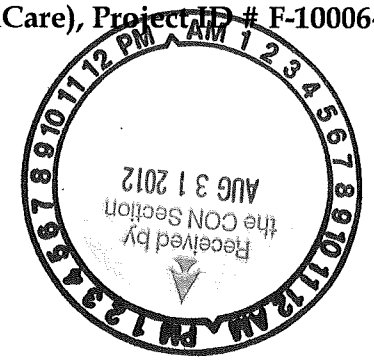
Competitive Comments on Mecklenburg County Home Health Agency Applications

submitted by

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

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

- **Continuum Home Care of Charlotte (Continuum), Project ID# F-10010-12**
- **Emerald Care (Emerald Care), Project ID # F-10008-12**
- **HealthKeeperz of Mecklenburg (HealthKeeperz), Project ID# F-10005-12**
- **Healthy @ Home – Carolinas Medical Center (Healthy @ Home), Project ID # F-10004-12**
- **J and D Health Care Services (J and D), Project ID # F-10012-12**
- **Maxim Healthcare Services (Maxim), Project ID # F-10003-12**
- **UniHealth Home Health (UniHealth), Project ID # F-10011-12**
- **Vizion One, Inc. (Vizion One), Project ID # F-10001-12**
- **Well Care Home Health of Mecklenburg (Well Care), # F-10007-12**
- **AssistedCare of the Carolinas (AssistedCare), Project ID # F-10006-12**



Continuum

(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.*

Continuum provides utilization projections that are overstated and based on unreasonable and unsubstantiated assumptions. First, according to its methodology and projections in Section IV, Continuum projects to provide 1,276 visits to 74 unduplicated patients in its first year of operation followed by 8,556 visits to 492 unduplicated patients in the second year. This represents a 570 percent increase in visits and 565 percent increase in patients over the course of one year. More importantly, Continuum's projected volume of unduplicated patients in the second year of operation is 51 percent higher than the deficit of 325 (per additional agency) identified in the *SMFP* for 2013, and Continuum fails to demonstrate that the growth in Mecklenburg County residents in need of home health care services will actually grow by that magnitude, particularly when the *SMFP* need methodology projects only an eight percent compound annual growth rate in Mecklenburg County home health patients served between 2010 and 2013. Further, nowhere in its application does Continuum provide any assumptions or methodology for its projected visits per patient by discipline.

As such, Continuum's application is not conforming with Criterion 3.

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

The need determination in the *2012 State Medical Facilities Plan* indicates a need for two additional Medicare-certified home health agencies in Mecklenburg County to serve a total of 651 patients **by 2013**, or approximately 325 unduplicated patients per additional agency.

Continuum proposes to serve 74 patients in Year 1 although the need identified in the *2012 SMFP* is for two new home health agencies to each serve approximately 325 patients, on average, in 2013. Therefore, Continuum does not represent the most effective alternative for meeting the need identified.

Continuum projects that its new agency will require twelve months for start-up (the second longest length of time for startup of all ten agencies) even though Continuum proposes to occupy existing space in the same building as its existing home care agency office. The applicant provides no information or capital costs for construction; therefore, it is assumed that no construction is required for the space. Despite the fact that Continuum's start-up period is the second longest of all applicants, its proposed start-up costs are the fifth lowest of all the applicants. See tables below.

Applicant	*Startup Interval*	*Startup Costs*
UniHealth	19 months	$711,000
Continuum	12 months	$290,391
HealthKeeperz	9 months	$153,592
Vizion	8 months	$461,303
Well Care	6 months	$550,000
AssistedCare	6 months	$407,187
Maxim	6 months	$225,000
Emerald Care	3 months	$166,921
J & D	1 month	$50,000
Healthy @ Home	0 months (for initial loss)	$600,000

Applicant	*Startup Costs*	*Startup Interval*
UniHealth	$711,000	19 months
Healthy @ Home	$600,000	0 months (for initial loss)
Well Care	$550,000	6 months
Vizion	$461,303	8 months
AssistedCare	$407,187	6 months
Continuum	$290,391	12 months
Maxim	$225,000	6 months
Emerald Care	$166,921	3 months
HealthKeeperz	$153,592	9 months
J & D	$50,000	1 month

It is questionable whether Continuum has proposed the most effective alternative possible. For these reasons, Continuum's application is not conforming with Criterion 4.

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

As discussed under Criterion 3, Continuum's utilization projections are unreasonable and unsubstantiated, therefore calling into question the reasonableness of its financial projections, which are directly related to projected utilization. Further, Continuum's projected contractual deductions in both Year 1 and Year 2 are questionable. Continuum shows a negative contractual adjustment for Medicare in both years, which results in the addition, rather than deduction, of $61,350 and $372,351 in Medicare revenue in Years 1 and 2, respectively. The negative contractual allowances are due to Continuum's calculation of Medicare reimbursement using a full episode payment rate of $3,240 which is the highest among all applicants and a LUPA episode payment rate of $338.75 which is the second highest of all applicants (see pages 116, 117, and 111). This can also be seen in Continuum's net patient revenue per visit which is the highest among applicants in both Year 1 and Year 2 at $162 and $188 respectively.

As discussed under Criterion 7, it is also questionable whether or not Continuum has projected appropriate and sufficient staff to provide the services it proposes in its application. As such, Continuum's projected expenses related to staffing and staff training are potentially understated.

Bad debt in Year 1 is projected exceptionally high at 19 percent of gross charges, based on an assumed delay in payments from Medicare and Medicaid during the start-up period. Continuum should accrue for and report the revenue in their financial statements until it is received. This is a misstatement of projected financial performance and makes Continuum's financial projections unreliable.

Finally, as discussed under Criterion 4, Continuum proposes the second longest start-up period, but the fifth lowest start-up costs among the ten applicants. Therefore, it is questionable whether Continuum can develop its agency over twelve months with the amount of start-up costs proposed.

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

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

Continuum proposes to provide psychiatric nursing but does not include a psychiatric nurse in its proposed staffing, nor does it appear to include costs specifically for a psychiatric nurse in its proforma financials. Neither does the applicant indicate that all nursing staff will be trained to identify and care for psychiatric/Alzheimer's/dementia patients as does AssistedCare. As such, Continuum has failed to demonstrate the availability of the necessary resources and manpower to provide the services it proposes and is not conforming with Criterion 7.

Emerald Care

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

Emerald Care has an existing home health agency in Gastonia, NC and, by its own admission, is already serving 201 patients in Mecklenburg County with that agency. Furthermore, all of Mecklenburg County is within a 60 mile radius of Emerald Care's home health agency which means that Emerald Care can now and is now serving patients it projects to serve with the proposed project. For these reasons, Emerald Care would not provide Mecklenburg County with a ***new home health agency***, as is specified by the *SMFP*, but would simply provide an additional branch for an existing home health agency that is already serving patients in Mecklenburg County. As Emerald Care states on page 14 of its application, "Patients residing in Mecklenburg County and who are already served out of the Gastonia office in neighboring Gaston County will be served by the proposed project. Some capacity in the Gastonia office will be freed for service to patients who reside more closely to it. No negative impact to the Gastonia office will occur. The Gastonia parent office served 3,053 patients in 2010 (*2012 SMFP* Table 12a). Of those 201 lived in Mecklenburg County. These estimated 201 patients will be transferred for care to the proposed branch office, and the staff that serves them will be based out of the new branch." [Emphasis added] Therefore, by Emerald Care's own admission, of the 330 patients it proposes to serve in Year 1, 201 are already being served and will simply be transferred to the new branch office. Therefore, in reality, Emerald Care will only serve 129 new Mecklenburg County patients in Year 1. Thus,

Emerald Care does not propose to meet the need for a new home health agency to serve 325 new patients (half the *2012 SMFP* identified need of 651) and is not conforming with Criterion 1.

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

First, as discussed under Criterion 1, Emerald Care essentially proposes to shift its own existing patients from its Gaston County agency office to the proposed branch office in Mecklenburg County. Therefore, Emerald Care has not demonstrated how it will meet the needs of the 325 additional home health patients (per new home health agency) identified in the 2012 *SMFP* for 2013.

Emerald Care provides utilization projections that are overstated and based on unreasonable and unsubstantiated assumptions. First, according to its methodology and projections in Section IV, Emerald Care projects to provide 7,570 visits to 329 unduplicated patients in its first year of operation followed by 12,570 visits to 475 unduplicated patients in the second year. This represents a 66 percent increase in visits and 44 percent increase in patients over the course of one year. More importantly, Emerald Care's projected volume of unduplicated patients in the second year of operation is 46 percent higher than the deficit of 325 (per additional agency) identified in the *SMFP* for 2013, and Emerald Care fails to demonstrate that the growth in Mecklenburg County residents in need of home health care services will actually grow by that magnitude, particularly when the *SMFP* need methodology projects only an eight percent compound annual growth rate in Mecklenburg County home health patients served between 2010 and 2013.

Additionally, based on its unduplicated patients and visits in Section IV of its application, Emerald Care projects 23 and 26.5 visits per unduplicated patient in Years 1 and 2, respectively, which is significantly higher than the actual average experience of existing Mecklenburg County home health providers in 2011 of 17.5 visits per unduplicated patient.

For these reasons, Emerald Care's application is not conforming with Criterion 3.

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

As discussed under Criterion 1, Emerald Care would not provide Mecklenburg County with a ***new home health agency***, as is specified by the *SMFP*, but would simply provide an additional branch for an existing home health agency that is already serving patients in Mecklenburg County. As such, Emerald Care has not proposed the most effective alternative for meeting the need for a new home health agency to serve 325 new patients (half the *2012 SMFP* identified need of 651) and is not conforming with Criterion 4.

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

As discussed under Criterion 3, Emerald Care's utilization projections are unreasonable and unsubstantiated, therefore calling into question the reasonableness of its financial projections, which are directly related to projected utilization. Further, Emerald Care's payor mix by patient, as stated in its application, totals only 97 percent, and therefore is misrepresented and inaccurate. In addition, Emerald Care assumes a short initial operating period of only three months and a lag on Medicare payments of only two months, both of which reduce the working capital requirements, calling into question whether or not Emerald Care has understated the actual working capital needs of the project.
For these reasons, Emerald Care is not conforming with 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.*

As discussed under Criterion 1, Emerald Care proposes to serve patients it already serves, which is a duplication of existing services. As such, Emerald Care is not conforming with Criterion 6.

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

As discussed under Criterion 1, Emerald Care would not provide Mecklenburg County with a ***new home health agency***, as is specified by the *SMFP*, but would simply provide an additional branch for an existing home health agency that is already serving patients in Mecklenburg County. By Emerald Care's own admission, of the 330 patients it proposes to serve in Year 1, 201 are already being served by its existing agency and will simply be transferred to the new branch office. As such, it is unclear how Emerald Care's proposal will improve access or support competition in the market and therefore, it is not conforming with Criterion 18(a).

HealthKeeperz

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

HealthKeeperz' projected payor mix includes no provision for charity care. This lack of access to the underserved is inconsistent with Policy Gen-3, and as such, the HealthKeeperz application is not conforming with Criterion 1.

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

HealthKeeperz provides utilization projections that are overstated and based on unreasonable and unsubstantiated assumptions. First, according to its methodology and projections in Section IV, HealthKeeperz projects to provide 6,115 visits to 282 unduplicated patients in its first year of operation followed by 8,578 visits to 415 unduplicated patients in the second year. This represents a 40 percent increase in visits and 47 percent increase in patients over the course of one year. More importantly,

HealthKeeperz' projected volume of unduplicated patients in the second year of operation is 28 percent higher than the deficit of 325 (per additional agency) identified in the *SMFP* for 2013, and HealthKeeperz fails to demonstrate that the growth in Mecklenburg County residents in need of home health care services will actually grow by that magnitude, particularly when the *SMFP* need methodology projects only an eight percent compound annual growth rate in Mecklenburg County home health patients served between 2010 and 2013.

Additionally, HealthKeeperz provides overstated visit projections based on an assumed visits per patient statistic that is higher than the actual experience of Mecklenburg County providers. On pages 61 and 62 of its application, HealthKeeperz states that it projects its visits per patient by discipline based on a blend of the actual Mecklenburg County average and the experience of its existing agencies in Robeson, Scotland, and Cumberland Counties, as shown in the following table excerpted from the HealthKeeperz application.

Existing Agencies
Average Patient Visits by Discipline
October 1, 2010 – September 30, 2011

Discipline	Mecklenburg Agencies	HealthKeeperz, Inc. Agencies	Average Mecklenburg and HealthKeeperz, Inc. Agencies
Nursing	8.8	12.6	10.7
PT	7.5	11.3	9.4
ST	7.2	7.5	7.3
OT	4.4	7.5	6.0
MSW	1.2	1.1	1.2
HHA	10.6	16.1	13.4

Source: Exhibit 8, Table 14

As stated on page 63 of the HealthKeeperz application, this results in 21.7 visits per unduplicated patient overall, which is higher than the actual average experience of all Mecklenburg County providers, 17.5 visits per unduplicated patient.

HealthKeeperz also chose to base its projected payor mix on a blend of actual Mecklenburg County experience and the experience of its Robeson, Scotland, and Cumberland County agencies rather than using just the actual experience of Mecklenburg County providers. This results in a proposed payor mix that is significantly different than actual Mecklenburg County

experience as shown below. Of particular note is that HealthKeeperz does not include Indigent in its proposed payor mix at all.

Payor	*HealthKeeperz Year 2 (Patients)*	*Mecklenburg County 2011 (Patients)*
Medicare	69.7%	58.2%
Medicaid	14.8%	10.8%
Commercial	8.6%	25.3%
VA	1.3%	--
Tricare	1.3%	--
Indigent	--	1.4%
Others (not specified)	4.3%	4.2%

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

County	*Median Household Income*	*% Below Poverty Level*
Mecklenburg	$55,294	12.5%
Robeson	$29,667	30.2%
Scotland	$29,368	29.5%
Cumberland	$46,834	16.6%

Source: www.census.gov

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

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

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

HealthKeeperz' payor mix projections show zero charity care for both visits and duplicated patients. Thus, HealthKeeperz fails to demonstrate that it will provide access to an underserved segment of the population.

The deductions from gross revenue on HealthKeeperz' Form B are also suspect. On a comparative basis, HealthKeeperz projects a combined charity care and bad debt percentage in its proformas that is lower than all other applicants (1.18 percent), making it questionable whether or not it actually accounted for a reasonable and sufficient amount of charity care and bad debt and as a result whether or not its net revenue projections are overstated. Total deductions from revenue are understated and only 7.5 percent of gross revenue, confirming that net revenue projections are inflated.

HealthKeeperz assumes a nine month initial operating period but only a one month lag in Medicare payments which is overly aggressive. HealthKeeperz' working capital requirements are the second lowest of all applicants. Such limited working capital for a nine month start-up appears to be understated.

HealthKeeperz' cost per visit from Table X.1 for speech therapy, occupational therapy, and social work are the lowest among all applicants, calling into question whether or not HealthKeeperz has projected sufficient resources to provide the services it proposes.

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

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

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

As discussed under Criteria 1 and 3, HealthKeeperz does not identify any allocation for indigent patients in its payor mix projections and as such is not conforming with Criterion 13(c).

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

As discussed under Criteria 1 and 3, HealthKeeperz does not identify any allocation for indigent patients in its payor mix projections. As such, HealthKeeperz has not demonstrated that it will have a positive impact on access to home health services for the underserved in the service area, and as such is not conforming with Criterion 18(a).

Healthy @ Home

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

Healthy @ Home is an existing Mecklenburg County home health agency that proposes to serve patients it already serves (see page 121 of the application). Healthy @ Home does not propose to serve "new" patients with its branch office until 2014 (see page 69 of the application). Furthermore, by its own admission, creating a branch office will not

provide any service or innovation that is not already available through Healthy @ Home's existing agency (see page 34) or that could be met through the creation of way-stations at a lower cost. Thus, Healthy @ Home does not propose to meet the need for a new home health agency to serve 325 new patients (half the *2012 SMFP* identified need of 651) and is not conforming with Criterion 1.

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

Healthy @ Home appears to provide extremely overstated utilization projections. According to its methodology and projections in Section IV, Healthy @ Home projects to provide 45,820 visits to 2,870 unduplicated patients in its first year of operation - from its new North Office proposed in its application alone. This volume of unduplicated patients is 821 percent higher than the deficit of 325 (per additional agency) identified in the *SMFP* for 2013, and Healthy @ Home fails to demonstrate how the growth in Mecklenburg County residents in need of home health care services can possibly be expected to grow by that magnitude, particularly when the *SMFP* need methodology projects only an eight percent compound annual growth rate in Mecklenburg County home health patients served between 2010 and 2013.

As such, Healthy @ Home's application is not conforming with Criterion 3.

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

As discussed under Criterion 1, Healthy @ Home would not provide Mecklenburg County with a ***new home health agency***, as is specified by the *SMFP*, but would simply provide an additional branch for an existing home health agency that is already serving patients in Mecklenburg County. Furthermore, by its own admission, creating a branch office will not provide any service or innovation that is not already available through Healthy @ Home's existing agency (see page 34) or that could be met through the creation of way-stations at a lower cost. As such, Healthy @ Home has not proposed the most effective alternative for meeting the need for a new home health agency to serve 325 new patients (half the *2012 SMFP* identified need of 651) and is not conforming with Criterion 4.

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

As discussed under Criterion 3, Healthy @ Home appears to provide extremely overstated utilization projections, thereby calling into question the reasonableness of its financial projections, which are directly related to projected utilization. Therefore, Healthy @ Home is not conforming with 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.*

As discussed under Criterion 1, Healthy @ Home proposes to serve patients it already serves, which is a duplication of existing services. As such, Healthy @ Home is not conforming with Criterion 6.

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

As discussed under Criterion 1, Healthy @ Home would not provide Mecklenburg County with a ***new home health agency***, as is specified by the *SMFP*, but would simply provide an additional branch for an existing home health agency that is already serving patients in Mecklenburg County. Healthy @ Home is an existing Mecklenburg County home health agency that proposes to serve patients it already serves (see page 121 of the application). Healthy @ Home does not propose to serve "new" patients with its branch office until 2014 (see page 69 of the application). As such, it is unclear how Healthy @ Home's proposal will improve access or support competition in the market and therefore, it is not conforming with Criterion 18(a).

J and D

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

As discussed under Criterion 3, J and D projects no service whatsoever to Medicaid patients and therefore has not demonstrated access to its proposed services by the underserved. As such, J and D is not conforming with Policy Gen-3 in the *State Medical Facilities Plan* and therefore is not conforming with Criterion 1.

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

First, nowhere in its application does J and D provide any assumptions or methodology for its volume projections. Nor does J and D specify its projected patient origin other than to state that it will serve residents of Mecklenburg, Gaston, Cabarrus, Lincoln, and Union Counties. It also states on page 17 of its application that "Most of the Patient are projected to come from Mecklenburg County." In the response to Section IV.1, J and D indicates in Table IV.1 that it would serve 50 unduplicated patients in Year 1 and 92 unduplicated patients in Year 2. However, the need identified in the *2012 SMFP* is for 325 patients to be served each by two additional home health agencies in Year 1 (half the total need of 651); J and D projects to meet only 15 percent of that need in Year 1. Also, absent any actual patient origin projections, one can deduce that if the proposed agency will serve only a total of 50 patients in Year 1, the number of patients served in Mecklenburg County (the location of the identified need) will be even less than 50.

Moreover, J and D indicates in Table IV.1 that occupational therapists will admit patients to the home health agency. However, regulations from CMS indicate that only nurses, physical therapists and speech therapists may admit to home health, further calling into question the validity of J and D's volume projections.

Additionally, J and D projects no service at all to Medicaid patients and therefore does not demonstrate how its proposed home health agency will be accessible to the underserved.

For these reasons, J and D is not conforming with Criterion 3.

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

As discussed under Criteria 1 and 3, J and D does not demonstrate its ability to meet the need identified to serve additional home health patients in Mecklenburg County or to provide access to the underserved, and therefore has not proposed an effective alternative and is not conforming with Criterion 4.

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

As discussed under Criterion 3, J and D's utilization projections and payor mix projections are unreasonable and unsubstantiated, therefore calling into question the reasonableness of its financial projections, which are directly related to projected utilization and payor mix.

Further, there are several errors and omissions in J and D's proforma income statement (Form B). J and D's projected contractual deductions in both Year 1 and Year 2 are non-existent. J and D does not include deductions to gross revenue for bad debt, charity care, or contractual allowances. As such, its net patient revenue is equal to gross revenue and therefore overstated in both years. This is clearly demonstrated by both the net patient revenue per visit and net patient revenue per unduplicated patient which are ten times higher than that projected by the other applicants. Moreover, as discussed under Criterion 7, J and D has not provided sufficient information regarding projected staffing and does not appear to account for any increase in staffing needs from Year 1 to Year 2. As such, it appears that J and D has understated its staffing expenses in Year 2. Perhaps the most notable omission is that J and D's projected Form B for Years 1 and 2 ends after the Occupational Therapy subtotal meaning that its Form B completely omits any expenses for Speech Therapy, Medical Social Work, or Administrative expense. As a result, J and D's

total expenses and net income are impossible to determine making J and D's financial projections completely unreliable and unusable.

J and D estimates a total of $6,000 in capital costs and $50,000 in working capital needs for the proposed project, the entirety of which will be funded with accumulated reserves. In both Sections VIII and IX, J and D indicates that a letter documenting funding availability is enclosed, but no such letter appears to be included with the application. As such, J and D has not demonstrated its ability to fund the project as proposed.

Finally, J and D does not propose to license the agency but proposes to have it Medicare certified by December 21, 2012. However, CMS will not certify an agency that is not licensed. Furthermore, due to the competitive nature of this review, it is not likely that the Agency will expedite the review. As such, the review period will extend for 150 days, which will be December 29, 2012 and the Certificate of Need (which gives the applicant permission to proceed) would not be awarded to the applicant until January 29, 2013. Therefore, J and D projects to certify the agency prior to CON approval and prior to its receipt of the Certificate, calling into question J and D's understanding of, and ability to develop and operate a Medicare-certified home health agency.

For these reasons, J and D is not conforming with Criterion 5.

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

In response to Section VII.1 and VII.2, J and D provides only one projected staffing table, but does not indicate for which year the FTEs are projected. As such, it appears that J and D has provided projected staffing for Year 1 and has not accounted for any increase in staff required by Year 2 despite the fact that its projected number of unduplicated patients nearly doubles from Year 1 to Year 2. Therefore, J and D has not demonstrated the availability of adequate manpower for the provision of services proposed and is not conforming with Criterion 7.

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

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

As discussed under Criterion 3, J and D projects no service at all to Medicaid patients and as such has not demonstrated access to the underserved, rendering its application not conforming with Criterion 13(c).

Maxim

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

Maxim provides utilization projections that are overstated and based on unreasonable and unsubstantiated assumptions. First, according to its methodology and projections in Section IV, Maxim projects to provide 7,363 visits to 426 unduplicated patients in its first year of operation followed by 9,499 visits to 503 unduplicated patients in the second year. This represents a 29 percent increase in visits and 18 percent increase in patients over the course of one year. More importantly, Maxim's projected volume of unduplicated patients in the second year of operation is 55 percent higher than the deficit of 325 (per additional agency) identified in the *SMFP* for 2013, and Maxim fails to demonstrate that the growth in Mecklenburg County residents in need of home health care services will actually grow by that magnitude, particularly when the *SMFP* need methodology projects only an eight percent compound annual growth rate in Mecklenburg County home health patients served between 2010 and 2013.

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

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

First, there are significant questions as to the quality of leadership of Maxim Healthcare Services and the ability of the company to qualify as a bona fide home health provider in this review as documented in a Department of Justice press release on September 12, 2011. The DOJ stated in part, "Maxim Healthcare Services Inc., one of the nation's leading providers of home healthcare services, has entered into a settlement to resolve criminal and civil charges relating to a nationwide scheme to defraud Medicaid programs and the Veterans Affairs program of more than $61 million...As part of the DPA [deferred prosecution agreement], Maxim has stipulated to a statement of facts which mirrors the language of the criminal complaint. In the event that Maxim fails to comply with the provisions of the DPA, Maxim has agreed that the U.S. Attorney's Office may proceed with its prosecution of Maxim and use the agreed-upon statement of facts against it in the prosecution." Because of the unknown outcome of these events that are still in process, it appears that Maxim's ability to develop a new home health agency as proposed in its application is questionable. For a copy of the entire DOJ press release, see Attachment 1.

Further, as discussed under Criterion 3, Maxim's utilization projections are unreasonable and unsubstantiated, therefore calling into question the reasonableness of its financial projections, which are directly related to projected utilization.

Additionally, Maxim's projected expenses are understated in that the Medical Records salary is not included at approximately $7,500 in both Year 1 and Year 2 thereby overstating the projected net income from the proposed operations. Maxim's gross revenue and net patient revenue appear to be overstated in Year 2 as evidenced by an 82.8 percent increase in gross revenue per visit in Year 2 over Year 1 and an 86.2 percent increase in net revenue per visit in Year 2 over Year 1. This apparent overstatement of both gross and net revenue in Year 2 results in a net margin percentage ((Net Patient Revenue - Total Costs)/Net Patient Revenue) per visit in Year 2 of 23.1 percent which is overstated and significantly higher than all other applicants.

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

(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.*

As discussed under Criterion 5, in Section VII, Maxim projects 0.25 FTE for a Medical Records position. However, no salary expenses are included for this position in Maxim's proforma financial statements, calling into question whether or not Maxim has actually demonstrated the availability of this support service. As such, Maxim's application is not conforming with Criterion 8.

UniHealth

(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.*

UniHealth provides utilization projections that are overstated and based on unreasonable and unsubstantiated assumptions. First, according to its methodology and projections in Section IV, UniHealth projects to provide 3,730 visits to 204 unduplicated patients in its first year of operation followed by 11,527 visits to 548 unduplicated patients in the second year. This represents a 209 percent increase in visits and 169 percent increase in patients over the course of one year. More importantly, UniHealth's projected volume of unduplicated patients in the second year of operation is 69 percent higher than the deficit of 325 (per additional agency) identified in the *SMFP* for 2013, and UniHealth fails to demonstrate that the growth in Mecklenburg County residents in need of home health care services will actually grow by that magnitude, particularly when the *SMFP* need methodology projects only an eight percent compound annual growth rate in Mecklenburg County home health patients served between 2010 and 2013.

Additionally, based on its unduplicated patients and visits in Section IV of its application, UniHealth projects 18.3 and 21 visits per unduplicated patient in Years 1 and 2, respectively, which is higher than the actual average experience of existing Mecklenburg County home health providers in 2011 of 17.5 visits per unduplicated patient.

Therefore, UniHealth's utilization projections are unreliable and its application is not conforming with Criterion 3.

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

In Section IX, UniHealth proposes a start-up period of 19 months at an initial operating cost of $711,168, the highest initial operating costs of all the applicants. UniHealth has identified several possible sites for its agency office; however, UniHealth has not included any capital costs for upfit of the space, so it is assumed that the spaces are immediately available for occupancy. Therefore, it is unclear why UniHealth believes it will require a year and a half to develop the agency at an initial operating cost that is more than $100,000 higher than the next highest applicant.

In its response to Section VI.9, UniHealth acknowledges that its home health agencies have had 29 civil rights equal access complaints filed in the past five years. While there may be legitimate explanations as to why some of the complaints have no merit, it is highly unlikely that all 29 are without merit. As such, these events call into question the care provided by UniHealth and clearly set UniHealth apart as a less effective alternative choice for a new Medicare-certified home health agency operator compared with other applicants that have had no civil rights equal access complaints filed in the past five years

For these reasons, UniHealth's proposed project is not the least costly or best alternative and is not conforming with Criterion 4.

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

As discussed under Criterion 3, UniHealth's utilization projections are unreasonable and unsubstantiated, therefore calling into question the reasonableness of its financial projections, which are directly related to projected utilization.

UniHealth indicates no self-pay and other in its payor mix projections, but at the same time projects bad debt of 1.3 percent of gross revenue in Year 2, calling into question the validity of its payor mix projections.

UniHealth's Medicare reimbursement is calculated using a Medicare reimbursement per episode rate of $3,073 which is the second highest among all applicants and a LUPA rate of $350 which is the second highest among all applicants, calling into question whether or not UniHealth's Medicare reimbursement is overstated.

For these reasons, UniHealth's application is not conforming with Criterion 5.

Vizion

(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.*

First, nowhere in its application does Vizion provide the assumptions and methodology used to project visits per patient by discipline. Based on its projected unduplicated patients and visits in Section IV of its application, Vizion projects 25 visits per unduplicated patient in Years 1 and 2, which is significantly higher than the actual average experience of existing Mecklenburg County home health providers in 2011 of 17.5 visits per unduplicated patient. As such, Vizion's utilization projections are overstated and based on unreasonable and unsubstantiated assumptions. Therefore, Vizion's application is not conforming with Criterion 3.

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

As discussed under Criterion 3, Vizion's utilization projections are unreasonable and unsubstantiated, therefore calling into question the reasonableness of its financial projections, which are directly related to projected utilization.

Also, as discussed under Criterion 7, Vizion has not demonstrated that it has projected sufficient staff to provide the services it proposes in its application. As such, Vizion's staffing expenses are understated, calling into question the reliability of its proforma financials and the financial feasibility of the project.

Vizion did not provide a lease agreement (either proposed or executed), although it was requested in XI. 1. (a) (f), and Vizion did not provide the terms of the lease as requested. Neither did Vizion respond to XI. 3. (d) which asks for a letter from a realtor documenting that the site is available. While Vizion proposes to locate its agency in the same building as its existing agency, without a lease agreement or a letter from a realtor, Vizion has not provided documentation that such space is available for the applicant, should its project be approved. Furthermore, while Vizion included an amount of $35,000 for "building rental" in its financials, there is no documentation or other evidence that the amount included is the actual lease amount. These omissions call into question the viability of its financials and its project as a whole. Moreover, in discussions with the CON Section, the Agency has indicated its preference that an applicant provides at least two sites if a draft lease agreement is not included with the application.

Moreover, Vizion did not respond to VIII.1.(c) which asks for the assumptions and methodology used to project capital costs for the project. Furthermore, Vizion did not respond to VIII. 3, 4, 5, 6, 7 or 8. Moreover questions 5, 6, and 8 of Vizion's application are not questions found in the home health application form provided by the CON Section. Therefore, it is unclear 1) whether Vizion's capital costs are accurate, 2) whether it has outstanding Certificate of Need projects that are under review or under development that could impact its ability to fund the proposed project, and 3) whether it can financially develop and support the project as proposed.

Finally, the Mecklenburg home health review began on August 1, 2012. According to North Carolina CON statute, the Agency has 150 days to render its decision, which would be December 29, 2012. Following the decision, the Agency must allow no less than 31 days for appeals to be filed on the decision. If there are no appeals, the Agency awards the Certificate of Need to the approved applicants, all of which at a minimum is 31 days or, for this decision, would be January 29, 2013. Vizion's application indicates that the project will require an eight-month startup period, which would be approximately September 10, 2013 or eight months from the award of the Certificate on January 29, 2013. However, in the project schedule in Section XII, Vizion proposes to have its new agency licensed on December 20, 2012 and certified on December 28, 2012, both prior to the Agency's decision. Therefore, Vizion proposes to develop the project without CON approval. These inconsistencies indicate that Vizion is not knowledgeable about the CON process and calls into question its ability to

successfully develop and operate a Medicare-certified home health agency, thereby calling into question the financial feasibility of the project.

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

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

First, Vizion did not even complete Table VII.2 as required by the CON application form. It did provide total FTEs by discipline on page 79 of its application, but provided no supporting detail. It also did not specify a year associated with these staffing projections. As such, it would appear that the projected staffing on page 79 of the application is Vizion's projected staffing for the first year of operation of its proposed home health agency. Nowhere does Vizion provide staffing for Year 2 of the project, suggesting that its number of FTEs is not projected to increase from Year 1 to Year 2 despite a 54 percent increase in visits from Year 1 to Year 2. Additionally, Section VII.3 of the application states, "In projecting performance standards in number of visits/day, what time considerations have been provided for travel, documentation, supervisory, and administrative duties? Provide all assumptions used to project staffing." Vizion did not respond to this question. Therefore, it is not clear what its staffing assumptions are, what travel time has (or has not) been included and if administrative time has been included. Therefore, it is impossible to determine whether or not Vizion has projected sufficient staff for the project.

However, in order to reasonably assess whether or not Vizion projected sufficient staff, AssistedCare applied its own assumptions regarding visits per FTE per day by discipline to Vizion's projected visits and projected FTEs. The results of this analysis, in the table below, suggest that Vizion did not project sufficient staff to provide the services proposed for any discipline. Specifically, Vizion did not project enough FTEs to perform the projected number of visits for each discipline in Year 2 as outlined in the table below.

Discipline	*Projected Year 2 Visits*	*Visits per FTE per Day*	*FTEs Needed for Projected Visits**	*Projected Year 2 FTEs*	*Difference*
Nursing	3,707	5.0	2.85	1.85	-1.00
Physical Therapy	2,958	5.0	2.28	1.48	-0.80
Speech Therapy	173	5.0	0.13	0.09	-0.04
Occupational Therapy	680	5.0	0.52	0.34	-0.18
Social Work	58	3.5	0.06	0.04	-0.02
CNA/Aide	549	6.0	0.35	0.28	-0.07

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

The deficit in projected FTEs equates to a total of 2,753 visits that Vizion projects, but will not have the ability to provide in Year 2 as shown in the table below.

Discipline	*FTEs Needed, but not Projected x*	*Visits per FTE per Day x*	*Days per Year =*	*Total Visits Unable to Provide*
Nursing	-1.00	5.0	260	1,300
Physical Therapy	-0.80	5.0	260	1,040
Speech Therapy	-0.04	5.0	260	52
Occupational Therapy	-0.18	5.0	260	234
Social Work	-0.02	3.5	260	18
CNA/Aide	-0.07	6.0	260	109
Total	**-2.12**			**2,753**

Given this underestimation of staff required to provide the level of services proposed in Table IV.2 of its application, Vizion is not conforming with Criterion 7.

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

Vizion failed to demonstrate that its proposed home health agency will be coordinated with the existing healthcare system. Vizion's application included 18 statements (not actual letters of support) from various individuals, most without any indication of their geographic location. Two of these statements were made by physicians – one in Maryland and one in

Washington, DC. Nowhere in its application did Vizion include any evidence that it has made any attempts to coordinate with the existing healthcare system in the area. As such, its application is not conforming with Criterion 8.

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

Vizion included no evidence that it made attempts to contact area clinical training programs to offer its agency as a training opportunity for health professionals in the area. Therefore, Vizion is not conforming with Criterion 14.

Well Care

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

Well Care provides utilization projections that are overstated and based on unreasonable and unsubstantiated assumptions. First, according to its methodology and projections in Section IV, Well Care projects to provide 7,205 visits to 378 unduplicated patients in its first year of operation followed by 11,268 visits to 591 unduplicated patients in the second year. This represents a 56 percent increase in both visits and patients over the course of one year. More importantly, Well Care's projected volume of unduplicated patients in the second year of operation is 82 percent higher than the deficit of 325 (per additional agency) identified in the *SMFP* for 2013, and Well Care fails to demonstrate that the growth in Mecklenburg County residents in need of home health care services will actually grow by that magnitude, particularly when the *SMFP* need methodology projects only an eight percent compound annual growth rate in Mecklenburg County home health patients served between 2010 and 2013.

Additionally, based on its unduplicated patients and visits in Section IV of its application, Well Care projects 19.1 visits per unduplicated patient in Years 1 and 2, which is higher than the actual average experience of existing Mecklenburg County home health providers in 2011 of 17.5 visits per unduplicated patient. As such, Well Care's utilization projections are overstated and based on unreasonable and unsubstantiated assumptions.

For these reasons, Well Care's application is not conforming with Criterion 3.

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

Well Care's projection of charity care deductions is a negligible 0.09 percent of gross revenue for both Year 1 and Year 2, which is the lowest of any applicant (with the exception of J and D, which projected no charity care deduction). In addition, Well Care's proposed level of charity care and bad debt combined, at only 1.20 percent of gross revenue in Years 1 and 2, is the second lowest (excluding J and D) of all applicants.

Well Care proposes to fund its new agency through funds in an investment account (see page 96 of Well Care's application). As an indication of its ability to fund the project with the investment funds, Well Care provides a letter from Scott Winslow, Senior Vice President at First Citizens Bank. Mr. Winslow indicates in the letter that Well Care's balance in the account equals $1,265,125.23 and includes "various stocks and bonds as well as cash." Well Care's total project (capital costs and initial operating expenses) equals $660,000. As such, the total amount required to develop the project equals more than half the amount in Well Care's investment account. However, because there is no indication of how much of Well Care's investment account consists of liquid and/or volatile assets, it is unclear exactly how much is actually available in the account for the project and how much is not immediately available because of illiquidity or potentially, loss in value. Therefore, it is questionable whether Well Care has sufficient funds to develop the project as proposed.

For these reasons, Well Care is not conforming with Criterion 5.

GENERAL COMPARATIVE COMMENTS

The AssistedCare, Continuum, Emerald Care, HealthKeeperz, Healthy @ Home, J and D, Maxim, UniHealth, Vizion, and Well Care applications each propose to develop one home health agency in response to the *2012 SMFP* need determination for two additional home health agencies in Mecklenburg County. Pursuant to N.C. GEN. STAT. § 131E-183(a)(1) and the *2012 SMFP*, no more than two new home health agency may be approved for Mecklenburg County in this review. Because each of the ten applicants proposes to develop a new home health agency in Wake County, all of the applications cannot be approved. AssistedCare acknowledges that each review is different and,

therefore, that the comparative review factors employed by the Project Analyst in any given review may be different depending upon the relevant factors at issue. Given the nature of the review, the Analyst must decide which comparative factors are most appropriate in assessing the applications.

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

- Access by Medicaid Recipients
- Visits per Unduplicated Patient
- Average Direct Cost per Visit
- Average Administrative Cost per Visit
- Total Cost per Visit
- Net Revenue per Visit
- Net Revenue per Unduplicated Patient
- Ratio of Net Revenue per Visit to Cost per Visit
- Nursing and Home Health Aide Salaries
- Provision of Specialized Services

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

Projected Access by Medicaid Recipients

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

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

Applicant	*Proposed Medicaid % by Visit-Yr. 2*
AssistedCare	8.2%
Continuum	8.2%
Emerald Care	7.4%
HealthKeeperz	14.9%
Healthy @ Home	16.2%
J and D	0.0%
Maxim	8.7%
UniHealth	9.2%
Vizion	12.9%
Well Care	14.5%
Current Mecklenburg County Average	*8.2%*

AssistedCare projects a percentage of Medicaid visits that is higher than or consistent with four other applicants. While five other applicants project a higher percentage of Medicaid visits, AssistedCare's projected percentage is the only one that is consistent with the actual historical experience of existing home health agencies in Mecklenburg County. Given the actual Mecklenburg County average of 8.2 percent Medicaid visits, it is questionable whether applicants projecting significantly higher than this will actually achieve their projections. Moreover, none of the five applications that projected higher Medicaid percentages than AssistedCare demonstrated why the Medicaid need in Mecklenburg County will be higher than that experienced by existing Mecklenburg County agencies. As previously discussed, Mecklenburg County is one of the most affluent counties in the state. Therefore, AssistedCare represents the most realistic and effective applicant in terms of providing access to home health services to Medicaid recipients.

Visits per Unduplicated Patient

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

Applicant	*Visits per Patient- Yr. 2*
AssistedCare	17.5
Continuum	17.4
Emerald Care	26.5
HealthKeeperz	20.7

Applicant	*Visits per Patient- Yr. 2*
Healthy @ Home	16.0
J and D	16.1*
Maxim	18.9
UniHealth	21.0
Vizion	25.0
Well Care	19.1
Mecklenburg County Average	*17.5*

*Note: J and D projects 19.0 visits per unduplicated patient in Year 1.

Emerald Care proposes the highest number of visits per patient at 26.5 visits, and therefore might appear to be the most effective alternative. However, as discussed previously, each applicant other than J and D overestimated projected visits and failed to demonstrate that their utilization projections are based on reasonable assumptions, and J and D's visit projections are completely unreliable and unsupported by any reasonable assumptions. In addition, none of these applicants' visit projections are consistent with the Mecklenburg County average. In contrast, AssistedCare's projected visits per patient are consistent with the actual experience of existing home health agencies in Mecklenburg County. Therefore, AssistedCare is the best representation of the experience of Mecklenburg County home health agencies and is the most effective alternative.

Average Direct Cost per Visit

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

Applicant	*Projected Visits Year Two*	*Direct Care Costs Year Two*	*Average Direct Care Cost per Visit Year 2*
AssistedCare	6,159	$529,668	$86.00
Continuum	8,556	$966,142	$112.92
Emerald Care	12,570	$1,059,192	$84.26
HealthKeeperz	8,578	$734,997	$85.68
Healthy @ Home	47,780	$4,895,971	$102.47
J and D	1,482	Not reported	--
Maxim	9,499	$783,753	$85.21
UniHealth	11,527	$1,043,443	$90.52
Vizion	8,125	$564,614	$69.49
Well Care	11,268	$971,065	$86.18

AssistedCare projects an average direct care cost per visit that is lower than or consistent with seven of the eight other applicants for which this data was available. Only Vizion projects a significantly lower average direct care cost per visit. As discussed in detail under Criterion 5, Vizion's financial projections are completely unreliable. Most relevant to this comparative factor, Vizion has understated and omitted significant direct care costs. As a result, AssistedCare represents a more effective alternative than Vizion, and an equally effective alternative compared to all other applicants with regard to average direct care cost per visit, based on reasonable assumptions.

Average Administrative Cost per Visit

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

Applicant	*Projected Visits Year Two*	*Administrative Costs Year Two*	*Average Administrative Cost per Visit Year 2*
AssistedCare	6,159	$329,621	$53.52
Continuum	8,556	$333,420	$38.97*
Emerald Care	12,570	$599,491	$47.69^
HealthKeeperz	8,578	$461,683	$53.82
Healthy @ Home	47,780	$1,897,679	$39.72
J and D	1,482	Not reported	--
Maxim	9,499	$391,953	$41.26
UniHealth	11,527	$667,742	$59.93
Vizion	8,125	$503,393	$61.96
Well Care	11,268	$523,840	$46.69

*Note: Continuum projects an average administrative cost per visit of $219.36 in Year 1.
^Note: Emerald Care projects an average administrative cost per visit of $70.75 in Year 1.

AssistedCare projects an average administrative cost per visit that is lower than or consistent with three of the eight other applicants for which this data was available. Of note, two of the applicants that project lower administrative costs per visit in Year 2 than AssistedCare (Continuum and Emerald Care) actually project significantly higher administrative cost per visit in Year 1, calling into question the reasonableness of their Year 2 projections. Further, as discussed under Criterion 5, Healthy @ Home, Maxim, and Well Care's financial projections are unreliable as they are based on unreasonable assumptions and volume projections. As a result, AssistedCare is the most effective alternative with regard to average administrative cost per visit, based on reasonable assumptions.

Total Cost per Visit

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

Applicant	*Projected Visits Year Two*	*Total Costs Year 2*	*Total Cost per Visit- Yr. 2*
AssistedCare	6,159	$859,289	$139.52
Continuum	8,556	$1,299,562	$151.89
Emerald Care	12,570	$1,658,683	$131.96
HealthKeeperz	8,578	$1,196,680	$139.51
Healthy @ Home	47,780	$6,793,650	$142.19
J and D	1,482	Not reported	--
Maxim	9,499	$1,175,706	$123.77
UniHealth	11,527	$1,711,185	$148.45
Vizion	8,125	$1,068,007	$131.45
Well Care	11,268	$1,494,905	$132.67

AssistedCare projects a total cost per visit that is lower than or consistent with four of the eight other applicants for which this data was available. Further, as discussed under Criterion 5, Emerald Care, Maxim, Vizion, and Well Care's financial projections are unreliable as they are based on unreasonable assumptions and volume projections. As a result, AssistedCare is the most effective alternative with regard to total cost per visit, based on reasonable assumptions.

Net Revenue per Visit

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

Applicant	*Projected Visits Year Two*	*Net Revenue Year Two*	*Net Revenue Per Visit*
AssistedCare	6,159	$931,653	$151.27
Continuum	8,556	$1,610,678	$188.25
Emerald Care	12,570	$1,937,522	$154.14
HealthKeeperz	8,578	$1,224,203	$142.71
Healthy @ Home	47,780	$6,931,041	$145.06

Applicant	*Projected Visits Year Two*	*Net Revenue Year Two*	*Net Revenue Per Visit*
J and D	1,482	$1,664,138	$1,123.90
Maxim	9,499	$1,528,574	$160.92
UniHealth	11,527	$1,752,642	$152.05
Vizion	8,125	$1,140,200	$140.33
Well Care	11,268	$1,740,941	$154.50

AssistedCare projects net revenue per visit that is lower than or consistent with six of the nine other applicants. Further, as discussed under Criterion 5, HealthKeeperz, Healthy @ Home, and Vizion's financial projections are unreliable as they are based on unreasonable assumptions and volume projections. As a result, AssistedCare is the most effective alternative with regard to net revenue per visit, based on reasonable assumptions.

Net Revenue per Patient

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

Applicant	*Projected Patients Year Two*	*Net Revenue Year Two*	*Net Revenue Per Patient*
AssistedCare	352	$931,653	$2,647
Continuum	492	$1,610,678	$3,274
Emerald Care	475	$1,937,522	$4,079
HealthKeeperz	415	$1,224,203	$2,950
Healthy @ Home	2,993	$6,931,041	$2,316
J and D	92	$1,664,138	$18,088
Maxim	503	$1,528,574	$3,039
UniHealth	548	$1,752,642	$3,198
Vizion	325	$1,140,200	$3,508
Well Care	591	$1,740,941	$2,946

Only one of the nine other applicants (Healthy @ Home) projects net revenue per patient that is lower than AssistedCare's projection. As discussed under Criterion 5, Healthy @

Home's financial projections are unreliable as they are based on unreasonable assumptions and volume projections. As a result, AssistedCare is the most effective alternative with regard to net revenue per patient, based on reasonable assumptions.

Ratio of Net Revenue per Visit to Cost per Visit

Applicant	*Visits Year Two*	*Net Revenue/Visit Year Two*	*Total Cost/Visit Year Two*	*Ratio of Net Revenue/Visit to Cost/Visit*
AssistedCare	6,159	$151.27	$139.52	108%
Continuum	8,556	$188.25	$151.89	124%
Emerald Care	12,570	$154.14	$131.96	117%
HealthKeeperz	8,578	$142.71	$139.51	102%
Healthy @ Home	47,780	$145.06	$142.19	102%
J and D	1,482	$1,123.90	--	--
Maxim	9,499	$160.92	$123.77	130%
UniHealth	11,527	$152.05	$148.45	102%
Vizion	8,125	$140.33	$131.45	107%
Well Care	11,268	$154.50	$132.67	116%

AssistedCare projects a ratio of net revenue per visit to cost per visit that is lower than or consistent with five of the eight other applicants for which this data is available. Further, as discussed under Criterion 5, HealthKeeperz, Healthy @ Home, and UniHealth's financial projections are unreliable as they are based on unreasonable assumptions and volume projections. As a result, AssistedCare is the most effective alternative with regard to ratio of net revenue per visit to cost per visit, based on reasonable assumptions.

Nursing and Home Health Aide Salaries

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

Applicant	*Registered Nurse Annual Salary Year Two*
AssistedCare	$71,070
Continuum	$65,938
Emerald Care	$73,987
HealthKeeperz	$70,627

Applicant	*Registered Nurse Annual Salary Year Two*
Healthy @ Home	$64,591
J and D	$43,680
Maxim	$72,774
UniHealth	$72,420
Vizion	Not reported
Well Care	$70,967

Applicant	*Home Health Aide Annual Salary Year Two*
AssistedCare	$29,870
Continuum	$21,532
Emerald Care	$32,493
HealthKeeperz	$30,810
Healthy @ Home	$30,363
J and D	$20,800
Maxim	$33,313
UniHealth	$32,895
Vizion	Not reported
Well Care	$32,188

AssistedCare projects an average RN salary that is higher than five of, and generally consistent with the other three of the eight other applicants for which this data is available. AssistedCare projects an average home health aide salary that is higher than two of, and generally consistent with the other six of the eight other applicants for which this data is available. As a result, AssistedCare represents an effective alternative with regard to nursing and home health aide salaries.

Specialized Services

AssistedCare is one of only two applicants (Continuum being the other) that utilize a web-based quality and data collection system that is already in place and operational. AssistedCare appears to be the only applicant that now uses electronic medical records which also include web-based software that allows physicians to view patient records remotely and to make changes to the orders and sign off in real time. No other applicant even proposes to have this capability. On pages 21 and 30 of its application, Maxim states it "is investing in health care technology..." for the new agency and on page 54, UniHealth states that it "***will utilize*** a McKesson point-of-care electronic medical record

system." However, AssistedCare has sophisticated systems in place and in use in Brunswick County and can add Mecklenburg County agency to the system immediately upon opening the agency. As such, it is a better alternative to Maxim and UniHealth as well as all the other applicants that do not even propose electronic medical records. Finally, AssistedCare is the only applicant that combines a comprehensive behavioral health program (including Alzheimer's and dementia care) with its medical care of home health patients through existing structures and professional relationships.

SUMMARY

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

ATTACHMENT 1

JUSTICE NEWS
Department of Justice
Office of Public Affairs

FOR IMMEDIATE RELEASE Monday, September 12, 2011

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

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

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

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

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

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

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

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

services that people depend on day in and day out."

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

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

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

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

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

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

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

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

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

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

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

Prosecution of Individuals

According to documents filed in these cases and statements made in Trenton, N.J., federal court:

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

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

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

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

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

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

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

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

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

Maxim's Remedial Actions

The government's willingness to enter into a DPA with Maxim is due, in significant part, to the company's

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

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

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

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

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

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

11-1169 Civil Division