for non-English speaking residents.

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

4. *Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.*

The application is non-conforming to other applicable statutory and regulatory Review Criteria. Therefore, HKZ did not demonstrate the least costly or most effective alternative has been proposed. As a result, the application is non-conforming to this Review Criterion. Please see discussion in Criterion (3), (5), (6), (7), (8), (13c), and (18a).

It should also be noted that HZK's total operating cost per visit in Project Year 2 ($160.78) is substantially higher than the other four applicants ($109.49, $137.32, $142.00, and $142.64).

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

Operational Projections

The applicant's operational projections are unsupported and unreliable for the following reasons:

- On HKZ application page 92, Section XII, the applicant states that the proposed agency will be licensed on July 1, 2013, open on October 1, 2013, and certified October 1, 2013. This timeline is illogical and not possible. First, it is not logical that an agency would become licensed and then wait three months to open. Second, an agency cannot open and be certified on the same day. An agency must be open and have served 10 skilled care patients and still have seven active (not Medicare patients) to request an on-site Medicare certification survey. If the agency has no deficiencies it will be recommended for Medicare certification[7]. Issuance of a Medicare tie-in number will take approximately three months. The agency cannot apply for Medicaid certification until it has a Medicare number. Medicaid certification will take another couple of months. Please see OHC Exhibit 29 for conversation logs documenting the certification process.
- The applicant's projected utilization by payor does not follow utilization assumptions and are based on inaccurate and unsupported data. Visit projections utilized in the HKZ application, which are the basis for the applicant's revenue assumptions, are based on the applicant's projected unduplicated patients times 16.3. The applicant then distributed the visits by payor and by visit type. As such the applicant's projected payor mix as a percent of visits should mirror the applicant's projected unduplicated admission payor mix provided on HKZ application page 55. It is does not. As detailed on HKZ application page 112, the applicant's payor mix as a percent of visits is projected to be 69.7 percent Medicare, 14.8 percent Medicaid, 14.5 percent commercial insurance, and 1.0 percent self-pay. On HKZ application page 55, the applicant assumes an unduplicated patient payor mix of 58.5 percent Medicare, 28.8 percent Medicaid, 7.4 percent private insurance, 2.5 percent VA, and 2.8 percent Tricare. It appears that the applicant actually applied its projected payor mix for duplicated patients found on HKZ application page 56. This is inappropriate based on the

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

applicant's methodology. Furthermore, even if the CON Section deems the applicant's methods appropriate, the applicant's duplicated patient payor mix is based on unsupported data. The applicant states on HKZ application page 56 that the projected duplicated payor mix is similar to HealthKeeperz, Inc.'s actual operating experience at its existing three North Carolina home health agencies. However, the applicant provides no back-up data to validate these percentages, and a review of these agencies' 2012 Home Health Licensure Renewal Applications shows that the projected payor mix is not similar to history. Please see Attachment F.

- HKZ failed to document that it will receive patient referrals sufficient to reach its projected number of patients. HKZ Exhibit 18 includes surveys that contain referral estimates. However, only 138 annual referrals are from Wake County providers. As such, annual referrals do not support the applicant's projected Project Year 2 patient total of 493. Having established referral relationships is important in a competitive market like Wake County. All three hospitals located in Wake County operate strong home health programs. Furthermore, according to a recent MedPAC report, depending on hospitals for referrals is insufficient. According to the report, approximately 65 percent of home health admissions are from non-hospital referral sources[8]. As such, it is important that new agencies have established relationships with area providers for referrals. As discussed in OHC's attached letter to CON, volume is critical to a home health agency's success in today's market.
- Throughout the HKZ application, the applicant attempts to validate its high projected Medicaid volume by stating that the proposed agency will serve a number of Medicaid incontinence patients like its three existing agencies. However, as discussed in Criterion (3), the applicant provides no documentation of need for incontinence services in Wake County.

Financial Projections

The applicant's financial projections are unsupported and unreliable for the following reasons:

- The applicant's projections for utilization are unsupported and unreliable. Please see discussion above. Consequently, costs and revenues that are based on the applicant's utilization projections are unreliable.
- On HKZ application page 108, the applicant provides projected Medicare episode reimbursement rates. However, the applicant provides no assumption to validate the rates. On HKZ application page 105, the applicant states that all reimbursement is based on current rates. However, the applicant fails to state whose current rates. Rates vary by region. If the applicant utilized the current rates for Healthkeeperz Inc.'s three agencies, this would not be reasonable. Wake County has a different geographic wage index factor from Scotland, Cumberland, and Robeson County.
- The applicant failed to decrease Medicare reimbursement. On HKZ application page 105, the applicant states that it did not decrease reimbursement rates because it is impossible to know future change. However, based on current legislation, home health PPS rates will decrease by 1.32 percent in CY 2013. Please see Attachment G.

[8] http://www.medpac.gov/documents/Mar12_EntireReport.pdf, page 220.

- On HKZ application page 108, the applicant provides projected visits per Medicare episode. However, the applicant provides no assumption to validate the visits.
- On HKZ application page 108, the applicant provides a projected Medicare episode breakout by type. However, the applicant provides no assumption for the percentages.
- On HKZ application page 106, the applicant states that benefits are estimated at 23 percent of salaries. However, the applicant's proforma statements are computed with benefits at 18 percent of salaries. Please see HKZ application pages 98-100.
- The applicant's Project Year 1, Form B projections, on HKZ application page 97, do not match detailed revenue and expense assumptions provided on HKZ application pages 98-100. Project Year 1, Form B proformas show net income of $38,594 and detailed revenue and expense assumptions, on HKZ application page 100, show Project Year 1 net income of -46,891.
- The applicant fails to budget supply costs for physical therapy, occupational therapy, speech therapy, and medical social work. The applicant provides no assumption for why this is reasonable.
- The applicant fails to budget travel costs for speech therapy and medical social work. The applicant provides no assumption for why this is reasonable. By definition, visits will involve travel to patient homes.
- The applicant fails to budget adequate expenses for appropriate levels of health manpower. Please see discussion in Criterion (7).
- The applicant fails to budget funds for a physician to sit on its required advisory committee. Please see discussion in Criterion (8).

Availability of Funds

The applicant provides insufficient data to demonstrate availability of funds necessary to operate the proposed project for the following reasons:

The applicant fails to apply a lag to Medicare and Medicaid receipts. On HKZ application page 102, HKZ projects Medicare and Medicaid revenue from opening day. This is not possible. As discussed above, it will be at least three months before an agency receives Medicare reimbursement and at least five months before it will receive Medicaid reimbursement. By underestimating the cash flow lag, the applicant understated its initial operating expenses by a minimum of approximately $100,000. This is important because HKZ's financing letter, in HKZ Exhibit 15, is not sufficient to cover any increase in initial operating or capital expense over $27,524. Therefore, the applicant does not demonstrate the availability of funds necessary to operate the proposed project.

In conclusion, the applicant did not adequately demonstrate the availability of sufficient funds for capital and operating needs and the applicant's utilization and financial projections are unreliable. Thus, the application is non-conforming to Criterion (5).

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

The application fails to provide separate analysis to demonstrate *that the project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.* Moreover, the applicant does not describe the unmet need that necessitated the inclusion of each of the proposed project components. Therefore, the applicant fails to provide alternate information to demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities and the application is non-conforming with this Review Criterion. Please also see discussion of need in Criterion (3).

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

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

- HKZ does not provide the time considerations that were utilized to project visits per day for LPNs, therapy staff, home health aides or medical social workers, as requested by application question VII.3. As such, it is impossible to verify if visit per day estimates are reasonable. As a result, it is impossible to determine if projected nursing, therapy, and medical social work staffing is accurate.
- On HKZ application page 79, the applicant projects one Medical Record FTE in Project Year 2. However, the applicant does not project a Medical Record FTE in Project Year 1. The applicant provides no explanation of how medical records will be handled in Project Year 1.
- The applicant has not budgeted for RN staff in Project Year 1. A comparison of the applicant's Form B proformas (HKZ application page 95) and detailed revenue and Project Year 1, Form B expense statements (HKZ application page 98) make it clear that nursing services expenses are off by one row (expenses are pushed up one line item) and are missing RN salaries and benefits.
- The applicant's projected physical therapy staff will not cover paid time off (PTO). The applicant is understaffed if the physical therapists take one day of PTO. Please see Table 2 below.

Table 2 - Staffing Calculation

a	Total PT Visits	2,695
b	Total Visits Covered by Staff at 259 Worked Days	2,098
c	Contracted PT Budget	$44,550
d	Contract PT Cost per Visit	$ 75.00
e	Contracted PT Visits Budgeted	594
f	Total Covered PT Visits	2,692
g	PT Visits not Covered	3

Notes:

a) HKZ application page 59
*b) 1.5 FTEs(Table VII.2)*5.4 visits per day(Table VII.2) *259*
c) HKZ application page 98
d) Table VII.2-HKZ application page 79
e) c/d
f) b+e
g) a-f

8. ***The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system.***

The applicant does not demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services for the following reasons:

- On HKZ application page 76, Section VII.5.(b), the applicant states that infusion therapy will be provided by Home Choice Partners. However, the applicant does not provide a copy of an executed contract or letter of intent from Home Choice Partners or any other infusion therapy provider.
- On HKZ application page 76, Section VII.5.(b), the applicant states that lab services will be provided by LabCorps. In HKZ Exhibit 19, the applicant provides a letter of support from LabCorps but the letter does not indicated that it would be willing to provide lab services to HKZ's proposed agency.

- On HKZ application page 9, Section II.1.(a), the applicant states that pharmacists will perform monthly reviews of the prescriptions of patients in the HealthKeeperz HealthSync Pharmacy Program and will coordinate delivery of medications. However, the applicant does not provide a copy of an executed contract or letter of intent from a pharmacist interested in providing these services nor are the services covered in the management contract provided in HKZ Exhibit 2.
- It is unclear who will provide physical therapy, occupational therapy, speech therapy, and medical social work services through both project years. On HKZ application page 325, HKZ Exhibit 12, the applicant provides a letter from Core Medical Group that states its interest in providing physical therapy, occupational therapy, speech therapy, and medical social work services. However, the letter states that it will only provide services during the early stages. Furthermore, based on a review of Core Medical Group's website, it does not appear that the company provides medical social worker services. On HKZ application page 320, HKZ Exhibit 12, the applicant provides a letter from Supplemental Healthcare that states it's interested in providing staffing services. However, it does not state what services it is interested in providing.
- The applicant does not provide evidence of a physician that is willing to serve on the agency's required advisory committee. An advisory committee is a requirement of Medicare Conditions of Participation (42 CFR 484.16).[9]

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

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

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

[9] http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/xml/CFR-2011-title42-vol5-part484.xml#seqnum484.16

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

The applicant's proposal will increase competition in the proposed service area but it will not have a have a positive impact upon the cost effectiveness, quality, and access to the services proposed for the following reasons:

- HZK's total operating cost per visit in Project Year 2 is substantially higher than the other four applicants. Please see discussion in Criterion (4).
- The applicant provides no plan, or funds, for care of non-English speaking residents. Please see discussion in Criterion (3).
- The applicant does not demonstrate a need for each of the proposed services described in Section II.1. Please see discussion in Criterion (3).
- The applicant's projected costs are unreliable because they are based on unsupported and unreliable operational and financial projections. Please see discussion in Criterion (5).
- The applicant does not demonstrate the availability of funds necessary to operate the proposed project. Please see discussion in Criterion (5).
- The applicant does not show evidence of the availability of resources including health manpower and management personnel, for the provision of the services proposed. Please see discussion in Criterion (7).
- The applicant does not demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. Please see discussion in Criterion (8).

10A NCAC 14C .2000

CRITERIA AND STANDARDS FOR HOME HEALTH SERVICES

10A NCAC 14C .2002 INFORMATION REQUIRED OF APPLICANT

(a) An applicant shall identify:

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

Projections are based on flawed and undocumented assumptions. Please see discussion in Criterion (3) and (5) above.

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

Projections are based on flawed and undocumented assumptions. Please see discussion in Criterion (3) and (5) above.

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

Projections are based on flawed and undocumented assumptions. Please see discussion in Criterion (3) and (5) above.

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

As discussed in Criterion (7), the applicant does not provide the time considerations that were utilized to project visits per day for LPNs, therapy staff, home health aides or medical social workers, as requested by application question VII.3. Please see discussion in Criterion (7) above.

(7) the projected average annual cost per visit for each service discipline;

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

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

Projections are based on flawed and undocumented assumptions. Please see discussion in Criterion (3) and (5) above.

10A NCAC 14C .2003 PERFORMANCE STANDARDS

An applicant shall project, in the third year of operation, an annual unduplicated patient caseload for the county in which the facility will be located that meets or exceeds the minimum need used in the applicable State Medical Facilities Plan to justify the establishment of a new home health agency office in that county. An applicant shall not be required to meet this performance standard if the home health agency office need determination in the applicable State Medical Facilities Plan was not based on application of the standard methodology for a Medicare-certified home health agency office.

Projections are based on flawed and undocumented assumptions. Please see discussion in Criterion (3) and (5) above.

10A NCAC 14C .2005 STAFFING AND STAFF TRAINING

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

The applicant is non-conforming. The applicant does not provide copies of letters of interest, preliminary agreements, or executed contractual arrangements from person necessary to provide the following services:

- Infusion
- Lab
- Pharmacist
- Physical, Speech, and Occupational Therapy
- Medical Social Work
- Physician for Advisory Committee

Please see discussion in Criterion (8) above.

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

Need

AssistedCare does not adequately demonstrate the need of the population to be served for the services proposed:

- AssistedCare does not demonstrate a need for each of the proposed services described in Section II.1. Section III.1.(a) instructs applicants to "*describe, in specific terms, the unmet need that necessitated the inclusion of each of the proposed services to be offered by the home health office as set forth in the description of the scope of services in Section II.1.*"
- AssistedCare does not provide an independent assessment of Wake County's projected home health need for each project year. On AssistedCare application page 76, Section III.1.(b), AssistedCare states that existing provider volume will increase by eight percent; however, AssistedCare provides no statistical methodology projecting the population's need for the home health services.

Access

AssistedCare does not adequately demonstrate 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 because it provides no plan, or funds, for care of non-English speaking residents. In a study by the US English Foundation, Wake County was found to be the most linguistically diverse county in the state of North Carolina, with 70 languages spoken. Please see Attachment B. Thus, to ensure access to all Wake County residents, applicants must demonstrate an ability to care for non-English speaking residents.

It should also be noted that AssistedCare provides the lowest access to Medicaid beneficiaries. Please see Table 3 below.

Table 3 - Medicaid as a Percent of Visits –Project Year 2

Applicant	Medicaid
HKZ	14.80%
Hillcrest	13.10%
OHC	12.99%
Maxim	7.40%
AssistedCare	6.90%

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

4. ***Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.***

The application is non-conforming to other applicable statutory and regulatory Review Criteria. Therefore, AssistedCare did not demonstrate the least costly or most effective alternative has been proposed. As a result, the application is not conforming to this Review Criterion. Please see discussion in Criterion (3), (5), (6), (7), (8), (13c), and (18a).

It should also be noted that AssistedCare's charges are the highest of all applicants for all service lines, it proposes the least number of visits per unduplicated patients, and offers the lowest access to Medicaid beneficiaries.

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

Operational Projections

The applicant's operational projections are unsupported and unreliable for the following reasons:

- Unduplicated patient projections on application page 77, Section III.1.(b), are arbitrary and based on unsubstantiated projections of need. Project Year 1 projections are based solely on the need determined in the 2011 SMFP. Project Year 2 projections are arbitrarily increased by approximately eight percent and do not consider what the actual need in Wake County will be in that year. Please see discussion in Criterion (3).

- It is impossible to validate when the proposed project will begin operations. Utilization projections provided in application Exhibit 27 project services starting in January, 2013. On AssistedCare application page 151, Section 12, the applicant states that the agency will be licensed December 1, 2013. An agency cannot be opened prior to being licensed. Furthermore, on AssistedCare application page 151, Section 12, the applicant states that the agency will be certified July 1, 2013. This is also impossible. A facility cannot be certified before it is licensed.
- AssistedCare failed to document a single patient referral. Having referral relationships is important in a competitive market like Wake County. All three hospitals located in Wake County operate strong home health programs. Furthermore, according to a recent MedPAC report, depending on hospitals for referrals is insufficient. According to the report, approximately 65 percent of home health admissions are from non-hospital referral sources[10]. As such, it is important that new agencies have established relationships with area providers for referrals. As discussed in OHC's attached letter to CON, volume is critical to a home health agency's success in today's market.

Financial Projections

The applicant's financial projections are unsupported and unreliable for the following reasons:

- The applicant's projections for utilization are unsupported and unreliable. Please see discussion above. Consequently, costs and revenues that are based on the applicant's utilization projections are unreliable.
- The applicant's Medicare reimbursement projections are unsubstantiated and unreasonable for the following reasons:
    - On AssistedCare application page 159, the applicant states that Medicare reimbursement for all non-LUPA episodes is based on the 2010 average per episode reimbursement (net of LUPAs) of all North Carolina home health providers per CMS. However, the applicant provides no documentation from CMS to validate the reimbursement rate.
    - On AssistedCare application page 159, states that it assumes no inflation or deflation for its non-LUPA Medicare episode reimbursement. This is an inappropriate assumption. Non-LUPA Medicare episode reimbursement has decreased every year since 2010 and it is projected to decrease again in 2013. Please see Attachment G.
- Applicant provides no basis for Medicaid supply reimbursement, private/commercial insurance reimbursement, or self-pay/other reimbursement.
- On AssistedCare application page 22, the applicant states that it will utilize Viterion Telehealth equipment. However, the applicant makes no indication in its application that costs associated with owning or leasing the equipment have been accounted for in the capital cost estimates or proformas.

[10] http://www.medpac.gov/documents/Mar12_EntireReport.pdf, page 220.

- On AssistedCare application page 37, the applicant states that it will utilize a web-based electronic medical record called CareAnywhere. However, the applicant makes no indication in its application that costs associated with utilizing the software have been accounted for in the capital cost estimates or proformas.
- The applicant fails to budget adequate expenses for appropriate levels of health manpower. Please see discussion in Criterion (7).
- The applicant fails to budget funds for a physician to sit on its required advisory committee. Please see discussion in Criterion (8).

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

The application fails to provide separate analysis to demonstrate *that the project will not result in unnecessary duplication of existing or approved health service capabilities or facilities*. Moreover, the applicant does not describe the unmet need that necessitated the inclusion of each of the proposed project components. Therefore, the applicant fails to provide alternate information to demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities and the application is non-conforming with this Review Criterion. Please also see discussion of need in Criterion (3).

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

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

- AssistedCare does not budget for a registered nurse that can provide psychiatric home health services. In application Section II.2, AssistedCare proposes a psychiatric home health program. In order to get paid by Medicare for a direct psychiatric patient admission, an agency must utilize a registered nurse that meets certain psychiatric care standards. Please see Attachment E. AssistedCare does not propose such a staff person.
- AssistedCare does not budget for a secretary and provides no alternative plan for how secretarially duties such as reception and scheduling will be handled.
- AssistedCare does not budget for a nurse supervisor or equivalent. As such, it is unclear who will handle admitting duties. All budgeted nursing staff must be making visits every day to cover provide enough coverage for the applicant's visit projections.
- AssistedCare does not provide the time considerations that were utilized to project visits per day for therapy staff, home health aides or medical social workers, as requested by application question VII.3. As such, it is impossible to verify if visit per day estimates are reasonable. As a result, it is impossible to determine if projected home health aide, therapy, and medical social work staffing is accurate. Furthermore, the applicant's assumptions to project nursing visits per day do not match the applicant's estimate of five visits per day. The applicant projects that nursing staff will make five visits per day in Table VII.2 on AssitedCare application page 129 and 130. However, the applicant's

nursing visits per day assumptions, provided on AssistedCare application page 122, Section VII.3, show nurses making 5.65 visits per day. Please see calculation below in Table 4. It should also be noted that 5.65 visits per day is unusually high productivity for a home health agency and particularly high for a county as large as Wake County, which has 835 square miles for providers to cover. The national average in 2010 for nursing visits per day was 4.96.[11]

Table 4 - Visits per Day Calculation

a	Worked hours per day	8
b	Visit length and Documentation	1
c	Travel and Supervisory/Admin duties	0.42
d	Total Time per Visit	1.42
e	Total Visits per Day	5.65

Notes

a) Assumed eight hour work day

b) AssistedCare application page 122 - ((50+10)/60 =1)

c) AssistedCare application page 122 - ((20+5)/60 = 0.42)

d) b+c

e) a/d

8. ***The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system***

The applicant does not demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services because it does not provide evidence of a physician that is willing to serve on the agency's required advisory committee. An advisory committee is a requirement of Medicare Conditions of Participation (42 CFR 484.16)[12].

The applicant does not demonstrate that the proposed service will be coordinated with the existing health care system. As discussed in Criterion (5), AssistedCare failed to document a single referral from area healthcare providers.

In conclusion, the applicant did not adequately demonstrate it will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services and does not demonstrate that the proposed services will be coordinated with the existing health care system. Thus, the application is non-conforming to Criterion (8).

[11] http://www.nahc.org/facts/10HC_Stats.pdf

[12] http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/xml/CFR-2011-title42-vol5-part484.xml#seqnum484.16

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

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

The applicant is non-conforming to this Criterion. As stated in Criterion (3), the applicant projects below average Medicaid/Medicare access and does not offer programs sufficient to care for non-English speaking residents. Please see discussion in Criterion (3).

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

The applicant's proposal will increase competition in the proposed service area but it will not have a have a positive impact upon the cost effectiveness, quality, and access to the services proposed for the following reasons:

- AssistedCare's charges are the highest of all applicants for all service lines, it proposes the least number of visits per unduplicated patients, and offers the lowest access to Medicaid beneficiaries. Please see discussion in Criterion (3) and (4).
- The applicant provides no plan, or funds, for care of non-English speaking residents. Please see discussion in Criterion (3).
- The applicant does not demonstrate a need for each of the proposed services described in Section II.1. Please see discussion in Criterion (3).
- The applicant's projected costs are unreliable because they are based on unsupported and unreliable operational and financial projections. Please see discussion in Criterion (5).
- The applicant does not show evidence of the availability of resources including health manpower and management personnel, for the provision of the services proposed. Please see discussion in Criterion (7).
- The applicant does not demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. Please see discussion in Criterion (8).

10A NCAC 14C .2000

CRITERIA AND STANDARDS FOR HOME HEALTH SERVICES

10A NCAC 14C .2002 INFORMATION REQUIRED OF APPLICANT

(a) An applicant shall identify:

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

Projections are based on flawed and undocumented assumptions. Please see discussion in Criterion (3) and (5) above.

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

Projections are based on flawed and undocumented assumptions. Please see discussion in Criterion (3) and (5) above.

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

Projections are based on flawed and undocumented assumptions. Please see discussion in Criterion (3) and (5) above.

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

As discussed in Criterion (7), the applicant does not provide the time considerations that were utilized to project visits per day for therapy staff, home health aides or medical social workers, as requested by application question VII.3. Furthermore, the applicant's assumptions to project nursing visits per day do not match the applicant's estimate of five visits per day. Please see discussion in Criterion (7) above.

(7) the projected average annual cost per visit for each service discipline;

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

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

Projections are based on flawed and undocumented assumptions. Please see discussion in Criterion (3) and (5) above.

10A NCAC 14C .2003 PERFORMANCE STANDARDS

An applicant shall project, in the third year of operation, an annual unduplicated patient caseload for the county in which the facility will be located that meets or exceeds the minimum need used in the applicable State Medical Facilities Plan to justify the establishment of a new home health agency office in that county. An applicant shall not be required to meet this performance standard if the home health agency office need determination in the applicable State Medical Facilities Plan was not based on application of the standard methodology for a Medicare-certified home health agency office.

Projections are based on flawed and undocumented assumptions. Please see discussion in Criterion (3) and (5) above.

10A NCAC 14C .2005 STAFFING AND STAFF TRAINING

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

The applicant does not provide copies of letters of interest, preliminary agreements, or executed contractual arrangements from a physician that is willing to serve on the agency's required advisory committee. An advisory committee is a requirement of Medicare Conditions of Participation (42 CFR 484.16). Please see discussion in Criterion (8) above.

COMPETITIVE REVIEW OF –
Maxim Healthcare Services, Inc. (*Maxim*), J-8819-12

CON REVIEW CRITERIA

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

Need

Maxim does not adequately demonstrate the need of the population to be served for the services proposed:

- Maxim does not demonstrate a need for each of the proposed services described in Section II.1. Section III.1.(a) instructs applicants to "*describe, in specific terms, the unmet need that necessitated the inclusion of each of the proposed services to be offered by the home health office as set forth in the description of the scope of services in Section II.1.*" It should also be noted that in Section II, Maxim application page 14, Maxim lists many services like grocery shopping and sitter services that are not eligible for reimbursement in the home health agency program.
- Maxim does not provide an independent assessment of Wake County's projected home health need for each project year. On Maxim application page 46, Section III.1.(b), Maxim states that existing provider volume will increase at the same rate as the Wake County population (2.6 percent); however, Maxim provides no statistical methodology projecting the population's need for the home health services.

Access

Maxim does not adequately demonstrate 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 for the following reasons:

- Maxim provides no funds or plan for care of non-English speaking residents. On Maxim application page 12, the applicant states it will provide foreign language interpreter services and hire Spanish-speaking staff members. However, the applicant provides no funds to pay for interpretation services. Additionally, the applicant provides no plan for recruitment of bi-lingual staff and no correspondence with any organization that can aide in hiring Spanish speaking staff. In a study by the US English Foundation, Wake County was found to be the most linguistically diverse county in the state of North Carolina, with 70 languages spoken. Please see Attachment B. Thus, to ensure access to all Wake County residents, applicants must demonstrate an ability to care for non-English speaking residents.

- Maxim projects no Medicare Outlier patients. Wake County's population in need of home health services will likely generate Outlier patients. Please see discussion in Criterion (5) below.

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

4. ***Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.***

The application is non-conforming to other applicable statutory and regulatory Review Criteria. Therefore, Maxim did not demonstrate the least costly or most effective alternative has been proposed. As a result, the application is not conforming to this Review Criterion. Please see discussion in Criterion (3), (5), (6), (7), (8), (13c), and (18a).

As discussed in Table 7, of OHC's attached letter to the CON Section, Maxim proformas show significant profit compared to those of its competitors. The high profits are attributed to offering fewer care coordination staff and high ratios of visits per FTE.

The shortage of care coordination staff will make Maxim less responsive to CMS Medicare initiatives to reduce hospital readmissions. CMS lists WakeMed Raleigh as having one of the highest readmission rates in the state for its three target diagnoses, CHF, AMI and pneumonia.[13], Wake County response to CMS efforts to reduce readmissions for CHF, heart attack, pneumonia and chronic obstructive pulmonary disease, will require a home health agency with staff training, protocols and capacity to manage care and to coordinate community resources for this population. The missing care coordination services in the Maxim agency will make it less valuable to Wake County patients.

Maxim failed to document promise of a single patient referral. Additionally, half of the applicant's eight physician letters of support are from pediatricians. As discussed in Criterion (3), the applicant provides no discussion of need for pediatric services.

With these shortcomings and compared to other applicants, Maxim is non-conforming with this criterion.

[13] https://data.medicare.gov/dataset/Hospital-Outcome-Of-Care-Measures/f24z-mvb9

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

Operational Projections

The applicant's operational projections are unsupported and unreliable for the following reasons:

- The applicant's payor mix assumptions provided on Maxim application page 67, Section IV.3, are unsupported. On application page 67, the applicant claims it can support a higher than average Medicaid mix because it will actively market Medicaid patients. However, the applicant provides no marketing plan and provides no correspondence with providers like Community Care of Wake and Johnson Counties, who typically care for/refer Medicaid beneficiaries.
- Maxim projects no Medicare Outlier patients. Based on the needs identified in OHC's survey of area healthcare providers, OHC believes this is an unreasonable assumption. As documented in OHC Exhibit 4, page 272, medication management, diabetes management, and wound care are the top three most needed services in Wake County. Primary diagnosis that indicates outliers are strongly associated with medical care complications such as surgical wound infections, diabetes, and skin conditions including chronic ulcers and cellulites[14]. As such, the approved agency in this batch will likely have Medicare Outlier patients.
- Maxim provides no methodology or assumption for estimating duplicated patients in Table IV.2 on Maxim application page 66.
- The absence of demonstrated referrals for older patients will require extra marketing and outreach costs. Developing referral relationships commensurate with the proposed service program is critical in a competitive market like Wake County. All three hospitals located in Wake County operate large home health programs. Furthermore, according to a recent MedPAC report, depending on hospitals for referrals is insufficient to maintain a viable home health agency program. According to the report, approximately 65 percent of home health admissions are from non-hospital referral sources[15]. As such, it is important that new agencies have established relationships with area providers for referrals. As discussed in OHC's attached letter to CON, volume is critical to a home health agency's success in today's market.

[14] https://apha.confex.com/apha/132am/techprogram/paper_89938.htm
[15] http://www.medpac.gov/documents/Mar12_EntireReport.pdf, page 220.

Financial Projections

The applicant's financial projections are unsupported and unreliable for the following reasons:

- Maxim's Medicare revenue projections are unreliable and unsubstantiated.
  - Maxim provides no basis for any of the three Medicare reimbursement rates provided on Maxim application page 113.
  - The applicant overestimated Partial Episode Payment (PEP) reimbursement. On Maxim application page 113, the applicant projects total PEP reimbursement of $57,067 and $74,600 in Project Year 1 and 2, respectively. On Maxim application page 113, the applicant projects five PEP episodes in Project Year 1 and six PEP episodes in Project Year 2. This equates to a per episode reimbursement rate of $11,413 and $12,433 in Project Year 1 and 2, respectively. PEPs are paid on an episode rate and by definition will be reimbursed at a rate less than the Full Episode rate. The applicant's Full Episode rate is projected as $2,600 in Project Year 1 and 2. Thus, Maxim has overstated PEP reimbursement by factors of five to six.
  - The applicant's Project Year 1 Medicare contractual adjustment of $24,727, projected in Form B, does not make sense. Based on the applicant's Medicare reimbursement assumptions provided on Maxim application page 113 and the applicant's gross revenue assumptions provided in Form B, the applicant should have a positive contractual of approximately $274,738 ($1,098,956 – $824,218 = $274,738).
  - The applicant's gross revenue in Project Year 2, projected in Form B, is equivalent to the applicant's total Medicare reimbursement estimate on Maxim application page 113. As such, it is unclear why there is an additional Medicare contractual adjustment of 43,098 in Form B in Project Year 1.
- Maxim provides no reimbursement assumptions for Medicaid, commercial insurance or self-pay and charity.
- The application appears to confuse licensure as a home care agency with certification for Medicare home health agency. Medicare will require that procedures like OASIS reporting be in place and operational and serving existing clients prior to Medicare certification. It is possible that the start up costs for an existing home care agency will be lower than for an agency starting from scratch. However, it is impossible to attain Medicare certification without some start up cost.
- The applicant provides no bad debt assumptions.
- The applicant budgets no supply costs for physical therapy, occupational therapy, speech therapy, and medical social worker. The applicant provides no assumption for why this is reasonable.
- The applicant provides no assumptions for any non-salary related administrative costs.
- On Maxim application page 12, the applicant states it will provide foreign language interpreter services. However, the applicant provides no funds to pay for interpretation services.

- On Maxim application page 12, the applicant states it will provide dietary consultation by a registered dietician. However, the applicant provides no funds to pay for dietician services.
- For reasons that are not clear, Exhibit 16 is missing the notes to the audited financials. The note on the bottom of page 5 of the financials indicates "The accompanying notes are an integral part of these consolidated financial statements..."

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

The application fails to provide separate analysis to demonstrate *that the project will not result in unnecessary duplication of existing or approved health service capabilities or facilities*. Moreover, the applicant:

- Does not describe the unmet need that necessitated the inclusion of each of the proposed project components.
- Describes a service program for older people and supports it with endorsements from pediatricians who do not speak to the needs of older people.

Therefore, the applicant fails to provide information to demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities and the application is non-conforming with this Review Criterion. Please also see discussion of need in Criterion (3).

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

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

- On Maxim application page 96, Section VII.3 the applicant states that FTE calculations in Table VII.2 are adjusted to account for vacation, holiday, and sick time. OHC believes this to be incorrect. With as few as ten total days off for vacation, holiday, and sick time, the applicant is short nursing, physical therapy, speech therapy, and medical social work staff. In total the applicant is short 0.18 FTEs. Please see Table 5.

Table 5 - Staffing Calculation with Seven Days of PTO

	a	b	c	D	e	f
Discipline	**Projected FTEs**	**Visits/Day**	**Projected Visits**	**Days Worked per FTE per Year**	**FTEs Needed**	**FTEs not Budgeted (- = Surplus)**
Nursing (only direct care)	3.10	5.6	4,412	250	3.15	0.05
PT	3.15	5.0	4,081	250	3.26	0.11
ST	0.16	5.0	209	250	0.17	0.01
MSW	0.13	3.5	119	250	0.14	0.01

Notes:

a) Table VII.2, Maxim application page 95
b) Table VII.2, Maxim application page 95
c) Table IV.2 Maxim application page 66
d) Assumes 10 days of PTO (Sick, Holiday, Vacation)
e) c/b/d
f) e-a

- On Maxim application page 95, Maxim estimates that registered nurses will make 5.6 visits per day. 5.6 visits per day is unusually high productivity for a home health agency and particularly high for a county as large as Wake County, which has 835 square miles for providers to cover. The national average in 2010 for nursing visits per day was 4.96[16]. A reduction in visits per day would require more nursing staff.

- The application does not explain special characteristics that might enable Maxim to achieve these high visit rates. In fact, with few support staff, Maxim will likely place more non-visit responsibilities on direct care staff. More non-visit time will make it difficult for direct care staff to meet the high productivity used in the forecasts.

8. ***The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system.***

The applicant does not demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services for the following reasons:

- The applicant states in its financial assumptions that it will contract clinical staff for pharmacy services. However, the applicant does not provide a copy of an executed contract or letter of intent from a pharmacy service provider.
- On Maxim application page 12, the applicant states it will provide foreign language interpreter services. However, the applicant does not provide a copy of an executed contract or letter of intent from an interpreter service provider.

[16] http://www.nahc.org/facts/10HC_Stats.pdf

- On Maxim application page 12, the applicant states it will provide dietary consultation by a registered dietician. However, the applicant does not provide a copy of an executed contract or letter of intent from a registered dietician.

The applicant does not demonstrate that the proposed service will be coordinated with the existing health care system. As discussed in Criterion (5), Maxim failed to document a single referral from area healthcare providers. Furthermore, of the applicant's eight physician letters of support, four are from pediatricians. As discussed in Criterion (3), the applicant provides no discussion of need for pediatric services.

In conclusion, the applicant did not adequately demonstrate it will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services and does not demonstrate that the proposed services will be coordinated with the existing health care system. Thus, the application is non-conforming to Criterion (8).

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

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

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

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

The applicant's proposal will increase competition in the proposed service area but it will not have a have a positive impact upon the cost effectiveness, quality, and access to the services proposed for the following reasons:

- As discussed in OHC's attached letter to the CON Section, Maxim financial proformas show significant profit. The high profits are attributed to offering fewer care coordination staff and forecasting high visit ratios for direct care staff. Both of these factors reflect fewer care enhancements for Wake County patients. The missing care elements in this agency will make it less valuable to patients.
- The applicant provides no plan, or funds, for care of non-English speaking residents. Please see discussion in Criterion (3).
- The applicant does not demonstrate a need for each of the proposed services described in Section II.1. Please see discussion in Criterion (3).
- Maxim projects to serve no Medicare Outlier patients. Wake County's population in need of home health services will likely generate Outlier patients. Please see discussion in Criterion (3) and (5).
- The applicant's projected costs are unreliable because they are based on unsupported and unreliable operational and financial projections. Please see discussion in Criterion (5).
- The applicant does not show evidence of the availability of resources including health manpower and management personnel, for the provision of the services proposed. Please see discussion in Criterion (7).
- The applicant does not demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. Please see discussion in Criterion (8).
- Maxim proposes the second lowest proportions of visits to Medicaid beneficiaries among applicants in this batch.

10A NCAC 14C .2000

CRITERIA AND STANDARDS FOR HOME HEALTH SERVICES

10A NCAC 14C .2002 INFORMATION REQUIRED OF APPLICANT

(a) An applicant shall identify:

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

Projections are based on flawed and undocumented assumptions. Please see discussion in Criterion (3) and (5) above.

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

Projections are based on flawed and undocumented assumptions. Please see discussion in Criterion (3) and (5) above.

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

Projections are based on flawed and undocumented assumptions. Please see discussion in Criterion (3) and (5) above.

(7) the projected average annual cost per visit for each service discipline;

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

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

The application forecasts are based on undocumented assumptions for both utilization and costs. Please see discussion in Criterion (3) and (5) above.

10A NCAC 14C .2003 PERFORMANCE STANDARDS

An applicant shall project, in the third year of operation, an annual unduplicated patient caseload for the county in which the facility will be located that meets or exceeds the minimum need used in the applicable State Medical Facilities Plan to justify the establishment of a new home health agency office in that county. An applicant shall not be required to meet this performance standard if the home health agency office need determination in the applicable State Medical Facilities Plan was not based on application of the standard methodology for a Medicare-certified home health agency office.

Projections are based on flawed and undocumented assumptions. Please see discussion in Criterion (3) and (5) above.

10A NCAC 14C .2005 STAFFING AND STAFF TRAINING

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

The applicant is non-conforming. The applicant does not provide copies of letters of interest, preliminary agreements, or executed contractual arrangements from person necessary to provide the following services:

- Dietician
- Interpreter
- Pharmacy

Please see discussion in Criterion (8) above.

Attachment B

NORTH CAROLINA

Population: 8,049,313 Number of Counties: 100

122
Languages spoken

13
Counties with 20 or more languages spoken

38
Counties with 10 or more languages spoken

80
Counties with 5 or more languages spoken

40
Languages with 1,000 or more speakers

Most Common Languages Spoken

Rank	Language	Speakers
1	English	6,909,650
2	Spanish	378,940
3	French	32,925
4	German	28,500
5	Vietnamese	13,595
6	Chinese	12,835
7	Korean	11,385
8	Arabic	10,835
9	Miao, Hmong	7,495
10	Tagalog	6,520
11	Greek	6,405
12	Japanese	6,315
13	Italian	6,235
14	Gujarathi	5,725
15	Laotian	4,600
16	Hindi	4,155
17	Russian	4,110
18	Kru, Ibo, Yoruba	3,585
19	Mon-Khmer, Cambodian	3,360
20	Urdu	3,210
21	Portuguese	3,170
22	Polish	2,965
23	Persian	2,430
t-24	Dutch	2,020
t-24	Thai	2,020
26	Swedish	1,700
27	India, n.e.c.	1,595
28	Telugu	1,580
29	Tamil	1,510
30	Mandarin	1,490
31	French Creole	1,440
32	Cherokee	1,415
33	Hebrew	1,320
34	Amharic	1,295
35	Serbocroatian	1,255
36	Cushite	1,220
37	Romanian	1,120
38	Bengali	1,100
39	Ukrainian	1,050
40	Hungarian	1,040
41	Swahili	970
42	Turkish	860
43	Cantonese	795
44	Bantu	790
45	Czech	755
46	Panjabi	710
47	Finnish	610
48	Danish	590
49	Marathi	565
50	Formosan	545

Counties With the Most Languages Spoken

Rank	County	Languages
1	Wake County	70
2	Mecklenburg County	68
3	Guilford County	58
4	Cumberland County	48
5	Durham County	46
6	Orange County	37
7	Forsyth County	36
8	Buncombe County	33
9	Onslow County	27
10	New Hanover County	24
11	Gaston County	23
12	Pitt County	21
13	Alamance County	20
t-14	Iredell County	18
t-14	Randolph County	18
t-14	Wayne County	18
t-17	Brunswick County	17
t-17	Henderson County	17
t-19	Burke County	16
t-19	Cleveland County	16
t-19	Craven County	16
t-19	Johnston County	16
t-19	Union County	16
24	Rowan County	15
t-25	Cabarrus County	14
t-25	Harnett County	14

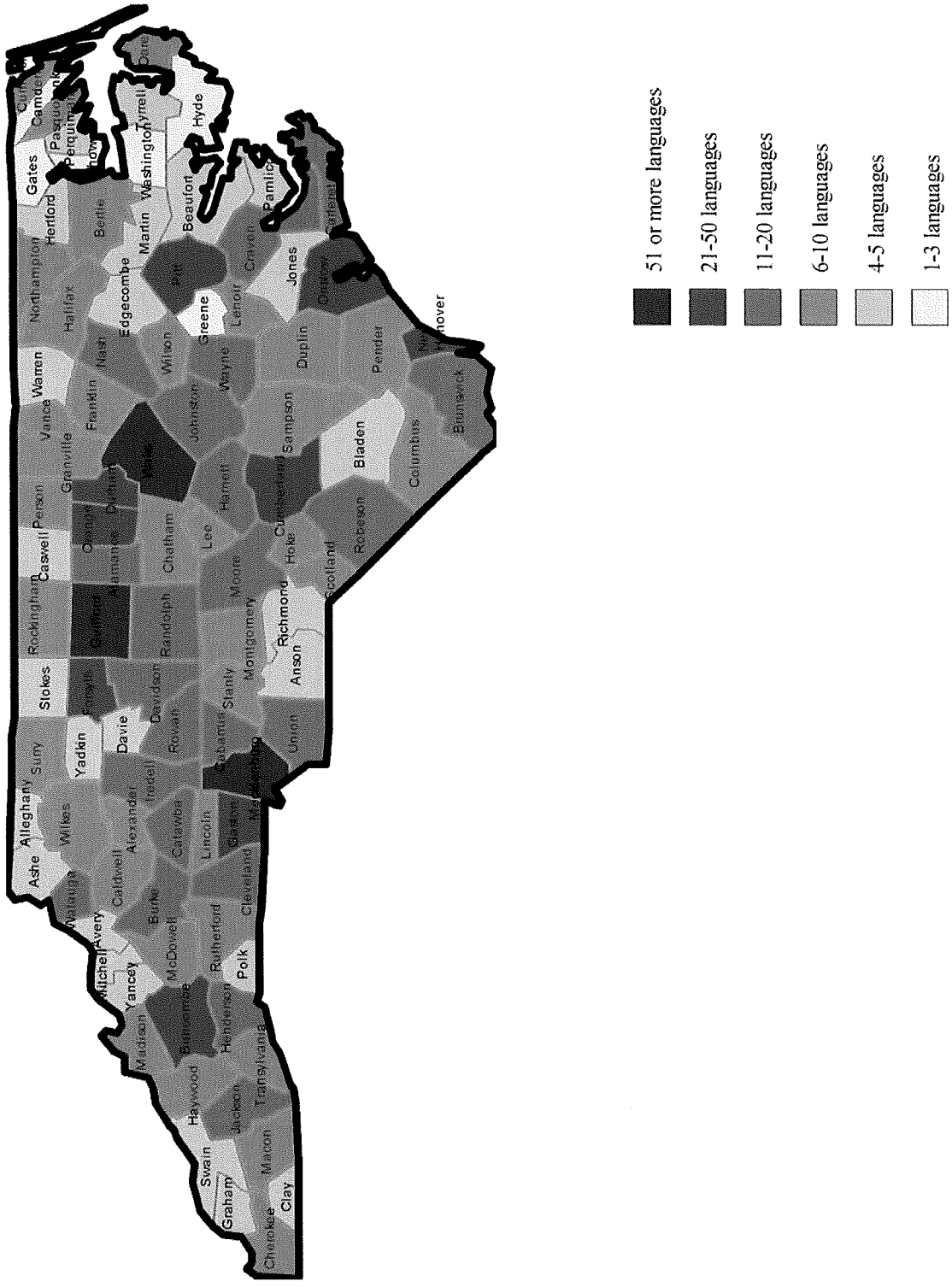
Languages in North Carolina

- Wake County's 70 languages tied for the 68th highest number recorded in any county in the United States. Other North Carolina counties that were highly ranked included: Mecklenburg County (t-77), Guilford County (t-116), Cumberland County (t-164), and Durham County (t-181)
- North Carolina has the second highest percentage of speakers of Cherokee in the United States. The Tar Heel State also ranks fifth in the percentage of Miao/Hmong speakers and sixth in the percentage of Chadic, Krio and Oto-Manguen speakers.
- Burke County has the seventh highest percentage of Miao/Hmong speakers of any county in the nation.

For information on how the data was derived, see Disclaimer
For data on all languages and counties in North Carolina, see Appendix

NORTH CAROLINA

Number of Languages Spoken By County



Attachment C

Durham County Nursing Care Facility Medicare Percentage
FY 2011

Facility	Total Medicare Days	Total Days of Care	Percent of Total Days of Care that are Medicare
Hillcrest Convalescent Center (NH0038)	10,693	31,407	34%
Kindred Transitional Care & Rehab (NH0119)	5,847	30,204	19%
Grace Healthcare of Durham (NH0136)	3,302	38,644	9%
UniHealth Post-Acute Care of Durham(NH0412)	9,674	29,787	32%
Brian Center Health and Rehab (NH0514)	17,465	42,808	41%
The Forest at Duke (NH0536)	962	20,505	5%
Carver Living Center (NH0543)	7,976	66,369	12%
Peak Resources-Treyburn (NH0562)	8,191	40,976	20%
Croasdaile Village (NH0587)	4,908	36,417	13%
The Cedars of Chapel Hill (NH0615)	833	14,054	6%
Kindred Transitional Care & Rehab-Rose Manor (NH0152)	7,729	37,937	20%
UniHealth Post-Acute Care-Carolina Point (NH0093)	6,106	28,103	22%
Total	**83,686**	**417,211**	**20%**

Source:

2012 Nursing Home Licensure Renewal Applications

Attachment D

Medicare Reimbursement Calculation
Full Episodes without Outliers
Hillcrest Home Health (J-8813-12)

Notes		2012	2013	2014	2015
a	Base Rate	$ 2,138.52	$ 2,095.75	$ 2,053.83	$ 2,012.76
b	Base Rate Reduction		2.00%	2.00%	2.00%
c	Case Mix (HHRG Weight)	1.36	1.36	1.36	1.36
d	Calculated case-mix adjusted prospective payment rate	$ 2,908.39	$ 2,850.22	$ 2,793.22	$ 2,737.35
e	Labor Portion of Prospective Payment Rate	$ 2,241.84	$ 2,197.01	$ 2,153.07	$ 2,110.00
f	Wage Index Factor	0.9648	0.9648	0.9648	0.9648
g	Wage Adjusted Labor Portion of Prospective Payment Rate	$ 2,162.93	$ 2,119.67	$ 2,077.28	$ 2,035.73
h	Non-Labor Portion of Prospective Payment Rate	$ 666.54	$ 653.21	$ 640.15	$ 627.35
i	Total adjusted Prospective Payment Rate	$ 2,829.47	$ 2,772.88	$ 2,717.43	$ 2,663.08
j	Rate in CON				$ 2,737.35
k	Overpayment per Episode				$ 74.27
l	Projected Full Episodes				374
m	Total Overpayment				$ 27,777.79

Notes:

a) Hillcrest Application Page 142
b) Hillcrest Application Page 142
c) Hillcrest Application Page 142
d) a*c
e) d*77.082%
f) Palmetto GBA
g) e*f
h) d*22.918%
i) g+h
j) Hillcrest Application Page 142
k) j-i
l) Hillcrest Application Page 142
m) k*l

Attachment E

Section 13

Psychiatric Evaluation, Therapy, and Teaching.--The evaluation, psychotherapy, and teaching activities needed by a patient suffering from a diagnosed psychiatric disorder that requires active treatment by a psychiatrically trained nurse and the costs of the psychiatric nurse's services may be covered as a skilled nursing service. Psychiatrically trained nurses are nurses who have special training and/or experience beyond the standard curriculum required for a registered nurse. The services of the psychiatric nurse are to be provided under a plan of care established and reviewed by a physician.

Because the law precludes agencies that primarily provide care and treatment of mental diseases from participating as HHAs, psychiatric nursing must be furnished by an agency that does not primarily provide care and treatment of mental diseases. If a substantial number of an HHA's patients attend partial hospitalization programs or receive outpatient mental health services, the intermediary may verify whether the patients meet the eligibility requirements specified in §204 and whether the HHA is primarily engaged in care and treatment of mental diseases.

Services of a psychiatric nurse would not be considered reasonable and necessary to assess or monitor use of psychoactive drugs that are being used for nonpsychiatric diagnoses or to monitor the condition of a patient with a known psychiatric illness who is on treatment but is considered stable. A person on treatment would be considered stable if their symptoms were absent or minimal or if symptoms were present but were relatively stable and did not create a significant disruption in the patient's normal living situation.

EXAMPLE 1: A patient is homebound for medical conditions, but has a psychiatric condition for which he has been receiving medication. The patient's psychiatric condition has not required a change in medication or hospitalization for over 2 years. During a visit by the nurse, the patient's spouse indicates that the patient is awake and pacing most of the night and has begun ruminating about perceived failures in life. The nurse observes that the patient does not exhibit an appropriate level of hygiene and is dressed inappropriately for the season. The nurse comments to the patient about her observations and tries to solicit information about the patient's general medical condition and mental status. The nurse advises the physician about the patient's general medical condition and the new symptoms and changes in the patient's behavior. The physician orders the nurse to check blood levels of medication used to treat the patient's medical and psychiatric conditions. The physician then orders the psychiatric nursing service to evaluate the patient's mental health and communicate with the physician about whether additional intervention to deal with the patient's symptoms and behaviors is warranted.

EXAMPLE 2: A patient is homebound after discharge following hip replacement surgery and is receiving skilled therapy services for range of motion exercise and gait training. In the past, the patient had been diagnosed with clinical depression and was successfully stabilized on medication. There has been no change in her symptoms. The fact that the patient is taking an antidepressant does not indicate a need for psychiatric nursing services.

EXAMPLE 3: A patient was discharged after 2 weeks in a psychiatric hospital with a new diagnosis of major depression. The patient remains withdrawn, in bed most of the day, refusing to leave home. The patient has a depressed affect and continues to have thoughts of suicide, but is not considered to be suicidal. Psychiatric nursing is necessary for supportive interventions until antidepressant blood levels are reached and the suicidal thoughts are diminished further, to monitor suicide ideation, ensure medication compliance and patient safety, perform suicidal assessment, and teach crisis management and symptom management to family members.

Attachment F

HealthKeeperz, Inc.
FFY 2011 Payor Mix Comparison as a Percent of Clients

	HC0403		HC1185		HC0359		Total	
Payor	**Clients**	**Percentage**	**Clients**	**Percentage**	**Clients**	**Percentage**	**Clients**	**Percentage**
Medicare*	709	50%	621	46%	573	48%	1,903	48%
Medicaid	633	45%	624	46%	472	39%	1,729	44%
Commercial	65	5%	95	7%	132	11%	292	7%
Indigent	10	1%	12	1%	-	0%	22	1%
Other	-	0%	-	0%	26	2%	26	1%
Total	1,417	100%	1,352	100%	1,203	100%	3,972	100%

*Includes Medicare HMO

Source: 2012 Home Health Licensure Renewal Applications

Attachment G

Medicare Home Health Base Rate Comparison

2010	2011	2012	CAGR
$ 2,312.94	$ 2,192.07	$ 2,138.52	-3.8%

Source:

www.federalregister.gov

LeadingAge

Expanding the World of Possibilities for Aging

CMS Home Health Final Rule for 2012 Cuts Medicare Payments By 3.56%

by Peter Notarstefano Published On: Nov 01, 2011Updated On: Dec 12, 2011

CMS

The Centers for Medicare and Medicaid Services (CMS) issued a final rule to update the Home Health Prospective Payment System (HH PPS) rates for Calendar Year (CY) 2012. Payments to home health agencies are estimated to decrease by approximately 2.31 percent or $430 million in CY 2012, the net effect of a 1.4 percent payment update, the wage index update, and the case-mix coding adjustment.

CMS also reduced HH PPS rates in CY 2012 to account for additional growth in aggregate case-mix that is unrelated to changes in patients' health status. CMS has finalized a 3.79% reduction to the home health PPS rates for CY 2012 and an additional 1.32% reduction for CY 2013.

This rule also finalizes structural changes to the HH PPS by removing 2 hypertension codes from the case-mix system, lowering payments for high therapy episodes, and recalibrating the HH PPS case-mix weights to ensure that these changes result in the same amount of total aggregate payments.

More Home Health Prospective Payment System Resources

- LeadingAge Comment Letter to Home Health Prospective Payment System Proposed Rule for 2012.
- 2012 home health proposed rule.
- Summary of the proposed rule.
- LeadingAge Home Health Rate Calculation Tool - Final Rule 2012.

Categories: home health , Medicare (home health) , Regulations (HCBS)

Comments

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