HAND DELIVERED

August 31, 2012

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

Re: Comments on Competing Mecklenburg County Home Health CON Proposals –

AssistedCare of the Carolinas (AssistedCare), F-10006-12

Continuum Home Care of Charlotte (Continuum), F-10010-12

Emerald Care (Emerald), F-10008-12

HealthKeeperz of Mecklenburg (HKZ), F-10005-12

Healthy @ Home-Carolinas Medical Center (HH-CMC), F-10004-12

J&D Health Care Services (J&D), F-10012-12

Maxim Healthcare Services (Maxim), F-10003-12

Vizion One (Vizion), **F-10001-12**

Well Care Home Health of Mecklenburg (Well Care), F-10007-12

Dear Mr. McKillip and Mr. Smith:

On behalf of UniHealth Home Health (UniHealth), Project ID # F-10011-12, thank you for the opportunity to comment on the above referenced applications for development of a new Medicarecertified home health agency in Mecklenburg County.

We recognize that the State's Certificate of Need (CON) award for the proposed home health agencies will be based upon the health planning objectives, outlined in G.S. 131E-175, the policies in the 2012 State Medical Facilities Plan (SMFP) and the statutory criteria in G.S. 131E-183. Specifically, we request that the CON Section give careful consideration to the extent to which each applicant demonstrates:

- 1. The need its proposed service area population has for the types of home health agency services it proposes to offer;
- 2. That the most effective alternative is proposed;
- 3. Immediate and sustainable financial feasibility of the proposed agency;

- 4. Availability of adequate staff to provide all proposed services;
- 5. Ability to provide all necessary ancillary and support services;
- 6. Mechanisms to make its services accessible to all proposed service area residents; and
- 7. Organizational structure, staff development programs and quality improvement programs that will enable it to sustain cost effective care delivery, quality and appropriate care, along with access to the proposed services.

The application from UniHealth, Project ID # **F-10011-12**, conforms to all of these criteria and planning objectives and is competitively superior to the nine competing applications.

Below is a brief discussion of why UniHealth is competitively superior to the other applications. Attached is an analysis of the competing applications discussed within the framework of the State's CON Review Criteria and applicable home health rules (10A NCAC 14C .2000). For each applicant, we have addressed only those criteria which we believe the application is non-conforming.

UniHealth has excluded J&D from the discussion below and does not provide a separate analysis of the J&D application. As will be clearly evident to the CON Section upon review, J&D's application is incomplete in a multitude of areas, thereby rendering a complete and thorough review of its proposal impossible. For example, the applicant does <u>not</u> provide: a complete Form B, proforma assumptions, utilization assumptions, or projected staffing for both project years. Other omissions that make the applicant non-conforming to the statutory criteria in G.S. 131E-183 include: no correspondence to or from area health professional training programs and no independent discussion of need.

WHY APPROVE UNIHEALTH HOME HEALTH

Overview

In a review that includes ten applicants, no one applicant is going to be the best at all competitive criteria. What should be considered is which proposal, as a whole, best promotes the 2012 SMFP Basic Principles: Quality, Access and Value. UniHealth believes its application is the best proposal to support all three principals and will benefit Mecklenburg County tremendously. UniHealth offers:

- The only service program specifically tailored to Mecklenburg County area resident needs;
- The most comprehensive care management program;
- Expanded geographic access to services for the residents of Mecklenburg County by proposing an office in the northern part of the county, away from existing providers;
- A program and staffing plan that can appropriately care for Mecklenburg County's diverse foreign-born population;
- A program that includes a high amount of charity care;
- The second highest percentage of Medicare and Medicaid access;

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- High visits per unduplicated patient;
- The highest compensation for Registered Nurses (RNs) and Home Health Aides (HHAs); and
- The lowest ratio of net revenue to total cost.

The following pages highlight the advantages of the UniHealth application in the context of the 2012 SMFP Basic Principles: Quality, Access and Value.

Quality

Service Need

Mecklenburg County's current and future need for home health services is documented with varying degrees of detail by applicants in this competitive batch. All applicants argue that sustained growth and aging of the population will generate a need for home health services in excess of what home health agencies that currently serve the county can handle at current growth rates. However, only UniHealth and Continuum provide a complete independent need analysis that projects need in Mecklenburg County. As a result, many applicants projected unreasonable patient counts. Additionally, UniHealth is the only applicant that explicitly determined and described in Section III.1.(a) the specific home health services needed by the population it proposes to serve. Thus, UniHealth is the only applicant conforming to G.S. 131E-183 (3). Please see Table 1 below.

Ten Medicare-certified home health agencies have licensed offices in Mecklenburg County; approximately 18 other agencies located outside of the county serve Mecklenburg County residents. Most of these existing agencies have expanded capacity and reached more patients every year. As a result, it has been three years since a new Medicare-certified home health agency has been approved. With ten agencies competing for the two new home health agency office opportunities, it is important that the two new providers selected will have capacity to fill service gaps in this large and diverse county and systems to assure high levels of quality in the services provided.

To determine what home health services are truly needed in the Mecklenburg County area, only one applicant, UniHealth, conducted a comprehensive survey of Mecklenburg County area healthcare providers. HKZ conducted a survey but its questions addressed only the need for core home health services (intermittent skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, medical social work) and two additional services (pharmacy and dietary counseling). In addition, HKZ surveyed a mere three providers; hardly enough to get an accurate outlook on what services are needed in this market. Continuum conducted a survey that included more services. Yet much like HKZ, Continuum was not able to get a complete understanding of what services are needed in Mecklenburg County as it surveyed only seven providers. Furthermore, four of the seven were completed by entities related to Continuum and two of the seven were completed by facilities located outside of Continuum's proposed service area. UniHealth, on the other hand, surveyed 63 Mecklenburg County area healthcare providers, who represented a broad cross-section of the

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community. Collectively, these persons identified 34 different home health agency services that the county needs and that fall within the scope of services of a home health agency. (Please see UniHealth Exhibit 15). Utilizing the results of the survey, UniHealth tailored its services to accurately meet the needs of Mecklenburg County residents.

Table 1 below lists the ten services identified in these surveys as most needed. As illustrated in Table 1, <u>UniHealth and Emerald propose the most comprehensive program to meet county needs.</u>

Table 1 highlights the difference between applicants that have addressed the need of the population to be served for the services to be provided, and those that have not. In many cases, applicants listed services, but did not describe how they would be provided. In a highly competitive batch such as this one, an applicant that provides a description of services should be seen a more qualified applicant.

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

Applicant	Medication Mgmt.	Diabetes Mgmt.	Wound	Falls Prevention	Heart Failure	Orthopedics	Stroke	Pain	Physical Therapy	Occupational Therapy	Documents Need of the Population to be Served for Services in III.1.(a).
AssistedCare	No(1)	No (1)	Yes	No(1)	No(1)	No(1)	No(1)	No(1)	Yes	Yes	Some(2)
Continuum	No (1)	No(1)	Yes	No (1)	No (1)	No(1)	No	No(1)	Yes	Yes	Some (3)
Emerald	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
НКZ	Yes	No	No(1)	No	No	No(1)	No (1)	No	Yes	Yes	No
нн-смс	Yes	No(1)	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No
Maxim	No(1)	No(1)	No(1)	No(1)	No(1)	No(1)	No(1)	No(1)	Yes	Yes	No
Vizion	No	Yes	Yes	No	Yes	No (1)	oN	Yes	Yes	Yes	Some(4)
Well Care	No(1)	No(1)	No(1)	Yes	Yes	Yes	No(1)	No	Yes	Yes	Some(4)
UniHealth	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Mentioned, not described in narrative or by a policy.

Only behavioral health.

Only cancer, AIDs, Alzheimer's, Medicaid, and Minorities. 4 3 2 1

Generic discussion of need of most common admitting diagnosis. However, the applicants made no attempt to correlate needs of the population to be served with the services to be offered.

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Care Management

Medicare costs are a significant part of the national budget and a matter of concern to policy makers. Medicaid costs are shared between state and federal budgets, so those concern both sets of policy makers. More than half of proposed home health agency patients will be covered by one or both of these benefit programs.

The number of patients who used home health care after being discharged from hospitals surged by about 70 percent (2.3 million to 4 million) from 1997 to 2008, according to *News and Numbers* from the Agency for Healthcare Research and Quality (AHRQ). In contrast, the number of patients routinely discharged from hospitals to their homes without the need for additional care grew by less than eight percent, from 27 million to 29 million patients, during the period¹. Home health agency patients are high risk for admission and readmission to hospitals². Some of this trend is attributed to Medicare's prospective payment episode structure. The Centers for Medicare and Medicaid Services (CMS) wants to control health care costs by decreasing hospital readmissions. Hospital stays are expensive and research studies have shown that approximately 75 percent of hospital readmissions by Medicare beneficiaries are preventable³.

Effective October 1, 2012, CMS will reduce Medicare payments to hospitals for "excessive rehospitalizations" of patients who have been admitted with a diagnosis of congestive heart failure (CHF), acute myocardial infraction (AMI) or pneumonia. "Excessive" will be a state-based comparative metric. Cuts will begin at one percent and increase to three percent. Cuts will be applied to all Medicare payments received by a hospital, regardless of diagnosis. Currently, the best performing U.S. hospitals produce one to three percent net operating margins, while 20 percent of all U.S. hospitals have negative operating margins. With narrow to negative margins, a one percent Medicare reimbursement penalty could prove catastrophic for any hospital that is not able to rein in its avoidable readmission rate. As a result, hospitals will refer their patients to the most efficient agencies that are least likely to readmit the hospital's patients. Therefore, home health agencies need to move away from general, episodic care toward sustained coordinated care of all patient needs by becoming coordinated care management companies⁴.

Skilled nursing care facilities and other community based providers are also major sources of referrals for home health agencies. Like hospitals, these industries are also being asked to prevent hospital admissions and lower costs. All of these trends point to more need for case and care management programs in home health agencies.

¹ http://www.ahrq.gov/news/nn/nn030911.htm

² Anderson, MA, et al Hospital readmission from home health care before and after prospective payment. J. Nurs. Scholarsh 2005,37(1), 73-9 http://www.ncbi.nlm.nih.gov/pubmed/15813590

³ 2 MedPAC: June 2007 Report to the Congress: Promoting Greater Efficiency in Medicare pp 107-115.

⁴ http://www.doctorsmakinghousecalls.com/wp-content/uploads/2011/09/Wyatt-Matas-White-Paper-How-Home-Healthcare-Thrives-with-Healthcare-Reform-Final.pdf

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

Table 2 - Comparison of Care Management Program

Applicant	Telehealth	Case Mgmt.	Medication Mgmt.	Home Safety	Point of Care Electronic Medical Records	Health Literacy / Education	Social Networks	Care Paths
AssistedCare	Yes	No	No(2)	No(2)	Yes	No	No	No
Continuum	No	No	No(2)	No(2)	No (2)	Yes (5)	No	No
Emerald Care	Yes	Yes	Yes	Yes	Yes	No	No	Yes
HKZ	No	No(2)	Yes	No	No	No(2)	No	No
нн-смс	Yes	Yes	Yes	Yes	No	Yes	No	Yes (3)
Maxim	No	No	No(2)	Yes	Yes	No	No	No
Vizion	No (2)	No(1)	No	No	No	No	Yes	No
Well Care	No(2)	No	No(2)	Yes	No(2)	No (2)	No	Yes (4)
UniHealth	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

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

Staffing

In order to offer a comprehensive service package that focuses on care management, a home health agency must recruit top caliber, experienced and/or highly trained direct care employees. In a competitive market like Mecklenburg County, a high salary is one way to recruit and retain such talent.

^{1.} Program description is for a personal home care program.

^{2.} Mentioned, do not describe in the narrative or in a policy.

^{3.} Currently only for Physical Therapy, Joint Replacement, Falls Prevention, and Nutrition Support.

^{4.} Currently only for Cardiac conditions, Falls Prevention, Physical Therapy.

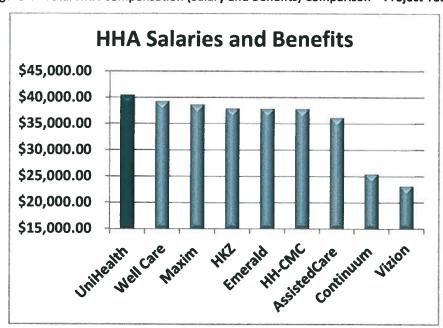
^{5.} Patient education materials provided but no health literacy initiatives.

UniHealth proposes the <u>highest total compensation for Registered Nurse (RN) and Home Health Aide (HHA) employees.</u>

\$95,000.00 \$90,000.00 \$85,000.00 \$75,000.00 \$70,000.00 \$65,000.00 \$55,000.00 \$55,000.00 \$50,000.00

Figure 1 - Total RN Compensation (Salary and Benefits) Comparison - Project Year 2





Visits per Unduplicated Patient

Medicare is the primary source of coverage for most home health agency visits; and, in North Carolina, most Medicare is Fee for Service. Medicare Fee for Service payments are prospective, episode-based, regardless of the number of visits. The system financially rewards fewer visits per episode. However, patients benefit from more contact with health care providers, as a higher number of visits per patient is often linked to higher quality of care provided. UniHealth ranks in the top four applicants on visits per unduplicated patient.

Table 3 - Visits per Unduplicated Patient Comparison - Project Year 2

Applicant	Visits / Unduplicated
Emerald	26.41
Vizion	25.00
HKZ	21.72
UniHealth	21.03
Well Care	19.07
Maxim	18.89
AssistedCare	17.49
Continuum	17.39
HH-CMC	15.96

Accreditation

HKZ is the only applicant that does not propose to be accredited by a third-party accrediting body. Accrediting bodies provide the structure and oversight necessary to ensure that patients always experience the safest, highest quality, best-value health care. As such, HKZ is a less effective alternative to UniHealth.

Competition

Adequate competition creates an environment that supports tendencies toward expanded access, higher salaries, and higher quality. Members of the State Health Coordinating Council (SHCC) agree. On page 3 the 2012 SMFP states, "A competitive marketplace should favor providers that deliver the highest quality and best value care."

For this reason, HH-CMC and Emerald are less effective alternatives to UniHealth. Although not licensed in Mecklenburg County, Emerald currently provides home health services to Mecklenburg County residents. HH-CMC is currently an existing Mecklenburg County provider. Thus, approving HH-CMC and Emerald would limit the amount of positive change that can occur by allowing a new

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provider into the market. For example, if UniHealth is approved over HH-CMC and Emerald, UniHealth will: influence higher salaries, influence expanded service programming focused on care management and readmission reduction; and will expand access to Medicare and Medicaid beneficiaries.

<u>Access</u>

Medicare and Medicaid

Medicare and Medicaid beneficiaries are typically more complex patients and in the greatest need of care services. UniHealth ranks second on access to Medicare and Medicaid beneficiaries.

Table 4 - Payor Mix Comparison - Project Year 2

Applicant	Projected Visits /Hours as % of Total Project Visits /Hours
Maxim	89.60%
UniHealth	88.66%
HH-CMC	88.20%
Well Care	86.88%
Emerald	85.30%
HKZ	81.70%
Continuum	75.97%
AssistedCare	75.90%
Vizion	65.90%

Charity Care

UniHealth is in the top three for Charity Care access and well above the average for applicants in this batch. Well Care, Maxim, and Emerald offer Charity Care that is substantially less than the competition and should be found competitively less superior. Currently, 17 percent, or approximately 163,000 Mecklenburg County residents are uninsured. Of the 163,000 that are uninsured, 10.9 percent, or approximately (104,400) are also unemployed; a rate higher than the state average of 10.6 percent⁵. Clearly, access to charity care is important.

⁵County Health Rankings and Roadmaps. http://www.countyhealthrankings.org/app/north-carolina/2012/mecklenburg/county/1/overall.

Applicant	As a Percent of Gross Revenue
Vizion	1.40%
HH-CMC	0.99%
UniHealth	0.95%
AssistedCare	0.91%
Continuum	0.90%
HKZ	0.60%
Emerald	0.32%
Maxim(1)	0.28%
Well Care	0.10%
Average	0.72%

Table 5 - Charity Care Comparison - Project Year 2

It should also be noted that <u>UniHealth is the only applicant to document a significant effort to contact</u>, and offer services to, organizations that care for low income, uninsured, and underinsured <u>individuals</u>. UniHealth contacted all four Community Care of North Carolina network agencies that serve its proposed service area and four clinics that serve low income, uninsured, and underinsured individuals. UniHealth also reached out to organizations that support immigrant populations. These organizations will also provide UniHealth with access to persons in need of charity care.

Special Needs Populations

UniHealth is the <u>only applicant that can appropriately care for Mecklenburg County's diverse and foreign-born population</u>. According to a study by the US English Foundation, Mecklenburg County residents speak 68 languages. Please see Attachment B. UniHealth is the only applicant to document relations with, and budget for, persons who can provide interpretation services in multiple languages. UniHealth is the only applicant to reach out to organizations that care for foreign-born individuals and request assistance in hiring bilingual staff.

UniHealth is also the only applicant to recognize the special needs of the many persons in home health care who have hearing disabilities. As described in Section III.1.(b), of the UniHealth application, UniHealth estimates that approximately 40 percent of home health agency clients in Mecklenburg County will likely suffer from hearing loss.

^{1.} Percentage does not match applicant's response to application Question VI.7.(c). Maxim miscalculated its Charity Care. Please see discussion in the attached comments on Maxim's application.

Location

Location is important to productivity in a large metropolitan area like Mecklenburg County. It can take over an hour to travel from one end of the county to the other when there is no traffic. The Charlotte urban area experiences the worst traffic congestion in the state and is 41st in the nation. Eight of the 10 existing Mecklenburg County home health agencies are located in Central or Southern Charlotte. As noted by multiple applicants, including UniHealth, Northern Mecklenburg is one of the fastest growing areas of Mecklenburg County. As such, the next agency approved for Mecklenburg County should be in Northern Mecklenburg County and in area with access to major highways, I-485, I-85, and I-77. UniHealth proposes such a location. Maxim and Emerald, on the other hand, are located in the center of Mecklenburg County, away from I-485, and therefore should be found less effective.

Documented Referral Sources

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

Table 6 – Documented Referral Comparison

Applicant	Year 2 Unduplicated Census	Promised Referrals from Service Area	Deficit (-) Surplus(+)
AssistedCare	352	0	-352
Continuum	492	462	-30
Emerald	476	0	-476
HKZ	395	156	-239
HH-CMC	2,993	0	-2,993
Maxim	503	0	-503
Vizion	325	0	-325
Well Care	591	0	-591
UniHealth	548	2,500	1,952

^{*}Referral estimates are from Mecklenburg County providers only. AssistedCare and HKZ census projections are based on serving only Mecklenburg County residents.

⁶ http://ui.uncc.edu/story/congestion-charlotte-holds-steady

<u>Value</u>

UniHealth proposes the lowest ratio of net revenue to total cost.

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

Applicant	Ratio of Net Revenue to Total Cost
UniHealth	1.02
HH-CMC	1.02
HKZ	1.03
Vizion	1.07
AssistedCare	1.08
Well Care	1.16
Emerald	1.17
Continuum	1.24
Maxim	1.30

UniHealth's low ratio of net revenue to total cost highlights its commitment to high visits, ample access to low income individuals, high salaries, and a robust service package. Well Care and AssistedCare show higher profits because of fewer staff in functions that are not directly reimbursable. Unlike UniHealth, Well Care and AssistedCare provide no OASIS Coordinator or full time Nurse Supervisor/Clinical Coordinator. Without an OASIS coordinator, an agency will rely on direct care staff to maintain, review and validate the required quality measures. This will leave less time for direct patient care. Without a program to coordinate community resources for home health agency patients, an agency will be vulnerable to both readmission to home health agency care and admission or readmission to other Medicare certified health care facilities. Well Care's visits per day per FTE are also high. This allows for fewer staff and a lower quality of care. Maxim's profits are substantially higher than the competition because of lower Medicaid, low benefits, no nurse supervisor, and its back office administrative staff is all part-time. Because of the complicated nature of OASIS-C and the requirement to document a face-to-face visit with a physician before an episode can be approved, an agency must have a robust administrative staff. Emerald shows high profits because it offers low Medicaid access, almost no indigent care, no OASIS Coordinator, and low benefits. Continuum shows a large profit because of extremely high net revenue per visits at \$188 per visit, whereas the average for applicants in this batch (less J&D) is \$154.36.

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CONCLUSION

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

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

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

Thank you for your time and consideration. Please do not hesitate to call me if you have any questions.

Sincerely,

Aneel Gill, MBA/MHA

Health Planner

UHS-Pruitt Corporation

678-533-6699

Attachments: (see following page)

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Attachments:

- A Noncompliance with CON Review Criteria and applicable home health rules: 10A NCAC 14C .2000
- **B** U.S. English Foundation Statistics
- C Historical Medicare Reimbursement Articles
- **D** Psychiatric Nurse Regulations
- **E** Historical Emerald Utilization Data
- F HKZ and Maxim Readmission Data
- **G** Maxim Medicare and Medicaid Revenue Calculation
- **H** Maxim Article
- I Medicare Timeline
- J CareAnywhere and Simione Conversation Logs

UniHealth Home Health (UniHealth), Project ID # F-10011-12

COMPETITIVE REVIEW OF — ASSISTEDCARE OF THE CAROLINAS (ASSISTEDCARE), F-10006-12

CON Review Criteria

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

Need

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

- AssistedCare does not demonstrate a need for each of the proposed services described in Section II.1. Section III.1.(a) instructs applicants to "describe, in specific terms, the unmet need that necessitated the inclusion of each of the proposed services to be offered by the home health office as set forth in the description of the scope of services in Section II.1."
- The applicant's independent need assessment of Mecklenburg County's projected home health need is incomplete. On AssistedCare application page 78, Section III.1.(b), AssistedCare bases 2013 Mecklenburg County home health need on the 2012 State Medical Facilities Plan (SMFP) methodology. The applicant projects 2014 Mecklenburg County home health need by growing projected county resident utilization by eight percent from 2013 to 2014. This is inappropriate. An applicant must also project patients served by existing providers and subtract the total from anticipated patients that will utilize home health services. This is important because if existing provider utilization is growing faster than projected utilization the need for a new agency disappears.

Access

The applicant only budgets and plans for Hispanic interpreter services. According to a study by the US English Foundation, Mecklenburg County residents speak 68 languages. Please see Attachment B. Thus, to ensure access to all Mecklenburg County residents, applicants must demonstrate an arrangement to care for all non-English speaking residents.

Conclusion

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

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

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

The absence of a Nurse Supervisor, or equivalent, and an OASIS Coordinator makes AssistedCare a less effective alternative. As discussed in Criterion (7), a nurse supervisor, or equivalent, would typically handle the time-consuming task of patient admissions. AssistedCare's calculations of time per visit and FTE calculations do not appear to make an allowance for the admission function. The application does not define who will handle admitting duties. As proposed, all of the applicant's Registered Nurse staff will need to be in the field making visits to meet workload projections. Similarly, without an on-site OASIS coordinator to ensure timely and correct OASIS-C submission, field staff will have one more administrative task to absorb, reducing the time available for direct patient care. Proper OASIS coding is critical to smooth administrative functions in a Medicare-certified agency.

The absence of these critical care coordination staff positions will also make AssistedCare less responsive to CMS Medicare initiatives to reduce hospital readmissions. According to CMS, Mecklenburg's Presbyterian Hospital has one of the highest readmission rates in the state for CMS' three target diagnoses, Congestive Heart Failure (CHF), Acute Myocardial Infarction (AMI) and pneumonia. To reduce readmissions for CHF, AMI, pneumonia and Chronic Obstructive Pulmonary Disease (COPD), all county hospitals will require home health agencies that have staff training, protocols and capacity to manage care and to coordinate community resources for people with these chronic diseases. The missing care coordination services in the AssistedCare agency will make it a less effective alternative for Mecklenburg County residents.

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

Operational Projections

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

• Unduplicated patient projections on application page 77, Section III.1.(b), are arbitrary and based on unsubstantiated projections of need. Project Year 1 projections are based solely on the need determined in the 2012 SMFP. Project Year 2 projections are

¹ http://www.cms.gov/Medicare/Demonstration-

Projects/DemoProjectsEvalRpts/downloads/CCTP FourthQuartileHospsbyState.pdf

- arbitrarily increased by approximately eight percent and do not consider, or otherwise attempt to, estimate the actual need in Mecklenburg County in 2013, given current trends. Please see discussion in Criterion (3).
- Because the applicant failed to correctly calculate the true home health need in Mecklenburg County, the applicant projected unreasonable patient estimates for Project Year 2 (2014). Based on a reasonable projection of need, UniHealth projects that 418 Mecklenburg County residents will have a need for home health services in 2014. Please see Section III.1.(b) of UniHealth's application. AssistedCare projects to serve 352 unduplicated patients in 2014. Because two new agencies may be approved as a result of the need determination in the 2012 SMFP, it is unreasonable to assume that AssistedCare will care for approximately 84 percent of the unmet need (352/418*100=84%).
- The applicant's calculation of visits by discipline in Table IV2., in application AssistedCare Exhibit 27, do not correspond with visit by discipline estimates provided in the applicant's proformas on AssistedCare application page 160. Please see Table 1 below.

	a		b		С		d	
Discipline	Project Year 1 – Table IV.2	Percent of Total	Project Year 1 – Proforma	Percent of Total	Project Year 2 – Table IV.2	Percent of Total	Project Year 2 – Proforma	Percent of Total
Nursing (only direct care)	3,269	57.3%	2,853	50.0%	3,529	57.3%	3,080	50.0%
PT	1,563	27.4%	1,920	33.7%	1,687	27.4%	2,703	33.7%
ST	160	2.8%	460	8.1%	172	2.8%	496	8.1%
ОТ	257	4.5%	114	2.0%	277	4.5%	123	2.0%
MSW	377	6.6%	28	0.5%	406	6.6%	30	0.5%
ННА	80	1.4%	330	5.8%	86	1.4%	356	5.8%
Total	5,705	100.0%	5,705	100.0%	6,159	100.0%	6.159	100.0%

Table _ - Visit by Discipline Comparison

Notes:

- a) Table IV.2, AssistedCare application page 396
- b) Proforma, AssistedCare application page 160
- c) Table IV.2, AssistedCare application page 396
- d) Proforma, AssistedCare application page 160
- AssistedCare provides no assumption to explain how visits per episode will be separated into months of service. It assumes all episode visits will be completed in the year the episode starts. It is unreasonable to assume that a patient who begins a new episode in the last two months of a project year will complete all his/her visits in that time frame. A standard home health episode lasts 60 days. Not every client in those two months will start care at the beginning of the period. Some will carry over.
- The applicant's utilization projections do not match the applicant's proposed schedule in Section XII. Utilization projections provided in AssistedCare application Exhibit 27 project services starting in April 2013. AssistedCare application page 154, Section XII, states that the agency will be licensed March 1, 2013.

• AssistedCare failed to document a single patient referral. Having referral relationships is important in a competitive market like Mecklenburg County. Both hospital systems located in Mecklenburg County operate strong home health programs. Furthermore, according to a recent MedPAC report, depending on hospitals for referrals is insufficient. According to the report, approximately 65 percent of home health admissions are from non-hospital referral sources². As such, it is important that new agencies have established relationships with area providers for referrals. As discussed in UniHealth's attached letter to CON, volume is critical to a home health agency's success in today's market.

Financial Projections

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

- The applicant's projections for utilization are unsupported and unreliable. Please see discussion above. Consequently, costs and revenues that are based on the applicant's utilization projections are unreliable.
- Applicant provides no basis for Medicaid supply reimbursement, private/commercial insurance reimbursement, or self-pay/other reimbursement.
- On AssistedCare application page 165, the applicant states that private/commercial reimbursement is based on assumed deductions of 38.1 percent. However, financial projections on AssistedCare application page 165 show only a 25 percent contractual adjustment. As such, the applicant overstated revenue by approximately \$26,075 and \$28,148 in Project Year 1 and Project Year 2, respectively. Please see Table 2 below.

Table 2 - AssistedCare Private/Commercial Revenue Comparison

Notes		Project Year 1	Project Year 2
a	Gross Revenue	\$199,044	\$ 214,868
b	Assumed Deduction	38.1%	38.1%
С	Appropriate Contractual Adjustment	\$ 75,834	\$ 81,865
d	Applicant's Estimated Contractual Adjustment	\$ 49,761	\$ 53,717
е	Missing Contractual Adjustment	\$ 26,075	\$ 28,148

Notes:

- a) Proforma, AssistedCare application page 165
- b) Proforma, AssistedCare application page 165
- c) a*b
- d) Proforma, AssistedCare application page 165
- e) c-c

² http://www.medpac.gov/documents/Mar12_EntireReport.pdf, page 220.

- On AssistedCare application page 22, Section II.1.(b), the applicant states that it will utilize Viterion Telehealth equipment. However, the applicant makes no indication in its application that costs associated with owning or leasing the equipment have been accounted for in the capital cost estimates, proformas, or management agreement. The applicant might argue in response to these comments that the management company owns telemonitoring equipment and that existing equipment will be utilized at the proposed facility, as was the case when multiple competitors commented on AssistedCare's recent Wake County home health application (J-8817-12). If this is the case, AssistedCare has not presented it and UniHealth questions the likelihood that the applicant's management company owns enough telemonitoring equipment to continue current and expanded operations in Brunswick County and offer telemonitoring services at the proposed Wake County and Mecklenburg County agencies without additional equipment.
- On AssistedCare application page 38, Section II.2, the applicant states that it will utilize a web-based electronic medical record called CareAnywhere. However, the applicant makes no indication in its application that costs associated with utilizing the software have been accounted for in the capital cost estimates, proformas, or management agreement. The applicant might argue in response to these comments that the management company has purchased the software and any AssistedCare agency can utilize the software, as was the case when multiple competitors commented on AssistedCare's recent Wake County home health application (J-8817-12). However, based on a conversation with CareAnywhere there is a fee associated with an increase in patients. Please see Attachment J.
- On AssistedCare application page 38, Section II.2, the applicant states that it will
 utilize Simione Financial Monitor. However, the applicant makes no indication in its
 application that costs associated with utilizing the software have been accounted for
 in the capital cost estimates, proformas, or management agreement. Per a
 conversation with Simione, fees will increase with the proposed project because a
 new Medicare provider number will be issued to the proposed agency. Please see
 Attachment J.
- On AssistedCare application page 114, Section VI.1, the applicant states that it will apply for Joint Commission Accreditation. However, the applicant has not budgeted for the cost of the accreditation. Joint Commission Accreditation can cost up to \$10,000. The applicant is likely to argue that the cost is covered in its management agreement. However, Exhibit A of AssistedCare Exhibit 3 states that the management company will supervise all third party surveys but it does not say that it will pay the cost of the surveys.
- The applicant fails to budget adequate expenses for appropriate levels of health manpower. Please see discussion in Criterion (7).
- The applicant fails to budget funds for a physician to sit on its required advisory committee. Please see discussion in Criterion (8).

Conclusion

In conclusion, the applicant's operational and financial projections are unreliable and unsupported. As such, the application is non-conforming to Criterion (5).

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

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

Additionally, utilization projections support that the proposed agency would duplicate services of a second agency. Please see discussion in 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.

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

- AssistedCare does not budget for a registered nurse that can provide psychiatric home health services. On AssistedCare application page 28, Section II.1.(b), the applicant states that it will offer a psychiatric program that can "receive referrals for patients whose primary diagnoses are psychiatric." For Medicare to reimburse for a direct psychiatric patient admission, an agency must provide those services with a registered nurse that meets certain psychiatric care standards. Please see Attachment D. These nurses are specially trained and generally require high salaries. AssistedCare does not propose such a staff person.
- AssistedCare does not budget for a nurse supervisor or equivalent. As such, it is unclear
 who will handle admitting duties. All budgeted nursing staff must be making visits
 every day to cover provide enough coverage for the applicant's visit projections.
- AssistedCare does not budget for a secretary and provides no alternative plan for handling secretarially duties such as reception and scheduling.
- AssistedCare's proposed nursing, speech therapy, home health aide, and medical social worker staffing plan does not provide enough staff to cover the applicant's proposed visits based on a 260 day work year. Please see Table 3 below. A 260 day work year accounts for no paid time off (PTO). If any PTO is added to the equation, the applicant's proposed staffing would be further under staffed.

Table 3 - AssistedCare Staffing Calculation

	a	b	С	d	е	f
Discipline	Projected FTEs	Visits/Day	Projected Visits	Days Worked per FTE per Year	FTEs Needed	FTEs not Budgeted (- = Surplus)
Nursing (only direct care)	2.37	5	3529	260	2.71	0.34
ST	0.09	5	172	260	0.13	0.04
ННА	0.23	6	406	260	0.26	0.03
MSW	0.03	3.5	86	260	0.09	0.06

Notes:

- f) Table VII.2, AssistedCare application page 132
- g) Table VII.2, AssistedCare application page 132
- h) Table IV.2 AssistedCare application page 132
- i) Assumes 260 day work week
- j) c/b/d
- k) e-a
- 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

Ancillary and Support Services

The applicant does not demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services because it does not provide evidence of a physician that is willing to serve on the agency's required advisory committee. An advisory committee is a requirement of Medicare Conditions of Participation (42 CFR 484.16)³.

Coordination with Existing Health Care System

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

Conclusion

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

http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/xml/CFR-2011-title42-vol5-part484.xml#segnum484.16

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

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

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

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

- The applicant does not demonstrate a need for each of the services it proposes in Section II.1. Please see discussion in Criterion (3).
- The applicant provides no plan for care of all non-English speaking residents. Please see discussion in Criterion (3).
- The absence of care coordination staff decreases the proposed agency's ability to provide care management services and decreases the resultant opportunity for staff education. These missing care elements will make this agency less valuable to patients. Please see discussion in Criterion (4).
- The applicant's projected costs are unreliable because they are based on unsupported and unreliable operational and financial projections. Please see discussion in Criterion (5).
- The applicant does not show evidence of the availability of resources including health manpower and management personnel, for the provision of the services proposed. Please see discussion in Criterion (7).
- The applicant does not demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. Please see discussion in Criterion (8).

10A NCAC 14C .2000 Criteria and Standards for Home Health Services

10A NCAC 14C .2002 INFORMATION REQUIRED OF APPLICANT

- (a) An applicant shall identify:
 - (3) the projected total unduplicated patient count of the new office for each of the first two years of operation;

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

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

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

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

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

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

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

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

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

10A NCAC 14C .2003 PERFORMANCE STANDARDS

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

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

10A NCAC 14C .2004 RESERVED FOR FUTURE CODIFICATION

10A NCAC 14C .2005 STAFFING AND STAFF TRAINING

(a) An applicant shall demonstrate that proposed staffing for the home health agency office will meet the staffing requirements as contained in 10A NCAC 13J which is incorporated by reference including all subsequent amendments. A copy of 10A NCAC 13J may be obtained from the Division of Health Service Regulation, Medical Facilities Licensure Section at a cost of two dollars and sixty cents (\$2.60).

As discussed in Criterion (7) above, the applicant under budgets nursing, speech therapy, home health aide, and medical social worker staff.

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

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

COMPETITIVE REVIEW OF — CONTINUUM HOME CARE OF CHARLOTTE (CONTINUUM), F-10010-12

CON Review Criteria

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

Need

Continuum does not adequately demonstrate the need of the population to be served for the services proposed. Continuum does not adequately demonstrate a need for each of the proposed services described in Section II.1. On Continuum application page 53, Section III.1.(b), the applicant attempts to validate the need for specialized home health services by providing survey results from seven area providers. The applicant claims that the seven surveys represent a comprehensive cross section of the Mecklenburg County healthcare providers. This is not a reasonable assumption. First, seven surveys is unreasonably low for a county as large as Mecklenburg County. Second, a closer examination of the surveys reveals that four of the seven were completed by entities related to Continuum and two of the seven were completed by facilities located outside of the applicant's proposed service area. Section III.1.(a) instructs applicants to "describe, in specific terms, the unmet need that necessitated the inclusion of each of the proposed services to be offered by the home health office as set forth in the description of the scope of services in Section II.1."

Access

Continuum provides no funds or plan for care of non-English speaking residents. Continuum application page 56, Section III.1.(b), states the proposed agency will have the ability to communicate in Spanish. However, the applicant provides no funds to pay for interpretation services in the proforma. Nor does the applicant provide a plan for recruitment of bi-lingual staff; it provides no correspondence with any organization that can aide in hiring Spanish speaking staff. According to a study by the US English Foundation, Mecklenburg County residents speak 68 languages. Please see Attachment B. Thus, to ensure access to all Mecklenburg County residents, applicants must demonstrate an arrangement to care for non-English and non-Spanish speaking residents.

Conclusion

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

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

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

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

Operational Projections

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

- On Continuum application page 46, Section III.1.(b), the applicant projects that in 2014, the applicant's second project year, approximately 457 Mecklenburg County residents will be in need of home health services. The applicant projects to serve all of this need. Because two new agencies will likely be approved as a result of the need determination in the 2012 SMFP, it is unreasonable to assume that Continuum will care for all of the unmet need.
- Continuum provides no assumption to explain how visits per episode will be separated into months of service. It assumes all episode visits will be completed in the year the episode starts. It is unreasonable to assume that a patient who begins a new episode in the last two months of a project year will complete all his/her visits in that time frame. A standard home health episode lasts 60 days. Not every patient in those two months will start care at the beginning of the period. Some will carry over.

Financial Projections

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

- The applicant's projections for utilization are unreasonable. Please see discussion above. Consequently, costs and revenues that are based on the applicant's utilization projections are unreliable.
- The applicant provides no detailed revenue assumptions for "Other" patients.
- On Continuum application page 111, the applicant projects 2012 Medicare reimbursement based on 2010 reimbursement estimates. The applicant assumes no deflation from 2010 to 2012. This is an inappropriate assumption. Non-LUPA Medicare episode reimbursement decreased in 2011 and 2012. Please see Attachment C.

- The applicant provides no bad debt assumptions for Project Year 2.
- The applicant failed to budget adequate expenses for utility costs in Form B. On application page 109, the applicant states that Rent/Utility costs will equal \$12,000 and \$12,400 in Project Years 1 and 2, respectively. This is only enough money to cover rent. The applicant's proposed lease agreement, in Continuum application Exhibit M, states that rent will cost \$1,000 per month (\$12,000 per year). However, utilities, including janitorial, are not covered in the proposed rent amount. Thus, the applicant did not budget for utilities in Form B. The applicant also did not budget for taxes. The applicant's proposed lease agreement, in application Exhibit M, states that

"the tenet is responsible for any taxes, documentary stamps or assessments of any nature imposed or assessed upon this Lease, Tenant's occupancy of the Premises or Tenant's trade fixtures, equipment, machinery, inventory, merchandise or other personal property located on the Premises and owned by or in the custody of Tenant as promptly as all such taxes or assessments may become due and payable without any delinquency, and shall pay all ad valorem property taxes which are now or hereafter assessed upon the Premises during the term of this Lease."

- The applicant's proposed agency space, 750 square feet, is too small for operational projections. As such, rent is underestimated. It is UniHealth management experience that this is too small to operate an agency with close to 500 unduplicated patients. United Home Care, Inc. operates 14 Medicare-certified home health agencies. Additionally, utilization projections support that the proposed agency would duplicate services of a second agency. Please see discussion in Criterion (5).
- The applicant does not include funds to pay for costs associated with accreditation through the Accreditation Commission for Home Care, Inc. (ACHC).
- The applicant failed to budget adequate expenses for appropriate levels of health manpower. Please see discussion in Criterion (7).
- The applicant failed to budget for a Medical Director. Please see discussion in Criterion (8).
- The applicant provides no funds to pay for interpretation services. Please see discussion in Criterion (3).

Conclusion

In conclusion, the applicant's operational and financial projections are unsupported and unreliable. As such, the application is non-conforming to Criterion (5).

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

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

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

The applicant does not show evidence of the availability of resources including health manpower and management personnel, for the provision of the services proposed for the following reason. Continuum does not budget for a registered nurse that can provide psychiatric home health services. On Continuum application page 15, Section II.1.(b), the applicant states that it will provide psychiatric nursing services. To qualify for Medicare reimbursement for a direct psychiatric patient admission, an agency must provide those services with a registered nurse that meets certain psychiatric care standards. Please see Attachment D. These nurses are specially trained and generally require high salaries. Continuum does not propose such a staff person.

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

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

- On Continuum application page 56, Section III.1.(b), the applicant states it will provide foreign language interpreter services. However, the applicant does not provide a copy of an executed contract or letter of intent from an interpreter service provider. As such, the applicant does not demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support service.
- The applicant does not provide evidence of a physician that is willing to serve on the agency's required advisory committee. An advisory committee is a requirement of Medicare Conditions of Participation (42 CFR 484.16)⁴.

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⁴ http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/xml/CFR-2011-title42-vol5-part484.xml#seqnum484.16

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

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

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

The applicant made no attempt to develop a relationship with area health professional training programs. As documented in Continuum application Exhibit K, the applicant attempted to develop a relationship with <u>only one</u> area health professional training programs. UniHealth identified at least 16 area health professional training programs that could be potential candidates for a training agreement. Clearly, the applicant spent no time trying to develop relationships with area health professional training programs and was trying to do the bare minimum to be deemed conforming to Criterion (14). UniHealth does not believe that an applicant that reached out to only one school, in a county with so many programs, has sufficiently demonstrated that the proposed agency will accommodate the clinical needs of health professional training programs in the area and should be found non-conforming to Criterion (14).

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

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

• The applicant does not demonstrate a need for each of the services it proposes in Section II.1. Please see discussion in Criterion (3).

- The applicant provides no plan, or funds, for care of non-English speaking residents. Please see discussion in Criterion (3).
- The applicant's projected costs are unreliable because they are based on unsupported and unreliable operational and financial projections. Please see discussion in Criterion (5).
- The applicant does not show evidence of the availability of resources including health manpower and management personnel, for the provision of the services proposed. Please see discussion in Criterion (7).
- The applicant does not demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. Please see discussion in Criterion (8).
- The applicant provides the second lowest access to Medicaid patients.
- The applicant provides the second lowest total salaries for Registered Nurses and Home Health Aides.

10A NCAC 14C .2000 Criteria and Standards for Home Health Services

10A NCAC 14C .2002 INFORMATION REQUIRED OF APPLICANT

- (a) An applicant shall identify:
 - (3) the projected total unduplicated patient count of the new office for each of the first two years of operation;

Projections are based on unreasonable assumptions. Please see discussion in Criterion (5) above.

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

Projections are based on unreasonable assumptions. Please see discussion in Criterion (5) above.

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

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

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

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

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

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

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

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

(b) An applicant shall specify the proposed site on which the office is proposed to be located. If the proposed site is not owned by or under the control of the applicant, the applicant shall specify an alternate site. The applicant shall provide documentation from the owner of the sites or a realtor that the proposed and alternate site(s) are available for acquisition.

The applicant is non-conforming to this Criterion. The applicant provides only one site. The site is not currently owned by, or under the control of, the applicant.

10A NCAC 14C .2003 PERFORMANCE STANDARDS

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

Projections are based on unreasonable assumptions. Please see discussion in Criterion (5) above.

10A NCAC 14C .2005 STAFFING AND STAFF TRAINING

(a) An applicant shall demonstrate that proposed staffing for the home health agency office will meet the staffing requirements as contained in 10A NCAC 13J which is incorporated by reference including all subsequent amendments. A copy of 10A NCAC 13J may be obtained from the Division of Health Service Regulation, Medical Facilities Licensure Section at a cost of two dollars and sixty cents (\$2.60).

As discussed in Criterion (7) above, the applicant fails to budget for a psychiatric nurse.

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

The applicant is non-conforming. The applicant does not provide copies of letters of interest, preliminary agreements, or executed contractual arrangements from person necessary to provide interpreter services or from a physician that is willing to serve on the agency's required advisory committee. Please see discussion in Criterion (8) above.

COMPETITIVE REVIEW OF – EMERALD CARE (EMERALD), F-10008-12

CON Review Criteria

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

Need

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

- Emerald does not demonstrate a need for each of the proposed services described in Section II.1. Section III.1.(a) instructs applicants to "describe, in specific terms, the unmet need that necessitated the inclusion of each of the proposed services to be offered by the home health office as set forth in the description of the scope of services in Section II.1."
- On Emerald application page 40, Section III.1.(b), the applicant projects that in 2013 between 2,514 and 3,575 Mecklenburg County residents in need of home health services will not be cared for by existing agencies. This is a gross exaggeration of the need and was calculated using an incorrect methodology. The applicant's methodology is based on the methodology utilized in the 2012 State Medical Facilities Plan (SMFP) to calculate home health. The 2012 SMFP methodology projects estimated patients to be served by existing agencies and subtracts that total from estimated county residents in need of home health care. If the existing agencies cannot fill the projected need then there is a deficit or need. When the deficit reaches 275 patients a need is triggered. On Emerald application pages 35 through 39, Section III.1.(b), the applicant provides two separate methodologies for projecting existing provider utilization in 2013. On Emerald application page 40, Section III.1.(b), the applicant subtracts the two estimates from estimated Mecklenburg County resident utilization calculated in the 2012 SMFP. However, the applicant did not accurately project existing provider utilization. In its attempt to do so, the applicant actually projected Mecklenburg County resident utilization. As such, when the applicant's projections are subtracted from the 2012 SMFP's projected 2013 provider utilization, the applicant projects a surplus. Please see Table 4 below.

Table 4 Emerald Need Calculation

	Emerald Methodology 1 (Linear Trend Analysis)	Emerald Methodology 2 (Four-Year Weighted Average)
2013 Total Home Health Patients Served, per the 2012 SMFP	18,065	18,065
2013 Patients in Need, Per Emerald application, p. 40	16,202	15,414
Deficit (-)/Surplus	1,863	2,651

• The applicant forecasts patients, but fails to project need for services in Project Year 2 (2014).

Access

Emerald does not adequately demonstrate the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed for the following reasons:

- The applicant's proposed access to Medicaid beneficiaries is below the county average. As stated on Emerald application page 63, Section VI.12, the applicant projects that 7.2 percent of visits will be covered by Medicaid. As noted in UniHealth application Exhibit 49, on average, 8.2 percent of visits provided by existing Mecklenburg County agencies were to Medicaid beneficiaries FY 2011.
- As discussed in Table 5, of UniHealth's attached letter to the CON Section, Maxim proposes the third lowest access to charity care at 0.32 percent of gross revenue. A rate far below the average for the applicant pool. The applicant pool average is approximately 0.72 percent of gross revenue.
- Emerald provides no funds or plan for care of non-English speaking residents. On Emerald application page 58, Section VI.3.(b), the applicant states it will provide foreign language interpreter services and hire Spanish-speaking staff members. However, the applicant does not demonstrate a relationship with an interpretation company willing to provide its services. Additionally, the applicant provides no plan for recruitment of bilingual staff and no correspondence with any organization that can aide in hiring Spanish speaking staff. According to a study by the US English Foundation, Mecklenburg County residents speak 68 languages. Please see Attachment B. Thus, to ensure access to all Mecklenburg County residents, applicants must demonstrate an arrangement to provide care for non-English speaking residents.

Conclusion

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

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

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

Although not licensed in Mecklenburg County, Emerald currently provides home health services to Mecklenburg County residents. Thus, approving Emerald would limit the amount of positive change that can occur by allowing a new provider into the market.

As discussed in UniHealth's attached letter to the CON Section, Emerald proposes to locate its agency in the center of Mecklenburg County and is a less effective alternative.

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

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

Operational Projections

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

- On Emerald application page 47, the applicant states that 0.1 percent of its unduplicated patients will be admitted to Occupational Therapy. This is not possible. The only three admitting disciplines are skilled nursing, physical therapy, and speech therapy⁵.
- The applicant does not provide duplicated patients in Table IV.2, as requested by the application. The applicant simply distributed unduplicated patients by service line.

⁵Medicare Benefit Policy Manual, Chapter 7- Home Health Services. http://www.cms.gov/Regulations-and-Guidance/Manuals/downloads/bp102c07.pdf

• The applicant's visits per patient, by payor type, are unreasonably high compared to agency history and current Mecklenburg County providers. Please see Table 5 below. Furthermore, the applicant provides no explanation why visits per patient, by payor type, increase from Project Year 1 to 2, or why the visits differ so markedly from its own history.

Table 5 - Visits per Patient Comparison

	a	b	С
Payor	Projected Year 2	Emerald – FY 2011	FY 2011 Mecklenburg County Average
Medicare	29.5	22.2	20.3
Medicaid	12.6	6.0	13.3
Commercial	32.2	19.2	13.3
Charity/Other	20.4	6.5	14.0

Notes:

- a) Emerald application page 48
- b) 2012 Licensure Renewal Application. Please see Attachment E.
- c) 2012 Licensure Renewal Application. Please see UniHealth application Exhibit 49.
- The applicant's proposed Medicare episodes per patient is unreasonably high based on a comparison of agency history and current Mecklenburg County providers. Please see Table 6 below.

Table 6 - Medicare Episodes per Patient Comparison

	a	b	С
Payor	Projected Year 2	Emerald Care – FY 2011	FY 2011 Mecklenburg County Median
Medicare Episodes per Patient	1.7	1.5	1.35

Notes:

- a) Emerald application page 903 and 913
- b) 2012 Licensure Renewal Application. Please see Attachment .
- c) 2012 Licensure Renewal Application. Please see UniHealth application Exhibit 49.
- The applicant's visit distribution by service line on Emerald application page 48, Section IV.3, does not match the applicant's detailed revenue assumptions provided in Emerald application Exhibit 31. Please see Table 7 below.

Table 7 - Emerald Visit Distribution Comparison

	a	b	С	d
Discipline	Project Year 1	Project Year 1	Project Year 2	Project Year 2
Nursing	38.00%	40.86%	38.00%	41.03%
Physical Therapy	43.90%	41.52%	43.90%	41.36%
Speech Therapy	5.70%	2.22%	5.70%	2.25%
Occupational Therapy	2.20%	5.70%	2.20%	5.71%
Medical Social Work	4.70%	4.42%	4.70%	4.40%
Home Health Aide	5.50%	5.28%	5.50%	5.26%

Notes:

- a) Emerald application page 48, Section IV.3
- b) Emerald application page 910, Exhibit 31
- c) Emerald application page 48, Section IV.3
- d) Emerald application page 919, Exhibit 31
- The applicant's Project Year 2 payor mix projections, as a percent of Patients, do not match throughout the document. Please see Table 8 below.

Table 8 – Emerald Payor Mix Comparison –As a Percent of Patients

Payor	Application Page 47	Application Page 64	Application Page 919
Medicare	70.1%	69.6%	69.7%
Medicaid	15.5%	15.6%	15.5%
Commercial	13.4%	11.3%	7.4%
Charity/Other/Private	0.5%	0.5%	7.4%
Total	99.5%	97.0%	100%

• The applicant's Project Year 2 payor mix projections, as a percent of visits, do not match throughout the document. Please see Table 9 below.

Table 9 - Emerald Payor Mix Comparison -As a Percent of Visits

Payor	Application Page 64	Application Page 919
Medicare	77.9%	77.9%
Medicaid	7.4%	7.4%
Commercial	14.3%	9.0%
Charity/Other/Private	0.4%	5.7%
Total	100%	100%

- Emerald assumed that all episode visits will be completed in the year the episode starts. This is an inappropriate assumption. It is unreasonable to assume that a patient who begins a new episode in the last two months of a project year will complete all his/her visits in that time frame. A standard home health episode lasts 60 days. Not every patient in those two months will start care at the beginning of the period. Some will carry over.
- Emerald failed to document that it will receive patient referrals sufficient to reach its projected number of patients. Both hospital systems located in Mecklenburg County operate strong home health programs. Furthermore, according to a recent MedPAC report, depending on hospitals for referrals is insufficient. According to the report, approximately 65 percent of home health admissions are from non-hospital referral sources⁶. As such, it is important that new agencies have established relationships with area providers for referrals. As discussed in UniHealth's attached letter to CON, volume is critical to a home health agency's success in today's market.

Financial Projections

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

- The applicant's projections for utilization are unsupported and unreliable. Please see discussion above. Consequently, costs and revenues that are based on the applicant's utilization projections are unreliable.
- On application page 83, Section X.7, the applicant states that it added a \$65 charge per Medicaid visit to its base charge for billable supplies. However, the applicant provides no basis for this assumption.
- On Emerald application pages 909 and 918, Emerald application Exhibit 31, the applicant provides a Project Year 1 and Project Year 2 salary break out for the clinical manager and the administrative staff. In the two breakouts the applicant budgets \$70,000 a year in bonuses. These bonuses are not accounted for in Form B.
- The applicant underestimated rent. The applicant included the rent calculation for its primary site. However, if the applicant's primary site is not available upon approval, the applicant will be forced to utilize its secondary site. The cost of the secondary site is approximately \$2,200 more a year (\$27,810-\$25,608=\$2,202).
- The applicant failed to budget adequate expenses for appropriate levels of health manpower. Please see discussion in Criterion (7).
- The applicant provides no funds to pay for interpretation services. Please see discussion in Criterion (3).

Conclusion

In conclusion, the applicant's operational and utilization projections are unsupported and unreliable. As such, the application is nonconforming to Criterion (5).

⁶ http://www.medpac.gov/documents/Mar12 EntireReport.pdf, page 220.

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

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

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

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

• The applicant's visits per Medical Social Worker (MSW) FTE are unreasonable. Table 10 below shows that Emerald's projected visits per FTE are well above national averages and the other competitors in this batch. Mecklenburg County is a large county and is home to approximately 9,800,000 residents. It can take over an hour to travel from one end of the county to the other when there is no traffic. The Charlotte urban area experiences the worst traffic congestion in the state and is 41st in the nation. Thus, this applicant did not adequately plan for the reality of the geography it intends to serve. If the applicant's visits per FTE were adjusted the applicant batch average, which is higher than the national average, Emerald would need 0.13 extra MSW FTEs to cover all proposed MSW visits, not considering paid time off. Please see Table 11.

Table 10 - MSW Visits per FTE Comparison

Applicant	MSW
Vizion	3.0
Maxim	3.5
HH-CMC	4.0
HKZ	
AssistedCare	3.5
Well Care	4.0
Emerald	5.0
Continuum	3.3
UniHealth	3.4
J and D	1.00
Applicant Average	3.71
National Average ⁷	3.48

Table 11 – MSW Staffing Calculation Utilizing the National Average Visits per Day

	а	b	С	D	е	f
Discipline	Projected FTEs	Visits / Day	Projected Visits	Days Worked per FTE per Year	FTEs Needed	FTEs not Budgeted (- = Surplus)
MSW	0.45	3.71	556	260	0.58	0.13

Notes:

- a) Table VII.2, Emerald application page 72
- b) Table__
- c) Table IV.2 Emerald application page 49
- d) Assumes 260 day work year
- e) c/b/d
- f) e-a

• The applicant failed to budget adequate expenses for physical therapy Staff. On Emerald application page 72, the applicant states that in Project Year 2 it will employ 3.40 physical therapists and 1.00 licensed physical therapist assistants with average annual salaries of \$94,585 and \$48,705, respectively. As such, the applicant should have budgeted approximately \$370,294 in salary expense for physical therapy staff ((3.40*94,585)+(1.00*48,705)). However, as shown on Emerald application page 940, the applicant budgets only \$332,459.

⁷ NAHC. http://www.nahc.org/facts/10HC Stats.pdf

- On application page 84, the applicant states that Clerical/Secretary staff and
 Dieticians will be available to the Charlotte office from the Gastonia office but no
 expenses are included in the Charlotte office. This is inappropriate. Some portion of
 the staff expenses should be allocated to the Charlotte office if they will be utilized
 by the office. Without the costs being allocated, the applicant is underestimating the
 agency costs.
- 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.

Ancillary and Support Services

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

- On Emerald application page 58, Section VI.3.(b), the applicant states it will provide foreign language interpreter services. However, the applicant does not provide a copy of an executed contract or letter of intent from an interpreter service provider. As such, the applicant does not demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support service.
- The applicant does not provide evidence of a physician that is willing to serve on the agency's required advisory committee. An advisory committee is a requirement of Medicare Conditions of Participation (42 CFR 484.16)⁸.

Coordination with Existing Health Care System

The applicant does not demonstrate that the proposed service will be coordinated with the existing health care system. As discussed in Criterion (5), Emerald failed to document a single referral from area healthcare providers and only provided seven letters of support from area health care providers. Furthermore, of the applicant's seven physician letters of support, six have no address.

Conclusion

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

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

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

As stated on Emerald application page 60, the applicant provided no charity care last year. This is reinforced by the applicant's 2012 home health licensure renewal application. Please see Attachment E. As noted in UniHealth application Exhibit 49, 1.4 percent of patients served by existing Mecklenburg County agencies were indigent in Federal Fiscal year (FY) 2011.

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

The applicant is non-conforming to this Criterion. As stated in Criterion (3), the applicant does not offer programs sufficient to care for non-English speaking residents, its access to Medicaid is below the current Mecklenburg County average, and its projected charity care is well below the average of the applicants in this batch. Please see discussion in Criterion (3).

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

The applicant will not increase competition in the proposed service area. Emerald currently provides home health services to Mecklenburg County residents. Thus, approving Emerald would limit the amount of positive change that can occur by allowing a new provider into the market. Please see discussion in Criterion (4).

If the CON Section disagrees with aforementioned conclusion the following reasons also why the proposed application will not have a have a positive impact upon the cost effectiveness, quality, and access to the services proposed for the following reasons:

- The applicant's projected Medicaid as a percent of visits is below the current Mecklenburg County average and is the lowest of all comparable applicants. Please see discussion in Criterion (3).
- The applicant offers minimal access to indigent patients. Please see discussion in Criterion (3).
- The applicant's minimal access to indigent patients is called into question when compared to historical data. In FY 2011, Emerald provided no access to indigent patients. Please see discussion in Criterion (13a).
- The applicant provides no plan, or funds, for care of non-English speaking residents. Please see discussion in Criterion (3).
- The applicant does not demonstrate a need for each of the services it proposes in Section II.1. Please see discussion in Criterion (3).
- The applicant's location in central Mecklenburg County will not increase geographic access. Please see discussion in Criterion (4).
- The applicant's projected costs are unreliable because they are based on unsupported and unreliable operational and financial projections. Please see discussion in Criterion (5).
- Geographically, the proposed project is in a location that duplicates services. Please see discussion in Criterion (6).
- The applicant does not show evidence of the availability of resources including health manpower and management personnel, for the provision of the services proposed. Please see discussion in Criterion (7).
- The applicant does not demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. Please see discussion in Criterion (8).

10A NCAC 14C .2000 Criteria and Standards for Home Health Services

10A NCAC 14C .2002 INFORMATION REQUIRED OF APPLICANT

- (a) An applicant shall identify:
 - (3) the projected total unduplicated patient count of the new office for each of the first two years of operation;

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

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

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

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

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

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

MSW projections are based on flawed and undocumented assumptions. Please see discussion in Criterion (7) above.

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

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

(8) the projected charge by payor source for each service discipline;

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

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

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

10A NCAC 14C .2003 PERFORMANCE STANDARDS

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

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

10A NCAC 14C .2005 STAFFING AND STAFF TRAINING

(a) An applicant shall demonstrate that proposed staffing for the home health agency office will meet the staffing requirements as contained in 10A NCAC 13J which is incorporated by reference including all subsequent amendments. A copy of 10A NCAC 13J may be obtained from the Division of Health Service Regulation, Medical Facilities Licensure Section at a cost of two dollars and sixty cents (\$2.60).

As discussed in Criterion (7), the applicant failed to budget adequate physical therapy, medical social work, clerical, and dietician staff.

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

The applicant is non-conforming. The applicant does not provide copies of letters of interest, preliminary agreements, or executed contractual arrangements from person necessary to provide interpreter services or from a physician that is willing to serve on the agency's required advisory committee. Please see discussion in Criterion (8) above.

COMPETITIVE REVIEW OF – HEALTHKEEPERZ OF MECKLENBURG (HKZ), F-10005-12

CON Review Criteria

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

Need

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

- HKZ does not demonstrate a need for each of the proposed services described in Section II.1. Section III.1.(a) instructs applicants to "describe, in specific terms, the unmet need that necessitated the inclusion of each of the proposed services to be offered by the home health office as set forth in the description of the scope of services in Section II.1."
- The applicant's independent need assessment of Mecklenburg County's projected home health need is incomplete. The applicant projects 2014 through 2016 Mecklenburg County home health need by growing projected county resident utilization annually by 5.98 percent from 2013 projections provided in Table 12C in the 2012 State Medical Facilities Plan (SMFP). This is inappropriate. An applicant must also project patients served by existing providers and subtract the total from anticipated Mecklenburg County resident home health service utilization. This is important because if existing provider utilization is growing faster than projected county resident utilization, the need for a new agency disappears.
- The applicant provides no independent need assessment for Union County for Project Years 1 through 3 (2014-2016).

Access

HKZ does not adequately demonstrate the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed because it provides no plan, or funds, for care of non-English speaking residents. According to a study by the US English Foundation, Mecklenburg County residents speak 68 languages. Please see Attachment B. Thus, to ensure access to all Mecklenburg County residents, applicants must demonstrate arrangements to care for non-English speaking residents.

Conclusion

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

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

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

As discussed in UniHealth's attached letter to the CON Section, HKZ is the only applicant that does not propose accreditation by a third-party. Accrediting bodies provide the structure and oversight necessary to ensure that patients always experience the safest, highest quality, best-value health care. As such, HKZ is a less effective alternative.

The absence of a Nurse Supervisor, or equivalent, and an OASIS Coordinator makes HKZ a less affective alternative. As discussed in Criterion (7), without a nurse supervisor, or equivalent, it is unclear who will handle admitting duties. All RN staff will need to be in the field making visits to meet workload projections. An on-site OASIS coordinator helps ensure timely and correct OASIS-C submission and allows field staff to receive immediate feedback on patient assessments and appropriate coding.

The shortage of care coordination staff will also make HKZ less responsive to CMS Medicare initiatives to reduce hospital readmissions. According to CMS Mecklenburg County's Presbyterian Hospital has one of the highest readmission rates in the state for CMS' three target diagnoses, Congestive Heart Failure (CHF), Acute Myocardial Infarction (AMI) and pneumonia. Mecklenburg County response to CMS efforts to reduce readmissions for CHF, AMI, pneumonia and Chronic Obstructive Pulmonary Disease (COPD), will require a home health agency with staff training, protocols and capacity to manage care and to coordinate community resources for this population. The missing care coordination services in the HKZ agency will make it less valuable to Mecklenburg County patients.

Reinforcement for this assumption can be found by examining the hospital admission rates from HKZ's existing home health operations. Based on data published on Medicare Home Health Compare as of August 17, 2012, HKZ's average hospital admission rate for its three existing agencies is approximately 37 percent. The average for North Carolina agencies is 26 percent. Please see Attachment F.

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

⁹ http://www.cms.gov/Medicare/Demonstration-

 $Projects/DemoProjects EvalRpts/downloads/CCTP_FourthQuartileHosps by State.pdf$

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

Operational Projections

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

- On HKZ application page 54, Section IV.3, the applicant projects 2014 Mecklenburg County home health service need as a percent of the 2013 Mecklenburg County home health service need projected in the 2012 SMFP. This is inappropriate. The need in 2014 is different from 2013. Please see UniHealth application Section III.1.(b).
- Because the applicant failed to correctly calculate the true home health need in Mecklenburg County, the applicant projected unreasonable patient estimates for Project Year 1 (2014). Based on a reasonable projection of need, UniHealth projects that 418 Mecklenburg County residents will need home health services in 2014. Please see Section III.1.(b) of UniHealth's application. HKZ projects to serve 282 unduplicated patients in 2014. Because two new agencies may be approved as a result of the need determination in the 2012 SMFP, it is unreasonable to assume that HKZ will care for approximately 68 percent of the unmet need (282/418*100=68%).
- Union County unduplicated patient projections on HKZ application page 56, Section III.1.(b), are arbitrary and based on unsubstantiated projections of need. Please see discussion in Criterion (3). The applicant arbitrarily asserts that it will serve 50 Union County residents a year in Project Years 1 through 3 and does not demonstrate the actual need in Union County during the project years.
- HKZ failed to document that it will receive patient referrals sufficient to reach its projected number of patients. HKZ Exhibit 18 includes three surveys that contain referral estimates. However, the responding providers estimate referring a maximum of 156 annual referrals. As such, annual referrals do not support the applicant's projected patient total of 395 patients in Project Year 2. Having established referral relationships is important in a competitive market like Mecklenburg County. Both hospital systems located in Mecklenburg County operate strong home health programs. Furthermore, according to a recent MedPAC report, depending on hospitals for referrals is insufficient. According to the report, approximately 65 percent of home health admissions are from non-hospital referral sources¹⁰. As such, it is important that new agencies have established relationships with area providers for referrals. As discussed in UniHealth's attached letter to CON, volume is critical to a home health agency's success in today's market.
- Throughout the HKZ application, the applicant attempts to validate its high projected Medicaid volume by stating that the proposed agency will serve a number of Medicaid incontinence patients like its three existing agencies. However, as discussed in Criterion (3), the applicant provides no documentation of need for incontinence services in Mecklenburg County.

¹⁰ http://www.medpac.gov/documents/Mar12 EntireReport.pdf, page 220.

Financial Projections

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

- The applicant's projections for utilization are unsupported and unreliable. Please see discussion above. Consequently, costs and revenues that are based on the applicant's utilization projections are unreliable.
- The applicant utilized inappropriate reimbursement rates for Medicaid. As such, the applicant overstated net Medicaid revenue by approximately \$13,400. Please see Table 12 below.

b d a e **Amount** Applicant's Reimburse-Total Over-**Discipline Visits Projected** ment Rate Revenue budgeted by Revenue **Applicant** SN \$103 668 \$69,024 \$4,834 \$73,858 РΤ \$110 415 \$45,484 \$51,173 \$5,689 OT \$110 23 \$2,521 \$2,810 \$289 ST \$110 82 \$8,987 \$10,057 \$1,070 **MSW** 5 \$0 \$872 \$872 HHA \$47 94 \$4,444 \$5,171 \$727 Total 1,287 \$130,461 \$143,941 \$13,480

Table 12 - HKZ Medicaid Calculation

Notes:

- a) NC DMA, http://www.ncdhhs.gov/dma/fee/home_health/hh_120701.pdf
- b) HKZ Application Page 121, Proforma Assumptions
- c) a*b
- d) HKZ Application Page 121, Proforma Assumptions
- e) d-c
- The applicant fails to budget supply costs for physical therapy, occupational therapy, speech therapy, and medical social work. The applicant provides no assumption for why this is reasonable.
- The applicant fails to budget travel costs for occupational therapy, speech therapy and medical social work. The applicant provides no assumption for why this is reasonable. By definition, visits will involve travel to patient homes.
- The applicant fails to budget adequate expenses for appropriate levels of health manpower. Please see discussion in Criterion (7).

Conclusion

In conclusion, the applicant's operational and financial projections are unreliable and unsupported. As such, the application is nonconforming to Criterion (5).

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

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

Additionally, utilization projections support that the proposed agency would duplicate services of a second agency. Please see discussion in 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.

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

- The applicant does not budget enough funds to support its occupational therapy visits in Project Year 2. The applicant budgets for only 530 visits and 546 visits are projected. On HKZ application page 92, the applicant states that in Project Year 2 an occupational therapist is paid \$77.00 per visit and that he/she will make 546 visits. As such, the applicant should have budgeted \$42,042 (\$77.00*546) for occupational therapy services. However, the applicant budgets only \$40,800. This will cover only 530 visits (40,880 / \$77.00).
- HKZ does not budget for a nurse supervisor or equivalent. As such, it is unclear who will handle admitting duties. According to HKZ estimates, all budgeted nursing staff must use all budgeted time for visits to provide enough coverage for the applicant's visit projections.

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

The applicant does not demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services for the following reason. On HKZ application page 9, Section II.1.(a), the applicant states that pharmacists will perform monthly reviews of the prescriptions of patients in the HealthKeeperz HealthSync Pharmacy Program and will coordinate delivery of medications. However, the applicant does not provide a copy of an executed contract or letter of intent from a pharmacist interested in providing these services nor are the services covered in the management contract provided in HKZ Exhibit 2.

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

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

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

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

- The applicant provides no plan, or funds, for care of non-English speaking residents. Please see discussion in Criterion (3).
- The applicant does not demonstrate a need for each of the services it proposes in Section II.1. Please see discussion in Criterion (3).

- HKZ is the only applicant that does not propose to be accredited by a third-party accrediting body. Accrediting bodies provide the structure and oversight necessary to ensure that patients always experience the safest, highest quality, best-value health care. As such, HKZ is a less effective alternative. Please see discussion in Criterion (4).
- The absence of care coordination staff decreases the proposed agency's ability to provide care management services and decreases the resultant opportunity for staff education. These missing care elements will make this agency less valuable to patients. Please see discussion in Criterion (4).
- The applicant's projected costs are unreliable because they are based on unsupported and unreliable operational and financial projections. Please see discussion in Criterion (5).
- The applicant does not show evidence of the availability of resources including health manpower and management personnel, for the provision of the services proposed. Please see discussion in Criterion (7).
- The applicant does not demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. Please see discussion in Criterion (8).

10A NCAC 14C .2000 Criteria and Standards for Home Health Services

10A NCAC 14C .2001 DEFINITIONS

10A NCAC 14C .2002 INFORMATION REQUIRED OF APPLICANT

- (a) An applicant shall identify:
 - (3) the projected total unduplicated patient count of the new office for each of the first two years of operation;

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

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

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

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

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

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

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

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

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

10A NCAC 14C .2003 PERFORMANCE STANDARDS

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

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

10A NCAC 14C .2005 STAFFING AND STAFF TRAINING

(a) An applicant shall demonstrate that proposed staffing for the home health agency office will meet the staffing requirements as contained in 10A NCAC 13J which is incorporated by reference including all subsequent amendments. A copy of 10A NCAC 13J may be obtained from the Division of Health Service Regulation, Medical Facilities Licensure Section at a cost of two dollars and sixty cents (\$2.60).

As discussed in Criterion (7) above, the applicant under budgets occupational therapy staff.

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

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

Please see discussion in Criterion (8) above.

COMPETITIVE REVIEW OF — HEALTHY @ HOME-CAROLINAS MEDICAL CENTER (HH-CMC), F-10004-12

CON Review Criteria

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

HH-CMC does not adequately demonstrate the need of the population to be served for the services proposed:

- HH-CMC does not demonstrate a need for each of the proposed services described in Section II.1. Section III.1.(a) instructs applicants to "describe, in specific terms, the unmet need that necessitated the inclusion of each of the proposed services to be offered by the home health office as set forth in the description of the scope of services in Section II.1."
- The applicant's independent need assessment of Mecklenburg County's projected home health need is unreasonable. On HH-CMC application page 68, Section III.1.(b), the applicant projects 2014 through 2016 Mecklenburg County home health need by age group by growing 2013 need projections provided in Table 12C in the 2012 State Medical Facilities Plan (SMFP) annually by Mecklenburg County's projected 2013-2016 population Compound Annual Growth Rate (CAGR) for each age group. HH-CMC application page 68, Section III.1.(b), states that it utilizes this methodology because carrying out the 2012 SMFP calculation into future years would project significantly greater need. The applicant is correct about this assumption. However, the applicant fails to account for the 2011 data that were available at the time applications were submitted, as were 2014 home health need projections from the Draft 2013 SMFP. 2014 need projections in the Draft 2013 SMFP show a significant drop in need. When the most recent population statistics, from the North Carolina Office of State Budget and Management, are incorporated into the Draft 2013 SMFP home health need methodology, Mecklenburg County shows an unmet need of 418 patients in 2014. Please see Section III.1.(b) of UniHealth's application. As such, the applicant over-estimated 2014 need by 284 patients (702-418=284).
- The applicant's need methodology is called into further question by its answer to application question III.5. On HH-CMC application page 80, Section III.5, the applicant states its belief that there are a sufficient number of home health agencies already serving Mecklenburg County. This contradicts one of the underlying assumptions in the applicant's need methodology: that patient need will outpace existing provider ability to serve the need.
- The applicant provides no independent need assessment for its secondary and tertiary service area counties for Project Years 1 through 3 (2014-2016).

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

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

HH-CMC currently provides home health services to Mecklenburg County residents. Thus, approving HH-CMC would limit the amount of positive change that can occur by allowing a new provider into the market.

HH-CMC proposes the lowest visits per unduplicated patient.

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

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

Operational Projections

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

- On HH-CMC application page 70, Section III.1.(b), the applicant provides a nine step methodology to project unduplicated and duplicated patients. For the following reasons this methodology is unsupported and unreasonable:
 - o The applicant provides no calculation tables to validate the numbers.
 - o The applicant inappropriately applies 2010 use rates. 2011 use rates were available in the *Draft 2013 SMFP* at the time the application was submitted. Use rates in all age groups except Age Group 65-74 decreased from 2010 to 2011. Please see Table 13 below.

Table 13 – North Carolina Average Home Health Use Rate Comparison

Age Group	2010 Use Rate	2011 Use Rate
Under 18	3.53	3.39
18-64	8.91	8.88
65-74	61.98	62.57
75+	168.77	167.54

- O Step 4 states that Federal Fiscal Year (FY) 2011 HH-CMC unduplicated patients by ZIP code were compared to the projected total ZIP code demand for home health for FY2011 from Step 3 to estimate HH-CMC's historical market share by ZIP code. However, according to Step 3, the applicant did not project need in 2011. It projected need for only 2012 through 2016. Furthermore, the applicant does not provide supporting 2011 population data by zip code in the application.
- Because the applicant failed to project home health need in Cabarrus County, the applicant projected unreasonable patient estimates for Project Year 1 (2014). Based on a reasonable projection of need, UniHealth projects that 37 Cabarrus County residents will need home health services in 2014. Please see Section Exhibit 74 of UniHealth's application. HH-CMC projects to increase its unduplicated Cabarrus County patients by 160 in 2014. This is unreasonable based on the projected need and would require HH-CMC to take a significant market share from existing area providers to meet these projections.
- The applicant fails to provide a single assumption that would allow a reviewer to recreate visit projections in Table IV.2 or payor projections in Section VI.12. The applicant simply states that projections are based on HH-CMC operating experience. A number of factors go into generating accurate and reliable visit projections, such as: readmission rate by payor type, episodes per Medicare admission, Medicare episode breakout, visits by payor type, and visits by payor type by service discipline. While UniHealth understands that these factors can be taken into account in a few different ways to generate visit estimates, UniHealth does not believe it is reasonable to provide no underlying assumptions. This is even truer for HH-CMC. As documented numerous times in HH-CMC's application, data reported to the Licensure section is consistently reported wrong, year after year. As such, a reviewer has no reason to believe that projections based on operating history are correct. For example, the applicant's projected visits as a percent of total visits provided on HH-CMC application page 103, Section VI.12, are very different from data provided in the applicant's 2012 licensure renewal application.

Financial Projections

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

- The applicant's projections for utilization are unreasonable. Please see discussion above. Consequently, costs and revenues that are based on the applicant's utilization projections are unreliable.
- It is impossible to validate the applicant's Medicaid, commercial, VA, charity, or self pay patient revenue projections or to determine if they are reasonable. First, the applicant provides no per visit reimbursement assumptions for Medicaid, commercial, VA, charity, or self pay patients. Second, the applicant provided no detailed utilization assumptions by payor. Visits by discipline differ by payor. As such, it is impossible to validate the applicant's gross and net revenue assumptions for Medicaid, commercial, VA, charity, or self pay patients.

- It is impossible to validate if the applicant's Medicare revenue projections are reasonable for the following reasons:
 - The applicant failed to provide detail utilization assumptions by payor. As such, it is impossible to verify projected Medicare patients.
 - o It is impossible to validate if the applicant's Medicare episode breakout is reasonable because the applicant failed to provide visits per Low Utilization Payment Adjustment (LUPA) episode and visits per Partial Episode Payment (PEP) episode assumptions. As such, it is impossible to convert visits to episodes to validate the episode breakout.
- On HH-CMC application page 129 the applicant states that it will utilize fleet cars for staff members traveling over 1,000 miles per month. The applicant failed to include any funds in capital cost estimates for additional fleet cars needed as a result of the proposed project.
- The applicant fails to budget adequate expenses for appropriate levels of health manpower. Please see discussion in Criterion (7).
- The applicant fails to budget funds for a physician to sit on its required advisory committee. Please see discussion in Criterion (8).

Availability of Funds

As discussed on HH-CMC application page 129, and detailed on HH-CMC application page 137, HH-CMC will operate with a negative profit of approximately \$490,000 in Project Year 2. On HH-CMC application page 129, the applicant states that the Charlotte-Mecklenburg Hospital Authority (CMHA) has historically and will continue to cover the losses from HH-CMC operations. However, the applicant fails to document that CMHA will have sufficient funds to cover the losses in the future. The applicant provides no forecasted financial statements for CMHA to validate that it is reasonable to assume funds will be available in 2014 and 2015.

Conclusion

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

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

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

Additionally, utilization projections suggest that the proposed agency would duplicate services in Cabarrus County. Please see discussion in 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.

The applicant does not show evidence of the availability of resources including health manpower and management personnel, for the provision of the services proposed because the applicant's FTE projections and staff salary projections are unreliable.

• FTE calculations in Table VII.2 for Registered Nurse (RN), Licensed Practical Nurse (LPN), licensed physical therapy assistant (LPTA), and part-time Registered Nurse (RN PRN) for Project Year 2 do not calculate correctly in Project Year 2. Projected FTEs in Table VII.2 Column 3 should total Column 1 + (Column 2(b)/2080). They do not for the aforementioned positions. Please see Table 14 below.

Employee Category	Proposed on Application Page 114	Correct Calculation	Proposed Less Correct
RN	18.8	16.8	2
LPN	2.5	3.8	-1.3
LPTA	5.8	5	0.8
RN PRN	2.2	3	-0.8

Table 14 - HH-CMC FTE Comparison - Project Year 2

on HH-CMC application page 114, Table VII.2, in Project Year 2, the applicant projects employing two FTE Directors of Professional Service at an average annual per employee salary of \$76,884. This is an annual cost of approximately \$153,768. On HH-CMC application page 135, the applicant budgets \$252,374 for expenses related to Directors of Professional Service salaries. The issue is the same in Project Year 1. There is no explanation of the discrepancy.

- On HH-CMC application page 114, Table VII.2, in Project Year 2, the applicant projects employing eight FTE Nurse Supervisors at an average annual per employee salary of \$64,591. This is an annual cost of approximately \$516,728. On HH-CMC application page 134, the applicant budgets \$670,498 for expenses related Supervisory salaries. The issue is the same in Project Year 1. There is no explanation of the discrepancy.
- The applicant under budgets for RN staff (including RN PRN) in Project Year 2. Multiplying RN and RN PRN FTEs provided in Column 3 of Table VII.2, on HH-CMC application page 114, by the salaries also provided in Table VII.2 the applicant under budgets costs in Form B, on HH-CMC application page 134, by approximately \$127,734. If RN and RN PRN FTEs are calculated by adding Column 1 + (Column 2(b)/2080) and multiplied by the same salaries, the applicant still under budgets costs by approximately \$50,558. Please see Table 15 below.

Table 15 - HH-CMC RN Salary Calculation - Project Year 2

	FTEs per Column 3 of Table VII.2	Salaries	Cost
RN	18.8	\$ 64,591	\$ 1,214,310.80
PRN	2.2	\$ 65,008	\$ 143,017.60
Total Cost			\$ 1,357,328.40
Total Cost in Form B			\$ 1,229,594.00
Amount Under Budget			\$ 127,734.40

	Corrected FTEs	Salaries	Cost
RN Cost	16.8	\$ 64,591	\$ 1,085,128.80
PRN Cost	3	\$ 65,008	\$ 195,024.00
Total Cost			\$ 1,280,152.80
Total Cost in Form B			\$ 1,229,594.00
Amount Under Budget			\$ 50,558.80

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

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

- The applicant does not provide evidence of a physician that is willing to serve on the agency's required advisory committee. An advisory committee is a requirement of Medicare Conditions of Participation (42 CFR 484.16)¹¹.
- On HH-CMC application page 135 that applicant states that some portion of "other" costs in Form B are for interpretation services. However, the applicant fails to document a person or company able to provide interpretation services.
- 14. The applicant shall demonstrate that the proposed health services accommodate the clinical needs of health professional training programs in the area, as applicable.

The applicant provides no existing contracts or correspondence from/ to area health professional training programs documenting that the proposed agency will accommodate the clinical needs of area health professional training programs. As such, the applicant is non-conforming to Criterion (14).

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

The applicant will not increase competition in the proposed service area. HH-CMC currently provides home health services to Mecklenburg County residents. Thus, approving HH-CMC would limit the amount of positive change that can occur by allowing a new provider into the market. Please see discussion in Criterion (4).

If the CON Section disagrees with aforementioned conclusion the following reasons also explain why the proposed application will not have a have a positive impact upon the cost effectiveness, quality, and access to the services proposed:

- The applicant does not demonstrate a need for each of the services it proposes in Section II.1. Please see discussion in Criterion (3).
- The applicant offers the lowest visits per unduplicated patient. Please see discussion in Criterion (4).

¹¹ http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/xml/CFR-2011-title42-vol5-part484.xml#seqnum484.16

- The applicant's projected costs are unreliable because they are based on unsupported and unreliable operational and financial projections. Please see discussion in Criterion (5).
- The applicant does not show evidence of the availability of resources including health manpower and management personnel, for the provision of the services proposed. Please see discussion in Criterion (7).
- The applicant does not demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. Please see discussion in Criterion (8).
- The applicant does not document that the proposed agency will accommodate the clinical needs of area health professional training programs. Please see discussion in Criterion (14).

10A NCAC 14C .2000 Criteria and Standards for Home Health Services

10A NCAC 14C .2002 INFORMATION REQUIRED OF APPLICANT

- (a) An applicant shall identify:
 - (3) the projected total unduplicated patient count of the new office for each of the first two years of operation;

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

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

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

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

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

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

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

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

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

10A NCAC 14C .2003 PERFORMANCE STANDARDS

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

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

10A NCAC 14C .2005 STAFFING AND STAFF TRAINING

- (a) An applicant shall demonstrate that proposed staffing for the home health agency office will meet the staffing requirements as contained in 10A NCAC 13J which is incorporated by reference including all subsequent amendments. A copy of 10A NCAC 13J may be obtained from the Division of Health Service Regulation, Medical Facilities Licensure Section at a cost of two dollars and sixty cents (\$2.60).
 - As discussed in Criterion (7) above, for multiple reasons it is impossible to verify the applicant's proposed staffing.
- (b) An applicant shall provide copies of letters of interest, preliminary agreements, or executed contractual arrangements between the proposed home health agency office and each health care provider with which the home health agency office plans to contract for the provision of home health services in each of the counties proposed to be served by the new office.

The applicant is non-conforming. The applicant does not provide copies of letters of interest, preliminary agreements, or executed contractual arrangements from person necessary to provide interpreter services or from a physician that is willing to serve on the agency's required advisory committee. Please see discussion in Criterion (8) above.

COMPETITIVE REVIEW OF — MAXIM HEALTHCARE SERVICES (MAXIM), F-10003-12

CON Review Criteria

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

Need

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

- Maxim does not demonstrate a need for each of the proposed services described in Section II.1. Section III.1.(a) instructs applicants to "describe, in specific terms, the unmet need that necessitated the inclusion of each of the proposed services to be offered by the home health office as set forth in the description of the scope of services in Section II.1." It should also be noted that in Section II, Maxim application page 15, Maxim lists many services like grocery shopping and sitter services that are not eligible for reimbursement in the home health agency program.
- The applicant's independent need assessment of Mecklenburg County's projected home health need is incomplete. On Maxim application page 49, Section III.1.(b), Maxim bases 2013 Mecklenburg Count home health need on the 2012 State Medical Facilities Plan (SMFP) methodology. The applicant projects 2014 and 2015 Mecklenburg County home health need by growing projected county resident utilization by 1.8 percent from 2013 to 2014 and by 1.8 percent from 2014 to 2015. This is inappropriate. An applicant must also project patients served by existing providers and subtract the total from anticipated patients in need of home health services. This is important because if existing provider utilization is growing faster than projected utilization the need for a new agency disappears.

Access

Maxim does not adequately demonstrate the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed for the following reasons:

Maxim provides no funds or plan for care of non-English speaking residents. On
Maxim application page 12, the applicant states it will provide foreign language
interpreter services and hire Spanish-speaking staff members. However, the applicant
provides no funds to pay for interpretation services. Additionally, the applicant

provides no plan for recruitment of bi-lingual staff and no correspondence with any organization that can aide in hiring Spanish speaking staff. According to a study by the US English Foundation, Mecklenburg County residents speak 68 languages. Please see Attachment 3. Thus, to ensure access to all Mecklenburg County residents, applicants must demonstrate an ability to care for non-English speaking residents.

• As discussed in Table 5, of UniHealth's attached letter to the CON Section, Maxim proposes the second lowest access to charity care at 0.28 percent of gross revenue. A rate far below the average for the applicant pool. The applicant pool average is approximately 0.72 percent of gross revenue.

Conclusion

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

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

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

As discussed in Table 7, of UniHealth's attached letter to the CON Section, Maxim proformas show significant profit compared to those of its competitors. The high profits are attributed to offering fewer care coordination and administrative staff, low staff benefits, and almost no charity care.

The shortage of care coordination staff will also make Maxim less responsive to CMS Medicare initiatives to reduce hospital readmissions. CMS lists Mecklenburg County's Presbyterian Hospital as having one of the highest readmission rates in the state for its three target diagnoses, Congestive Heart Failure (CHF), Acute Myocardial Infarction (AMI) and pneumonia. Mecklenburg County response to CMS efforts to reduce readmissions for CHF, AMI, pneumonia and Chronic Obstructive Pulmonary Disease (COPD), will require a home health agency with staff training, protocols and capacity to manage care and to coordinate community resources for this population. The missing care coordination services in the Maxim agency will make it less valuable to Mecklenburg County patients.

¹² http://www.cms.gov/Medicare/Demonstration-

Projects/DemoProjectsEvalRpts/downloads/CCTP_FourthQuartileHospsbyState.pdf

Reinforcement for this assumption can be found by examining the hospital admission rates from Maxim's existing home health operations. Based on data published on Medicare Home Health Compare as of August 17, 2012, Maxim's average hospital admission rate for its two existing facilities is approximately 43 percent. The average for North Carolina agencies is 26 percent. Please see Attachment F.

As discussed in UniHealth's attached letter to the CON Section, Maxim proposes to locate its agency in the center of Mecklenburg County and is a less effective alternative.

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

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

Operational Projections

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

- Because the applicant failed to correctly calculate the true home health need in Mecklenburg County, the applicant projected unreasonable patient estimates for Project Year 2 (2014). Based on a reasonable projection of need, UniHealth projects that 418 Mecklenburg County residents will need home health services in 2014. Please see Section III.1.(b) of UniHealth's application. Maxim projects to serve 502 unduplicated patients in 2014. As such, the applicant projected utilization that surpasses the need.
- Maxim provides no assumption to explain how visits per episode will be separated into months of service. It assumes all episode visits will be completed in the year the episode starts. It is unreasonable to assume that a patient who begins a new episode in the last two months of a project year will complete all his/her visits in that time frame. A standard home health episode lasts 60 days. Not every patient in those two months will start care at the beginning of the period. Some will carry over.
- Maxim provides no methodology or assumption for estimating duplicated patients in Table IV.2 on Maxim application page 68.
- Maxim failed to document a single patient referral. The absence of demonstrated referrals for older patients will require extra marketing and outreach costs. Developing referral relationships commensurate with the proposed service program is critical in a competitive market like Mecklenburg County. Both hospital systems located in Mecklenburg County operate strong home health programs. Furthermore, according to a recent MedPAC report, depending on hospitals for referrals is insufficient. According to the report, approximately 65 percent of home health

admissions are from non-hospital referral sources¹³. As such, it is important that new agencies have established relationships with area providers for referrals. As discussed in UniHealth's attached letter to CON, volume is critical to a home health agency's success in today's market.

• Almost all utilization assumptions are based on Maxim corporate history. The applicant provides no documentation for any of the assumptions.

Financial Projections

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

• Medicare revenue is overstated by approximately \$163,348 in Project Year 2. Please see Table 16 below.

Table 16 - Maxim Medicare	Revenue Calculation	Comparison
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Notes		Project Year 2	
a	Applicant's projected YR 2 Medicare Revenue	\$ 1,353,192	
b	UniHealth's calculation of YR 2 Medicare Revenue	\$ 1,189,844	
С	Amount Maxim over budgeted	\$ 163,348	

Notes:

- a) Form B. (\$1,395,043 \$41,851 = \$1,353,192)
- b) Attachment G.
- c) a-b
- Medicaid revenue is overstated by approximately \$24,000 in Project Year 2. Please see Table 17 below.

Table 17 - Maxim Medicaid Revenue Calculation Comparison

Notes		Project Year 2	
a	Applicant's projected YR 2 Medicaid Revenue	\$ 108,471	
b	UniHealth's calculation of YR Medicaid Revenue	\$ 84,464	
С	Amount Maxim over budgeted	\$ 24,007	

Notes:

- a) Form B. (\$114,180 -\$5,709 = \$108,471)
- b) Attachment G.
- c) a-b

¹³ http://www.medpac.gov/documents/Mar12 EntireReport.pdf, page 220.

- The applicant provides no charity care assumptions. Charity care deductions are significantly greater than gross charity care revenue. As shown in Form B, the applicant projects gross charity care revenue of \$3,818 and \$4,512 in Project Year 1 and Project Year 2, respectfully. As also shown in Form B, the applicant projects gross charity care deductions from revenue of \$10,315 and \$24,325 in Project Year 1 and Project Year 2, respectfully. This is important because the applicant's charity care, as a percent of gross revenue, drops from approximately 1.49 percent annually to 0.28 percent in Project Year 2. As such, Maxim offers the second lowest percentage of charity care.
- Maxim provides no inflation assumptions for Medicaid and commercial insurance reimbursement.
- Maxim provides no assumption to calculate rent. Furthermore, because the applicant does not provide a rent assumption, one is left to estimate how much space will be utilized for home health operations. By dividing proposed rent by total rent due for the suite UniHealth estimates that the proposed agency will occupy approximately 915 square feet. Please see Table 18 below. It is UniHealth management experience that this is too small to operate an agency with over 500 unduplicated patients. United Home Care operates 14 Medicare-certified home health agencies.

Table 18 - Square Footage Calculation

Notes		Project Year 1	Project Year 2
а	Proposed Home Health Agency Rent	17,545	18,070
b	Total Suite Rent	\$ 53,948.88	\$ 55,567.32
С	Agency Rent as a Percent of Total Suite Rent	32.5%	32.5%
d	Total Suite Square Footage	2,816	2,816
е	Proposed Home Health Agency Square Footage	915	915

Notes:

- a) Form B
- b) Maxim application Exhibit 2
- c) a/b*100
- d) Maxim application Exhibit 2
- e) c*d
- The applicant's initial operating expense cannot be validated because the applicant provided no cash flow or any cash flow assumptions.
- On Maxim application page 12, Section II.1.(b), the applicant states it will provide foreign language interpreter services. However, the applicant provides no funds to pay for interpretation services.
- The applicant fails to budget adequate expenses for appropriate levels of health manpower. Please see discussion in Criterion (7).

Availability of Funds

The applicant provides audited financial statements as of December 31, 2010 and 2009. The application was submitted July 16, 2012. As such, the applicant provides financial statements that are 18 months old. An 18 month lag on financial data is far too long to validate an applicant's available cash. It is of particular concern for Maxim. On Maxim application page 111, Section VIII.2, and page 115, Section IX.2, the applicant states that it will be pay for all capital costs and working capital costs with cash. Audited financial statements in Exhibit 16 stated that as of December 31, 2010, Maxim had cash and cash equivalents of \$30,775,460. However, in September 2011, Maxim agreed to pay \$150 million dollars to resolve criminal and civil probes of fraudulently overbilling federal and state governments. Please see Attachment H. As such, financial statements more recent than December 31, 2010 should have been provided to demonstrate availability of cash for the proposed project.

Conclusion

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

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

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

Additionally, utilization projections suggest that the proposed agency would duplicate services of a second approved agency. Please see discussion in 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.

The applicant does not show evidence of the availability of resources including health manpower and management personnel, for the provision of the services proposed and is non-conforming to Criterion (7) for the following reason. The applicant has not budgeted for appropriate levels of administrative staff. According to the applicant's proposed organization chart provided in Maxim application Exhibit 3, the applicant under staffed Administrator, Branch Manager, Medical Records, Secretary FTEs. Please see Table 19 below.

Table 19 – Maxim Administrative Staff Comparison

Staff Position	FTEs Needed Per Maxim Organizational Chart	Budgeted FTEs –Project Year 2		
Administrator	1	0.33		
Branch Manager	1	0.50		
Medical Records	1	0.25		
Secretary (Personnel Coordinator)	1	0.20		

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.

Ancillary and Support Services

On Maxim application page 12, Section II.1.(b), the applicant states it will provide foreign language interpreter services. However, the applicant does not provide a copy of an executed contract or letter of intent from an interpreter service provider. As such, the applicant does not demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support service.

Coordination with the Existing Health Care System

The applicant does not demonstrate that the proposed service will be coordinated with the existing health care system. As discussed in Criterion (5), Maxim failed to document a single referral from area healthcare providers and only provided seven letters of support from area health care providers. Furthermore, of the applicant's seven physician letters of support, six have no address.

Conclusion

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

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

The applicant is non-conforming to this Criterion. As stated in Criterion (3), the applicant does not offer programs sufficient to care for non-English speaking resident and offers minimal access to indigent patients. Please see discussion in Criterion (3).

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

The applicant made no attempt to develop a relationship with area health professional training programs. As documented on Maxim application page 80, Section V.1.(a), the applicant attempted to develop a relationship with <u>only one</u> area health professional training program. UniHealth identified at least 16 area health professional training programs that could be potential candidates for a training agreement. Clearly, the applicant spent no time trying to develop relationships with area health professional training programs and was trying to do the bare minimum to be deemed conforming to Criterion (14). UniHealth does not believe that an applicant that reached out to only one school, in a county with so many programs, has sufficiently demonstrated that the proposed agency will accommodate the clinical needs of health professional training programs in the area and should be found nonconforming to Criterion (14).

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

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

- The applicant provides no plan, or funds, for care of non-English speaking residents. Please see discussion in Criterion (3).
- The applicant offers minimal access to indigent patients. Please see discussion in Criterion (3).
- The applicant does not demonstrate a need for each of the proposed services described in Section II.1. Please see discussion in Criterion (3).
- The applicant's location in central Mecklenburg County will not increase geographic access. Please see discussion in Criterion (4).
- The applicant's projected costs are unreliable because they are based on unsupported and unreliable operational and financial projections. Please see discussion in Criterion (5).
- The applicant did not adequately demonstrate the availability of sufficient funds for capital and operating needs. Please see discussion in Criterion (5).
- The applicant does not show evidence of the availability of resources including health manpower and management personnel, for the provision of the services proposed. Please see discussion in Criterion (7).
- The applicant does not demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. Please see discussion in Criterion (8).
- The applicant did not demonstrate that the proposed agency will accommodate the clinical needs of health professional training programs in the area. Please see discussion in Criterion (14).

10A NCAC 14C .2000 Criteria and Standards for Home Health Services

10A NCAC 14C .2002 INFORMATION REQUIRED OF APPLICANT

- (a) An applicant shall identify:
 - (3) the projected total unduplicated patient count of the new office for each of the first two years of operation;

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

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

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

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

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

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

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

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

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

10A NCAC 14C .2003 PERFORMANCE STANDARDS

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

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

10A NCAC 14C .2005 STAFFING AND STAFF TRAINING

(a) An applicant shall demonstrate that proposed staffing for the home health agency office will meet the staffing requirements as contained in 10A NCAC 13J which is incorporated by reference including all subsequent amendments. A copy of 10A NCAC 13J may be obtained from the Division of Health Service Regulation, Medical Facilities Licensure Section at a cost of two dollars and sixty cents (\$2.60).

As discussed in Criterion (7) above, the applicant does not budget for appropriate levels of administrative staff.

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

The applicant is non-conforming. The applicant does not provide copies of letters of interest, preliminary agreements, or executed contractual arrangements from person necessary to provide interpreter services. Please see discussion in Criterion (8) above.

COMPETITIVE REVIEW OF – VIZION ONE (VIZION), F-10001-12

CON Review Criteria

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, ambulatory surgery operating rooms, or home health offices that may be approved.

This applicant used an older form of the home health agency CON application. Hence, in some sections the information provided is difficult to compare to other applicants. For that reason, this application should be eliminated on the basis of a comparative review.

Policy GEN-3: BASIC PRINCIPLES, requires an applicant to:

"demonstrate ...how the project will promote safety and quality, ...while promoting equitable access and maximizing healthcare value for resources expended ...shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services."

Vizion provides a very limited answer to Question VI.3, Vizion application page 73, which asks for a description of the availability of services to groups with limited financial access. The application indicates only that it will not discriminate on the basis of age, disability, gender, race, payor source or ability to pay. The response to Question VI.4 asks the reader to hunt for the Charity policy somewhere in the application. It is on Vizion application page 55, and indicates that care for patients with limited ability to pay will be limited to the amount designated for that purpose by the agency. Such amount is loosely defined as approximately 1.4 percent (Vizion application page 53). The application indicates that "Vizion has the financial ability to fund whatever level of indigent care is required." However, this is contradicted in the financial information in the application. See discussion in Criterion 5. Although Vizion claims to be an existing home care agency, the application contains no evidence of charity care in that existing agency.

Vizion forecasts a high percent bad debt (five percent of commercial insurance) or 1.9 percent of Gross revenue. It is difficult to tell from the proformas, which begin on Vizion application page 131, if this is true bad debt or commercial contractual allowance. The revenue summary presents it as contractual allowance and the detail shows it as bad debt. With no supporting information from the existing agency, the application contains no foundations against which to validate the assertion. The application provides no supporting information from other home health agencies owned by the applicant.

The application contains no documentation of efforts to reach out to referral groups that serve persons of limited means. Letters of support in Vizion application Exhibit 3 are from vendors who assisted with the home care office opening and a transportation franchise that serves a Vizion company in Kansas (Vizion application page 242). Other letters reference home care services in Washington, DC. Patient letters appear to reference home care services, not home health agency services. Vizion application page 256 specifically mentions personal care services. Though important, personal care services are far less clinically complex than home health agency services.

In Vizion application Exhibit 5, the application presents a table suggesting that Vizion operates full service home health agencies in Massachusetts and Pennsylvania. On August 23, 2012, the Medicare Compare Home Health Agency website did not list a Vizion Home Health Agency in Worcester, Massachusetts or Philadelphia, Pennsylvania. A close examination of the response to Question I.11.(d) suggests that Vizion may not have experience operating a home health agency. That response indicates experience with "home and community and home health services."

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

Need

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

- Vizion does not adequately demonstrate a need for each of the proposed services described in Section II.1. In Section III.1.(b), the applicant attempts to validate the need for specialized home health services by providing descriptions of services typically offered in a generic Medicare-certified home health agency. The application makes no attempt to correlate needs of the population to be served with the services to be offered. Disease discussions are generic to home health agencies in the United States or to residents of North Carolina. Section III.1.(a) instructs applicants to "describe, in specific terms, the unmet need that necessitated the inclusion of each of the proposed services to be offered by the home health office as set forth in the description of the scope of services in Section II.1."
- On Vizion application page 50, Section III.1.(b), the applicant makes a limited attempt at a statistical projection of need for Mecklenburg County. However, the applicant stops at 2013. Services proposed extend to 2014. Furthermore, the applicant only projects county residents in need of home health services in 2013. This is inappropriate. An applicant must also project patients served by existing providers and subtract the total from anticipated patients in need of home health services. This is important because if existing provider utilization is growing faster than projected utilization the need for a new agency disappears.

 On Vizion application page 6, the applicant indicates that its secondary service area is a 60-mile radius of Mecklenburg County. However, the applicant provides no discussion of need for these areas.

Access

Vizion does not adequately demonstrate the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed for the following reasons:

• This application proposes the lowest percentage of patients who are Medicare beneficiaries of all applicants in the batch. Please see Table 20 below. This is inconsistent with the discussion of home health agency need in Section III of the application, which focuses on persons over 75. The applicant's projections are also lower than the current Mecklenburg County average (58 percent). Please see UniHealth application Exhibit 49.

Table 20 - Applicant Medicare Comparison - Project Year 2

Applicant	Medicare Patients as a Percent of Total Duplicated Patients
Vizion	53.00%
Continuum	58.03%
AssistedCare	58.20%
HKZ	58.30%
Well Care	60.00%
нн-смс	64.40%
Maxim	67.90%
Emerald	69.60%
UniHealth	74.61%
J&D	89.00%

• Vizion provides no funds or plan for care of non-English speaking residents. On Vizion application page 24, Section II.1.(b), the application lists a need for language assistance, but includes no budget or plan to support it. The applicant provides no plan for recruitment of bi-lingual staff and no correspondence with any organization that can aide in hiring Spanish speaking staff. According to a study by the US English Foundation, Mecklenburg County residents speak 68 languages. Please see Attachment B. Thus, to ensure access to all Mecklenburg County residents, applicants must demonstrate an ability to care for non-English speaking residents.

Conclusion

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

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

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

Vizion proposes the lowest salaries and the lowest benefits of all applicants. For example, nurse salaries and benefits are \$71,754.97 compared to the batch median of \$85,199.08. This will make it difficult for this applicant to compete for qualified, trained staff. Because Vizion shows no evidence of experience with home health agency services or home office capacity to support a new agency with policies, procedures and training, low salaries will make it particularly vulnerable.

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

Operational Projections

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

- Because the applicant failed to correctly calculate the true home health need in Mecklenburg County, the applicant projected unreasonable patient estimates for Project Year 2 (2014). Based on a reasonable projection of need, UniHealth projects that 418 Mecklenburg County residents will need home health services in 2014. Please see Section III.1.(b) of UniHealth's application. Vizion projects to serve 325 unduplicated patients in 2014. Because two new agencies may be approved as a result of the need determination in the 2012 State Medical Facilities Plan (SMFP), it is unreasonable to assume that Vizion will care for approximately 78 percent of the unmet need (325/418*100=78%).
- The applicant provides no assumption to validate its unduplicated patient fill-up on Vizion application page 107.

- On Vizion application page 106, the applicant calculates unduplicated patients by admitting discipline by multiplying projected unduplicated patients by the percent of total visits that were Physical Therapy (PT), Speech Therapy (ST), and Skilled Nursing (SN) in Mecklenburg County in 2009. This is an unreasonable assumption. This methodology is comparing apples and oranges. As the applicant itself notes on Vizion application page 105, once patients are admitted to either PT, ST, SN, they can receive services from PT, ST, Occupational Therapy (OT), SN, Home Health Aide (HHA), and Medical Social Worker (MSW). As such, it is impossible to tell admitting discipline by looking at visits.
- Vizion failed to document a single patient referral. The absence of demonstrated referrals for older patients will require extra marketing and outreach costs. Developing referral relationships commensurate with the proposed service program is critical in a competitive market like Mecklenburg County. Both hospital systems located in Mecklenburg County operate strong home health programs. Furthermore, according to a recent MedPAC report, depending on hospitals for referrals is insufficient. According to the report, approximately 65 percent of home health admissions are from non-hospital referral sources¹⁴. As such, it is important that new agencies have established relationships with area providers for referrals. As discussed in UniHealth's attached letter to CON, volume is critical to a home health agency's success in today's market.
- On Vizion application page 104, Section XII, the applicant states that the agency will be certified only eight days after the proposed agency is licensed. That is an unreasonable estimate. It will take at least a month to get Certification Section recommendation approval. An agency cannot even get on the review schedule until it has served 10 patients¹⁵. Additionally, once the Certification Section recommends approval, it is another one to three months for a Medicare number to be issued. Please see Attachment I.
- Vizion provides no assumption to explain how visits per episode will be separated into months of service. It assumes all episode visits will be completed in the year the episode starts. It is unreasonable to assume that a patient who begins a new episode in the last two months of a project year will complete all his/her visits in that time frame. A standard home health episode lasts 60 days. Not every patient in those two months will start care at the beginning of the period. Some will carry over.
- The applicant's estimate of Low Utilization Payment Adjustment (LUPA) at 1.63 percent of total episodes is unreasonable. In Federal Fiscal Year (FY) 2011, the Mecklenburg County median was 13.36 percent and in Calendar Year (CY) 2011, United Home Care's average was 8.27 percent. Please see UniHealth application Exhibit 49. The applicant appears to have multiplied projected Medicare episodes by a percent of Medicare gross revenue that was LUPAs for existing agencies that served Mecklenburg County residents in FY 2009. This is inappropriate. The percent of gross revenue will be much smaller than the percent of episodes because the LUPA payment is much less than a full episode.

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¹⁴ http://www.medpac.gov/documents/Mar12_EntireReport.pdf, page 220.

¹⁵ http://www.ncdhhs.gov/dhsr/ahc/flohh.htm

Financial Projections

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

- The applicant's projections for utilization are unsupported and unreliable. Please see discussion above. Consequently, costs and revenues that are based on the applicant's utilization projections are unreliable.
- The applicant's start-up costs are unreliable. On Vizion application page 118, Proforma Assumptions, the applicant projects three months of start-up expenses beginning in October 2012. However, the applicant does not project CON approval until November 2012. Furthermore, direct expenses are based on serving 10 patients at 25 visits per patient during the three month period. This is an unreasonable assumption. The applicant will not be able to serve patients until it is licensed. The applicant projects licensure on December 20, 2012.
- The applicant under budgeted its capital costs. Furniture allowance is too sparse to permit all field staff to be seated in the office at the same time. Additionally, the Depreciation Schedule (Vizion application page 117) includes three computers that are not listed in the Section VIII.1 capital costs.
- The application lists a telehealth program, but includes no budget for it.
- On application page 71, Section VI.2, the applicant claims that it will pursue CHAP accreditation, but includes no budget for it.
- On Vizion application page 24, Section II, the applicant lists a need for language assistance, but includes no budget to support it.
- The application asserts that Vizion has an existing lease, but the application in Section XI.1, Vizion application page 102, fails to produce it, noting that it will be "provided on request." Thus, it is impossible to verify the applicant's projections for cost of space.
- The applicant fails to budget supply costs for physical therapy, occupational therapy, speech therapy, and medical social work. The applicant provides no assumption for why this is reasonable.
- The applicant fails to budget adequate expenses for appropriate levels of health manpower. Please see discussion in Criterion (7).
- By underestimating LUPA episodes the applicant inflated revenue projections.
 Please see discussion above.

Availability of Funds

On Vizion application page 263, Vizion Exhibit 4, the application contains a letter from Tileta Venable, Operational Manager, indicating that Vizion One, Inc. has \$486,857 in cash reserves available to fund the project. The letter has no date and it does not commit those funds to the project, or indicate that this person has authorization to commit funds. In fact, the signature page for the application suggests that this person is not an officer in the company. Vizion application page 6, Section I.9.(a), lists three officers in the company. Vizion application page 87, Section VIII, indicates that the Vizion One, Inc. Balance Sheet on December 31, 2011 had adequate cash for the fixed capital, but the application is not directly signed by an officer of the company and the application contains no correspondence from an officer committing funds from the balance sheet to the project. Moreover, Vizion application Exhibit 4 suggests that at the time of the application, Vizion One, Inc. had only \$486,857 in cash reserves. This is \$89,505 less than required to cover fixed and working capital requirements (Section VIII.1 + IX.1 = \$576,362 required for fixed and working capital). The balance sheet on Vizion application page 96, Proforma Form A, shows a total of \$560,064 in "Additional Contributed Capital" over the first two years, but the application does not explain the source of these funds.

Conclusion

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

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

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

Additionally, utilization projections support that the proposed agency would duplicate services of a second approved agency. Please see discussion in 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.

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

- The applicant under budgets for Clerical staff. On Vizion application page 98, the applicant budgets \$60,000 and \$61,500 for Clerical salaries in Project Year 1 and 2, respectively. Based on the Clerical FTEs and corresponding salaries provided on Vizion application page 76 and 77, Table VII.2, the applicant under budgeted by \$600 and \$615 in Project Year 1 and 2, respectively. This is approximately 0.2 FTEs annually.
- Section VII.7 describes 24/7 staff availability but does not explain how the staffing pattern makes this workable. With fewer than two FTE staff for all positions, the mechanism is not immediately apparent.
- The response to Question I.11.(b) suggests that the applicant has no experience operating a home health agency. The application contains no evidence that a related corporation has such experience. Staff experience in Vizion Exhibit 6 shows no history of work in a certified home health agency. Section VII.6 describes a comprehensive in-service training program, but the program is not described, referenced or budgeted elsewhere in the application.
- 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.

Ancillary and Support Services

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

- The applicant does not provide evidence of a physician that is willing to serve on the agency's required advisory committee. An advisory committee is a requirement of Medicare Conditions of Participation (42 CFR 484.16)¹⁶.
- On Vizion application page 13, Section II.1.(b), the applicant states that it will utilize a consultant dietician/nutritionist. However, the applicant does not provide a copy of an executed contract or letter of intent from a dietician or nutritionist. As such, the applicant does not demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support service.

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

Coordination with Existing Health Care System

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

Conclusion

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

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

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

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

The applicant provides no correspondence from, or to, area health professional training programs documenting that the proposed agency will accommodate the clinical needs of area health professional training programs. As such, the applicant is non-conforming to Criterion (14).

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

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

- The applicant provides no plan, or funds, for care of non-English speaking residents. Please see discussion in Criterion (3).
- The applicant does not demonstrate a need for each of the services it proposes in Section II.1. Please see discussion in Criterion (3).
- The application provides no compelling evidence of a distinctive service program that will improve service area competition. Its sole differentiation is its ownership by an African American. However, this absentee ownership is no guarantee of service to a possibly underserved subgroup. The application fails to demonstrate that African Americans in the service area are underserved.
- The applicant proposes lowest salaries and the lowest benefits in the batch. This will make it difficult for this applicant to compete for qualified, trained staff. Please see discussion in Criterion (4).
- The applicant's projected costs are unreliable because they are based on unsupported and unreliable operational and financial projections. Please see discussion in Criterion (5).
- The applicant does not show evidence of the availability of resources including health manpower and management personnel, for the provision of the services proposed. Please see discussion in Criterion (7).
- The applicant does not demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. Please see discussion in Criterion (8).
- The applicant did not demonstrate that the proposed agency will accommodate the clinical needs of health professional training programs in the area. Please see discussion in Criterion (14).

10A NCAC 14C .2000 Criteria and Standards for Home Health Services

10A NCAC 14C .2002 INFORMATION REQUIRED OF APPLICANT

(a) An applicant shall identify:

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

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

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

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

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

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

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

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

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

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

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

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

(b) An applicant shall specify the proposed site on which the office is proposed to be located. If the proposed site is not owned by or under the control of the applicant, the applicant shall specify an alternate site. The applicant shall provide documentation from the owner of the sites or a realtor that the proposed and alternate site(s) are available for acquisition.

The applicant does not provide documentation that the site is under the control of the applicant.

10A NCAC 14C .2003 PERFORMANCE STANDARDS

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

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

10A NCAC 14C .2005 STAFFING AND STAFF TRAINING

(a) An applicant shall demonstrate that proposed staffing for the home health agency office will meet the staffing requirements as contained in 10A NCAC 13J which is incorporated by reference including all subsequent amendments. A copy of 10A NCAC 13J may be obtained from the Division of Health Service Regulation, Medical Facilities Licensure Section at a cost of two dollars and sixty cents (\$2.60).

As discussed in Criterion (7) above, the applicant does not budget for appropriate levels of administrative staff.

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

The applicant does not provide copies of letters of interest, preliminary agreements, or executed contractual arrangements from a physician that is willing to serve on the agency's required advisory committee or from a dietician/nutritionist. Please see discussion in Criterion (8).

COMPETITIVE REVIEW OF — WELL CARE HOME HEALTH OF MECKLENBURG (WELL CARE), F-10007-12

CON Review Criteria

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

Need

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

- On Well Care application page 39, Section III.1.(b), the applicant attempts to validate need for pediatric home health services by saying that local providers stated there is a need for such services. However, the applicant provided letters from only two healthcare providers who specifically say there is a need for pediatric home health services. This is not sufficient evidence of need. During the application process UniHealth conducted a comprehensive survey of 63 Mecklenburg County area healthcare providers. Access to pediatric services was not seen as a problem by area providers. Only six providers scored pediatric services as a 4 or 5 on a scale of 1 to 5 with 5 being most needed. Please see UniHealth application Exhibit 15. Furthermore, the Mecklenburg County home health use rate per 1,000 population for 0-18 is higher than the state average in 2011. Per the 2013 Draft State Medical Facilities Plan (SMFP), the Mecklenburg County home health use rate per 1,000 population for 0-18 is 3.39 in 2011 and the State average is 2.79.
- On Well Care application page 40, Section III.1.(b), the applicant attempts to validate the need for specialized home health services. The applicant provides a table that outlines the percentage of persons using Medicare home health by major diagnostic classification in 2010 in the United States. However, the applicant provides no discussion of the need in the Mecklenburg County area for these services.
- On Well Care application page 40, Section III.1.(b), the applicant attempts to validate the need for psychiatric home health nursing services by stating that "the service is probably not offered by many of the home health agencies in Mecklenburg County based on the applicant's review of the description of home health services provided in the agencies' websites." This in no way confirms a need for a service. The applicant also states that local providers confirmed the need for psychiatric services. However, the applicant does not provide a letter from any area provider that specifically states there is a need for psychiatric nursing services.
- The applicant's independent need assessment of Mecklenburg, Cabarrus, Iredell, Lincoln, Gaston, and Union County's projected home health need is incomplete. On Well Care application page 46, Section III.1.(b), Well Care bases 2013 Mecklenburg, Cabarrus, Iredell, Lincoln, Gaston, and Union County home health need on the 2012 SMFP methodology. The applicant projects 2014 through 2016 Mecklenburg County,

Cabarrus, Iredell, Lincoln, Gaston, and Union County home health need by growing projected county resident utilization by half of the compound annual growth rate (CAGR) from 2010. This is inappropriate. An applicant must also project patients served by existing providers and subtract the total from anticipated county resident home health service utilization. This is important because if existing provider utilization is growing faster than projected utilization the need for a new agency disappears.

Access

Well Care does not adequately demonstrate the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed for the following reasons:

- Charity care is important. Even with health reform, not all home health patients will have adequate coverage. As discussed in Table 5, of UniHealth's attached letter to the CON Section, Well Care provides the lowest access to charity care at 0.10 percent of gross revenue. This is essentially no charity care and is a rate far below the average for the applicant pool. The applicant pool average is approximately 0.72 percent of gross revenue.
- Well Care provides no funds, or arrangements, for care of non-English speaking residents. On Well Care application page 34, Section III.1.(b), the applicant states it will provide foreign language translation services and hire bi-lingual staff members. However, the applicant provides no funds to pay for interpretation services. Additionally, the applicant provides no plan for recruitment of bi-lingual staff and no correspondence with any organization that can aide in hiring Spanish speaking staff. According to a study by the US English Foundation, Mecklenburg County residents speak 68 languages. Please see Attachment B. Thus, to ensure access to all Mecklenburg County residents, applicants must demonstrate an ability to care for non-English speaking residents.

Conclusion

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

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

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

The absence of a Nurse Supervisor, or equivalent, and an OASIS Coordinator makes Well Care a less affective alternative. As discussed in Criterion (7), without a nurse supervisor, or equivalent, it is unclear who will handle admitting duties. According to Well Care projections, all of its proposed Registered Nurse (RN) staff will need to be in the field making visits to meet workload requirements. An on-site OASIS coordinator helps ensure timely and correct OASIS-C submission and allows field staff to receive immediate feedback on patient assessments and appropriate coding.

The shortage of care coordination staff will also make Well Care less responsive to CMS Medicare initiatives to reduce hospital readmissions. CMS lists Mecklenburg County's Presbyterian Hospital as having one of the highest readmission rates in the state for its three target diagnoses, Congestive Heart Failure (CHF), Acute Myocardial Infarction (AMI) and pneumonia. Mecklenburg County response to CMS efforts to reduce readmissions for CHF, AMI, pneumonia and Chronic Obstructive Pulmonary Disease (COPD), will require a home health agency with staff training, protocols and capacity to manage care and to coordinate community resources for this population. The missing care coordination services in the Well Care agency will make it less valuable to Mecklenburg County patients.

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

Operational Projections

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

On Well Care application page 47, Section III.1.(b), the applicant projects 2014 Mecklenburg, Cabarrus, Iredell, Lincoln, Gaston, and Union County home health service need as a percent of the 2013 Mecklenburg County home health service need projected in the 2012 SMFP. This is inappropriate. The need in each county varies differently between 2014 and 2013. Please see UniHealth application Section III.1.(b).

¹⁷ http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/CCTP_FourthQuartileHospsbyState.pdf

- Because the applicant failed to correctly calculate the true home health need in Mecklenburg County, the applicant projected unreasonable patient estimates for Project Year 1 (2014). Based on a reasonable projection of need, UniHealth projects that 418 Mecklenburg County residents will need home health services in 2014. Please see Section III.1.(b) of UniHealth's application. Well Care projects to serve 325 unduplicated patients in 2014. Because two new agencies will be approved as a result of the need determination in the 2012 SMFP, it is unreasonable to assume that Well Care will care for approximately 78 percent of the unmet need (325/418*100=78%).
- Well Care failed to document that it will receive patient referrals sufficient to reach its projected number of patients. Both hospital systems located in Mecklenburg County operate strong home health programs. Furthermore, according to a recent MedPAC report, depending on hospitals for referrals is insufficient. According to the report, approximately 65 percent of home health admissions are from non-hospital referral sources¹⁸. As such, it is important that new agencies have established relationships with area providers for referrals. As discussed in UniHealth's attached letter to CON, volume is critical to a home health agency's success in today's market.
- All utilization assumptions for Well Care's application are based on Well Care
 corporate history. The applicant has no experience in Mecklenburg County. The
 applicant provides no documentation for any of the utilization assumptions.

Financial Projections

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

- The applicant's projections for utilization are unsupported and unreliable. Please see discussion above. Consequently, costs and revenues that are based on the applicant's utilization projections are unreliable.
- The applicant overstated Medicare revenue. The applicant's proposed percent of episodes that are Low Utilization Payment Adjustment (LUPA) episodes (3.38 percent) is far too low, as described in Table 21 below. As a result, the applicant's percent full episode with and without outliers and percent Partial Episode Payments (PEP) are too high when compared to: North Carolina data, Mecklenburg County data and United Home Care, Inc.'s experience operating 13 Medicare-certified home health agencies.

According to Well Care application page 112, the applicant projects LUPA per episode payments of \$310, outlier per episode payments of \$2,990, full episode without outlier per episode payments of \$2,600 and PEP per episode payments of \$1,109. As such, an increase in LUPAs and decrease in the remaining three episode types will decrease Medicare Revenue.

¹⁸ http://www.medpac.gov/documents/Mar12 EntireReport.pdf, page 220.

Table 21 - Well Care LUPA Comparison

	а	b	С	d	е	
Start Type	Last Approve d Home Health CON	Current United Home Care Percentage	NC Jan 2011 - Dec 2011 per Palmetto GBA	FY 2010 Mecklenburg Co Median Percentage (from Cost Reports)	FY 2011 Mecklenburg Co. Median Percentage (from Licensure Reports)	Projected Well Care
Full Eps w/out Outliers (MCR Only)	90.71%	90.85%		83.16%		92.20%
Full Eps w/Outliers (MCR only)	0.50%	0.35%	0.67%	0.65%		1.91%
LUPAs (MCR only)	7.81%	8.27%	15.84%	14.28%	13.36%	3.38%
PEPs Only (MCR only)	0.93%	0.53%		2.06%		2.51%

Notes:

- a) CON Application J-8511-10.
- b) United Home Care, Inc. internal data.
- c) Palmetto GBA data. Please UniHealth application Exhibit 49.
- d) 2010 Medicare home health cost report data from CMS. Please UniHealth application Exhibit 49.
- e) 2012 Home Health Licensure Renewal Applications. Please UniHealth application Exhibit 49.
 - The applicant failed to budget adequate expenses for appropriate levels of health manpower. See discussion in Criterion (7).
 - The applicant failed to budget for interpretation services, proposed on Well Care application page 34, Section III.1.(b).

Conclusion

In conclusion, the applicant's financial and operational projections are unreliable and unsupported. As such, the application is nonconforming to Criterion (5).

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

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

Additionally, utilization projections support that the proposed agency would duplicate services of a second approved agency. Please see discussion in 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.

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

- Well Care does not budget for a registered nurse that can provide psychiatric home health services. On Well Care application page 14, Section II.1.(b), the applicant states that "psychiatric nursing care will be provided by trained psychiatric nurses with prior experience." In order to get paid by Medicare for a direct psychiatric patient admission, an agency must provide those services with a registered nurse that meets certain psychiatric care standards. Please see Attachment D. These nurses are specially trained and generally require high salaries. Well Care does not propose such a staff person.
- The applicant's visits per FTE are unreasonable. Table 22 below shows that Well Care's projected visits per FTE are well above national averages and the other competitors in this batch. Mecklenburg County is a large county and is home to approximately 9,800,000 residents. It can take over an hour to travel from one end of the county to the other when there is no traffic. The Charlotte urban area experiences the worst traffic congestion in the state and is 41st in the nation¹⁹. Thus, this applicant did not adequately plan for the reality of the geography it intends to serve. If the applicant's visits per FTE were adjusted the national average, which is higher than the applicant batch averages, and staff were given as few as five days off, Well Care would not have enough nursing or physical therapy (PT) staff to cover its proposed visits in Project Year 2. Please see Table 23.

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¹⁹ http://ui.uncc.edu/story/congestion-charlotte-holds-steady

Table 22 - Visits per FTE Comparison of Batch Applicants

Applicant	Nursing	PT	ST	ОТ	HH Aide	MSW
Vizion	5.00	5.0	5.0	5.0	5.0	3.0
Maxim	5.00	5.0	5.0	5.0	5.4	3.5
HH-CMC	4.75	4.2	4.0	5.3	5.5	4.0
HKZ	5.45	5.4			5.2	
AssistedCare	5.00	5.0	5.0	5.0	6.0	3.5
Well Care	5.50	5.5	5.5	5.5	6.5	4.0
Emerald	5.00	5.0	5.0	5.0	5.0	5.0
Continuum	5.15	5.4	4.4	5.2	5.4	3.3
UniHealth	4.47				5.0	3.4
J and D	3.33	4.00	2.00	3.00	3.00	1.00
Applicant Average	4.87	4.94	4.49	4.86	5.20	3.71
National Average ²⁰	4.96	5.39		5.3	5.17	3.48

Table 23 - Staffing Calculation Utilizing Well Care at National Average Visits per Day

	a	b	С	d	е	f
Discipline	Projected FTEs	Visits/Day	Projected Visits	Days Worked per FTE per Year	FTEs Needed	FTEs not Budgeted (- = Surplus)
Nursing (only direct care)	5.2	4.96	6648	255	5.26	0.06
PT	2.0	5.39	2817	255	2.05	0.05

Notes:

- a) Table VII.2, Well Care application page 88
- b) Table 22
- c) Table IV.2, Well Care application page 60
- d) Assumes 260 day work less five days for paid time off
- e) c/b/d
- f) e-a

²⁰ NAHC. http://www.nahc.org/facts/10HC_Stats.pdf

- On Well Care application pages 81 and 83, Section VII.6.(a), the applicant states that it
 will employ a registered nurse (RN) case manager and a home care coordinator. These
 positions are not budgeted for in Table VII.2 or in the proformas. All budgeted nursing
 staff must be making visits every day to cover provide enough coverage for the
 applicant's visit projections.
- Based on United Home Care, Inc. operating experience it does not believe that 0.5
 Administrative FTEs is sufficient to cover all administrative, medical records, and billing support necessary to assure delivery of appropriate clinical care. Additionally, according to the job descriptions provided in Well Care application Exhibit 19, Well Care has a job description for a team assistant, a medical records specialist, and a billing specialist.
- With its high demand productivity requirements and absence of registered nurse level administrative support, Well Care shows no capacity to develop the program described in Section II.1.(b). As noted in UniHealth's attached letter to the CON Section, Well Care provided limited narrative on how it will implement its program.
- 8. The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system.

The applicant does not demonstrate that the proposed service will be coordinated with the existing health care system. As discussed in Criterion (5), Well Care failed to document a single referral from area healthcare providers. As such, the applicant is non-conforming to Criterion (8).

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

The applicant is non-conforming to this Criterion. As stated in Criterion (3), the applicant does not offer programs sufficient to care for non-English speaking resident and offers almost no access to indigent patients. Please see discussion in Criterion (3).

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

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

- The applicant provides no plan, or funds, for care of non-English speaking residents. Please see discussion in Criterion (3).
- The applicant offers almost no access to indigent patients. Please see discussion in Criterion (3).
- The applicant does not demonstrate a need for each of the services it proposes in Section II.1. Please see discussion in Criterion (3).
- The absence of care coordination staff decreases the proposed agency's ability to provide care management services and decreases the resultant opportunity for staff education. These missing care elements will make this agency less valuable to patients. Please see discussion in Criterion (4).
- The applicant's projected costs are unreliable because they are based on unsupported and unreliable operational and financial projections. Please see discussion in Criterion (5).
- The applicant does not show evidence of the availability of resources including health manpower and management personnel, for the provision of the services proposed. Please see discussion in Criterion (7).

10A NCAC 14C .2000 Criteria and Standards for Home Health Services

10A NCAC 14C .2002 INFORMATION REQUIRED OF APPLICANT

- (a) An applicant shall identify:
 - (3) the projected total unduplicated patient count of the new office for each of the first two years of operation;

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

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

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

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

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

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

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

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

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

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

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

10A NCAC 14C .2003 PERFORMANCE STANDARDS

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

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

10A NCAC 14C .2005 STAFFING AND STAFF TRAINING

(a) An applicant shall demonstrate that proposed staffing for the home health agency office will meet the staffing requirements as contained in 10A NCAC 13J which is incorporated by reference including all subsequent amendments. A copy of 10A NCAC 13J may be obtained from the Division of Health Service Regulation, Medical Facilities Licensure Section at a cost of two dollars and sixty cents (\$2.60).

As discussed in Criterion (7) above, the applicant does not budget for a psychiatric nurse. Additionally, staffing patterns are unreasonable because visits per FTE estimates are too high.

Attachment B

U.S. English Foundation Statistics

NORTH CAROLINA

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

122

Languages spoken

Counties with 20 or more languages spoken

38
Counties with
10 or more
languages
spoken

80
Counties with
5 or more
languages
spoken

Languages with 1,000 or more speakers

	Most Common Languages S	poken
Rank	Language	Speakers
1	English	6,909,650
2	Spanish	378,940
3	French	32,925
4	German	28,500
5	Vietnamese	13,595
6	Chinese	12,835
7	Korean	11,385
8	Arabic	10.835
9	Miao, Hmong	7,495
10	Tagalog	6,520
11	Greek	6,405
12	Japanese	6,315
13	Italian	6,235
14	Gujarathi	5,725
15	Laotian	4,600
16	Hindi	4,155
17	Russian	4,110
18	Kru, Ibo, Yoruba	3,585
19	Mon-Khmer, Cambodian	3,360
20	Urdu	3,210
21	Portuguese	3,170
22	Polish	2,965
23	Persian	2,430
t-24	Dutch	2,020
t-24	Thai	2,020
26	Swedish	1,700
27	India, n.e.c.	1,595
28	Telugu	1,580
29	Tamil	1,510
30	Mandarin	1,490
31	French Creole	1,440
32	Cherokee	1,415
33	Hebrew	1,320
34	Amharic	1,295
35	Serbocroatian	1,255
36	Cushite	1,220
37	Romanian	1,120
38	Bengali	1,100
39	Ukrainian	1.050
40	Hungarian	1,040
41	Swahili	970
42	Turkish	860
43	Cantonese	795
44	Bantu	790
45	Czech	755
46	Panjabi	710
47	Finnish	610
48	Danish	590
49	Marathi	565
50	Formosan	545
		3 15

Most Common Languages Spoken

Counties With the Most Languages Spoken

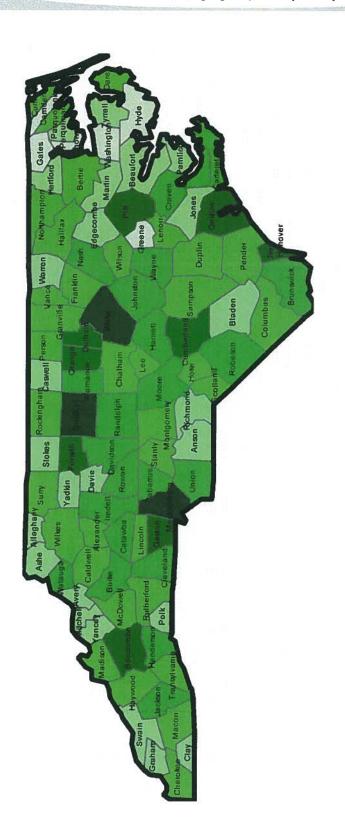
Rank	County	 Languages
1	Wake County	70
2	Mecklenburg County	68
3	Guilford County	58
4	Cumberland County	48
5	Durham County	46
6	Orange County	37
7	Forsyth County	36
8	Buncombe County	33
9	Onslow County	27
10	New Hanover County	24
11	Gaston County	23
12	Pitt County	21
13	Alamance County	20
t-14	Iredell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

Languages in North Carolina

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

NORTH CAROLINA

Number of Languages Spoken By County



51 or more languages

21-50 languages

11-20 languages

6-10 languages 4-5 languages

1-3 languages

Attachment C

Historical Medicare Reimbursement Articles

Medicare Home Health Base Rate Comparison

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

Source:

www.federalregister.gov

Comments on Competing CON Proposals for a New Medicare-certified Home Health Agency in Mecklenburg County UniHealth Home Health (UniHealth), Project ID # F-10011-12

(protime) levels to the physician, notwithstanding that the patient's prothrombin time tests indicate essential stability.

40.1.2.14 - Student Nurse Visits (Rev. 1, 10-01-03) A3-3118.1.B.14, HHA-205.1.B.14

Visits made by a student nurse may be covered as skilled nursing care when the HHA participates in training programs that utilize student nurses enrolled in a school of nursing to perform skilled nursing services in a home setting. To be covered, the services must be reasonable and necessary skilled nursing care and must be performed under the general supervision of a registered or licensed nurse. The supervising nurse need not accompany the student nurse on each visit.

40.1.2.15 - Psychiatric Evaluation, Therapy, and Teaching (Rev. 1, 10-01-03) A3-3118.1.B.15, HHA-205.1.B.15

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

Because the law precludes agencies that primarily provide care and treatment of mental diseases from participating as HHAs, psychiatric nursing must be furnished by an agency that does not primarily provide care and treatment of mental diseases. If a substantial number of an HHA's patients attend partial hospitalization programs or receive outpatient mental health services, the intermediary will verify whether the patients meet the eligibility requirements specified in §30 and whether the HHA is primarily engaged in care and treatment of mental disease.

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

EXAMPLE 1:

A patient is homebound for medical conditions, but has a psychiatric condition for which he has been receiving medication. The patient's psychiatric condition has not required a

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

EXAMPLE 2:

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

EXAMPLE 3:

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

40.1.3 - Intermittent Skilled Nursing Care (Rev. 1, 10-01-03) A3.3118.1.C, HHA-205.1.C

The law, at §1861(m) of the Act defines intermittent, for the purposes of §§1814(a)(2) and 1835(a)(2)(A), as skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable.)

To meet the requirement for "intermittent" skilled nursing care, a patient must have a medically predictable recurring need for skilled nursing services. In most instances, this definition will be met if a patient requires a skilled nursing service at least once every 60

days. The exception to the intermittent requirement is daily skilled nursing services for diabetics unable to administer their insulin (when there is no able and willing caregiver).

Since the need for "intermittent" skilled nursing care makes the patient eligible for other covered home health services, the intermediary should evaluate each claim involving skilled nursing services furnished less frequently than once every 60 days. In such cases, payment should be made only if documentation justifies a recurring need for reasonable, necessary, and medically predictable skilled nursing services. The following are examples of the need for infrequent, yet intermittent, skilled nursing services:

- 1. The patient with an indwelling **silicone** catheter who generally needs a catheter change only at 90-day intervals;
- 2. The patient who experiences a fecal impaction (i.e., loss of bowel tone, restrictive mobility, and a breakdown in good health habits) and must receive care to manually relieve the impaction. Although these impactions are likely to recur, it is not possible to pinpoint a specific timeframe; or
- 3. The blind diabetic who self-injects insulin may have a medically predictable recurring need for a skilled nursing visit at least every 90 days. These visits, for example, would be to observe and determine the need for changes in the level and type of care which have been prescribed thus supplementing the physician's contacts with the patient.

There is a possibility that a physician may order a skilled visit less frequently than once every 60 days for an eligible beneficiary if there exists an extraordinary circumstance of anticipated patient need that is documented in the patient's plan of care in accordance with 42 CFR 409.43(b). A skilled visit frequency of less than once every 60 days would only be covered if it is specifically ordered by a physician in the patient's plan of care and is considered to be a reasonable, necessary, and medically predictable skilled need for the patient in the individual circumstance.

Where the need for "intermittent" skilled nursing visits is medically predictable but a situation arises after the first visit making additional visits unnecessary, e.g., the patient is institutionalized or dies, the one visit would be paid at the wage-adjusted LUPA amount for that discipline type. However, a one-time order; e.g., to give gamma globulin following exposure to hepatitis, would not be considered a need for "intermittent" skilled nursing care since a recurrence of the problem that would require this service is not medically predictable.

Although most patients require services no more frequently than several times a week, Medicare will pay for part-time (as defined in $\S 50.7$) medically reasonable and necessary skilled nursing care seven days a week for a short period of time (two to three weeks). There may also be a few cases involving unusual circumstances where the patient's prognosis indicates the medical need for daily skilled services will extend beyond three weeks. As soon as the patient's physician makes this judgment, which usually should be

made before the end of the 3-week period, the HHA must forward medical documentation justifying the need for such additional services and include an estimate of how much longer daily skilled services will be required.

A person expected to need more or less full-time skilled nursing care over an extended period of time, i.e., a patient who requires institutionalization, would usually not qualify for home health benefits.

40.2 - Skilled Therapy Services (Rev. 1, 10-01-03) A3-3118.2, HHA-205.2

40.2.1 - General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy

(Rev. 144, Issued: 05-06-11, Effective: 04-01-11, Implementation: 05-05-11)

The service of a physical therapist, speech-language pathologist, or occupational therapist is a skilled therapy service if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the general supervision of a skilled therapist. To be covered, the skilled services must also be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury. It is necessary to determine whether individual therapy services are skilled and whether, in view of the patient's overall condition, skilled management of the services provided is needed.

The development, implementation, management, and evaluation of a patient care plan based on the physician's orders constitute skilled therapy services when, because of the patient's condition, those activities require the skills of a qualified therapist to ensure the effectiveness of the treatment goals and ensure medical safety. Where the skills of a therapist are needed to manage and periodically reevaluate the appropriateness of a maintenance program because of an identified danger to the patient, such services would be covered, even if the skills of a therapist were not needed to carry out the activities performed as part of the maintenance program.

While a patient's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by nonskilled personnel.

A service that is ordinarily considered nonskilled could be considered a skilled therapy service in cases in which there is clear documentation that, because of special medical complications, skilled rehabilitation personnel are required to perform the service. However, the importance of a particular service to a patient or the frequency with which it must be performed does not, by itself, make a nonskilled service into a skilled service.

Attachment E

Historical Emerald Utilization Data

License No: <u>HC0353</u> Facility ID: 923830

For questions regarding this page, call the Association for Home & Hospice Care of North Carolina at (919) 848-3450.

Home Health Services Reporting

E. Clients/Visits by Payer Source for your Designated Reporting Period

Instructions:

- Report data related to clients who are receiving <u>PART-TIME INTERMITTENT HOME HEALTH</u> * services through your Medicare certified agency <u>regardless of payer source</u>.
- These are services provided on a <u>per visit</u> basis: Nursing, PT, OT, ST, MSW and In-Home Aide (Home Health Aide). This includes patient services reimbursed by Medicare, Medicaid, private insurance, etc.
- Clients admitted twice during the reporting period and reimbursed by the same payer should be counted only once.
- Clients admitted once during the reporting period, for whom payment was obtained from two sources, should be reported twice, once for each payment source.
- Do not provide data here related to clients on page 3 of this report.

Examples	Mrs. Brown was admitted on four different occasions to the home health agency. Medicare was the only payor for each admission. Therefore, Mrs. Brown would be reported as one Medicare client, but the number of visits would include all visits from the four admissions.				
	Mrs. Smith was admitted once to the home health agency, but received services paid for by both Medicare and Medicaid. Mrs. Smith would be reported as one Medicare client and one Medicaid client. Her visits should reflect the number of visits paid by each of the payers.				
	Mr. Jones was admitted to the home health agency on six different occasions during this reporting period. Three admissions were under Medicare and three were under Medicaid. Mr. Jones would be reported as one Medicare client and one Medicaid client. His visits should reflect the number of visits paid by each of the payers.				
	Payment Source	# Clients	# Visits	Visits/Client	

Payment Source	# Clients	# Visits
Medicare	1747	38696
Medicare HMO		
Medicaid	650	3891
Medicaid HMO		
Private Insurance	339	6498
Private Insurance HMO		
Indigent Non-Pay		
Other (specify):		
Self Pays	4	26
0		1 1
Total	2,740	49,111
<u> </u>		

[&]quot;Other" may include Self-pay, Worker's Comp, VA/Champus, Title III, Title XX & United Way/Grants.

License No: <u>HC0353</u> Facility ID: 923830

For questions regarding this page, call the Association for Home & Hospice Care of North Carolina at (919) 848-3450.

E. <u>Clients/Visits by Payer Source for your Designated Reporting Period (continued)</u>

1. The following information may either be collected off your system or requested by you from the Centers for Medicare and Medicaid Services (CMS) or Palmetto Government Benefits Administrators (PGBA). It is expected that your system data will be more up-to-date.

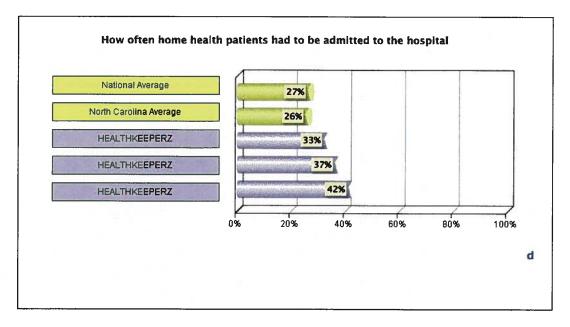
Please specify the 12-month reporting period, by month and year, of the following information:

From	n: October, 2010 To: Septem	nber	,2011
	Month/Year	Month/Y	['] ear
a.	Number of Medicare episodes	= _	1992
b.	Average number of Medicare episodes per beneficiary	==	1.5
c.	Average number of Medicare Visits per episode (all disciplines)	-	18.2
d.	For Medicare – the percent of Lupas	=	9.4%

UniHealth Home Health (UniHealth), Project ID # F-10011-12

Comments on Competing CON Proposals for a New Medicare-certified Home Health Agency in Mecklenburg County

HKZ and Maxim Readmission Data



What does it mean?

This shows how often patients were admitted to the hospital while under the care of the home health team.

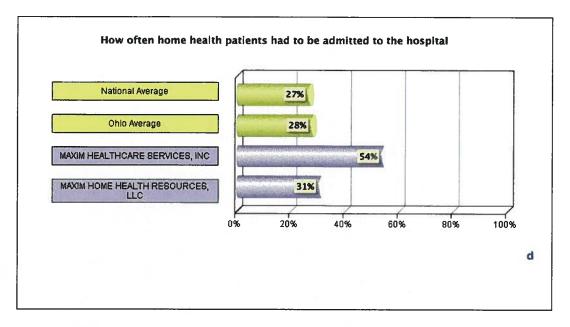
Why is this information important?

Some home health patients may need to be admitted to the hospital, even if they are getting good care. For example, some chronic medical conditions can't be cured and, over time, may make a patient's health worse. For some patients, a readmission to the hospital may be a planned part of continuing treatment for their medical conditions. However, some inpatient hospital care may be avoided if the home health team is doing a good job checking the patient at each visit to find problems early, and communicating regularly with the doctor and other members of the team about the patient's condition. The home health team should check how the patient is eating, drinking, how well they are taking their prescription and other drugs, and how safe the home environment is. If the patient shows signs of getting worse, the home health team should notify the doctor as soon as possible. In some cases, the doctor will want to see patient or have the patient go to an urgent care facility or a hospital. Lower numbers are better for this measure, because the home health team, in many instances, can prevent the need for hospital care. At the same time, the home health team should ensure that patients who need hospital care are hospitalized as soon as possible. Lower numbers are better for this measure.

Data Last Updated: July 19, 2012

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What does it mean?

This shows how often patients were admitted to the hospital while under the care of the home health team.

Why is this information important?

Some home health patients may need to be admitted to the hospital, even if they are getting good care. For example, some chronic medical conditions can't be cured and, over time, may make a patient's health worse. For some patients, a readmission to the hospital may be a planned part of continuing treatment for their medical conditions. However, some inpatient hospital care may be avoided if the home health team is doing a good job checking the patient at each visit to find problems early, and communicating regularly with the doctor and other members of the team about the patient's condition. The home health team should check how the patient is eating, drinking, how well they are taking their prescription and other drugs, and how safe the home environment is. If the patient shows signs of getting worse, the home health team should notify the doctor as soon as possible. In some cases, the doctor will want to see patient or have the patient go to an urgent care facility or a hospital. Lower numbers are better for this measure, because the home health team, in many instances, can prevent the need for hospital care. At the same time, the home health team should ensure that patients who need hospital care are hospitalized as soon as possible. Lower numbers are better for this measure.

Data Last Updated: July 19, 2012

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UniHealth Home Health (UniHealth), Project ID # F-10011-12 Comments on Competing CON Proposals for a New Medicare-certified Home Health Agency in Mecklenburg County

Maxim Medicaid Calculation

Gross Medicaid Revenue Calculation - Project Year 2

	a	b	С
Discipline	Charge	Visits	Total Revenue
SN	\$125	383	\$47,875
PT	\$130	298	\$38,740
OT	\$130	68	\$8,840
ST	\$130	22	\$2,860
MSW	\$175	5	\$875
ННА	\$70	50	\$3,500
Total		826	\$102,690

Net Medicaid Revenue Calculation - Project Year 2

	d	b	е		
Discipline	Relmbursement Rate	Visits	Total Revenue		
SN	\$103	383	\$39,575		
PT	\$110	298	\$32,661		
ОТ	\$110	68	\$7,453		
ST	\$110	22	\$2,411		
MSW		5	\$0		
ННА	\$47	50	\$2,364		
Total		826	\$84,464		

Contractual Adjustment

18,225.81

Notes:

- a) Maxim Application Page 117, Section X.2
- b) Maxim Application Page 76, Section IV.3
- c) a*b
- d) NC DMA, http://www.ncdhhs.gov/dma/fee/home_health/hh_120701.pdf
- e) d*b

Maxim Medicare Revenue Calculation				
Maxim Medicare Revenue Calculation			,	Year 2 Total
Medicare Visits (a)				rear 2 rotar
SN				2 522
PT				3,532
ОТ				2,802
ST				647
MSW				187
HHA				40
Total				472
Total				7,680
Gross Charges per Visit		PY 2 (b)		
SN	\$	125	\$	441,500
PT	\$	130	\$	364,260
ОТ	\$	130	\$	84,110
ST	\$	130	\$	24,310
MSW	\$ \$ \$ \$ \$ \$	175	\$	7,000
ННА	\$	70	\$	33,040
Total			\$	954,220
Episodes (c)				
Full Episodes without Outliers				429
Full Episodes with Outliers				10
LUPAs				56
PEPs Only				5
Total				500
Net reimbursement per episode		PY 2 (d)		
Full Episodes without Outliers	\$	2,646	\$	1,135,134
Full Episodes with Outliers	\$	3,430		34,300
LUPAs	\$	270	\$	15,120
PEPs Only	\$	1,058	\$	5,290
Total			\$	1,189,844
Contractual allowance			\$	235,624

Notes:

- a) Maxim application page 79, Section IV.3
- b) Maxim application page 117, Table X.2
- c) Maxim application page 73, Section IV.3
- d) Maxim application page 121

UniHealth Home Health (UniHealth), Project ID # F-10011-12 Comments on Competing CON Proposals for a New Medicare-certified Home Health Agency in Mecklenburg County



Romney Campaigns in Chillicothe, Ohio



Standard Chartered Settles with NY For \$340 Million



Finding a Suit that Fits You With the Fabric Czar

Bloomberg News

Maxim Settles With U.S. for \$150 Million Over Fraud Probe

By David Voreacos on September 12, 2011

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(Updates with U.S. attorney statement in 15th paragraph.)

Sept. 12 (Bloomberg) -- Maxim Healthcare Services Inc., which provides in-home health and nursing services, will pay \$150 million to resolve criminal and civil probes of fraudulently overbilling federal and state governments.

The U.S. Justice Department filed a criminal conspiracy charge in federal court in New Jersey against Maxim, and agreed to defer prosecution for two years. Nine people, including three regional account managers, have pleaded guilty since 2009 in federal court in Trenton, New Jersey.

"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 Tony West, assistant attorney general of the Justice Department's civil division at a news conference in Newark, New Jersey.

Maxim, based in Columbia, Maryland, will pay a \$20 million criminal fine and \$130 million to resolve civil allegations under the U.S. False Claims Act and claims by 43 U.S. states. The civil recovery is the largest ever in a home health care fraud, West said. The False Claims Act allows private citizens to sue on behalf of the government and share in any recovery.

"We take full responsibility for these events set forth in the deferred prosecution agreement and we are pleased to reach a settlement that will allow us to move forward with the important work of caring for our patients and clients," said Brad Bennett, chief executive officer of Maxim. Bennett was appointed in October 2009.

'Emphasized Sales Goals'

As part of its deferred-prosecution agreement, Maxim admitted that between 2003 and 2009, it conspired to defraud government health programs of \$61 million.

"Certain aspects of Maxim's operations emphasized sales goals at the expense of clinical and compliance responsibilities, as reflected in certain aspects of its culture, training, incentive compensation, and allocation of personnel resources," Maxim admitted in court documents.

The criminal investigation is ongoing and "it's certainly a possibility" that others will be charged, J. Gilmore Childers, the First Assistant U.S. Attorney in New Jersey, said at the news conference. He said the regional account managers oversaw hundreds of employees and millions of dollars in revenue.

Sweeping Changes

The company, which has 88,000 employees, has made sweeping changes to its top management since May 2009 and has cooperated with the probe, said Childers. Maxim had revenue last year of more than \$1 billion, said Executive Assistant U.S. Attorney Michael Martinez.

Maxim has signed a corporate integrity agreement and will be overseen by a corporate monitor.

"Companies like Maxim, that provide health care services to Medicaid patients, are expected to take necessary steps to prevent fraud and abuse by instituting strong compliance programs and maintaining effective internal controls," New Jersey Attorney General Paula Dow said in a statement. Under the agreement, New Jersey will collect about \$2.7 million.

The probe began after a whistleblower lawsuit filed by New Jersey resident Richard W. West, who will collect a \$15.4 million award. West, a 63-year-old resident of Tuckerton, New Jersey, was diagnosed with muscular dystrophy in 1981. Over 15 months in 2003 and 2004, Maxim claimed more than 700 hours of services not provided, according to Dow.

West said in an interview that he hired a lawyer from Baltimore, Robin Page West of Cohan, West & Karpook, to help him. Neither Richard West, Robin West or Tony West of the Justice Department are related.

'Finally Over'

"I am pleased that it's finally over," Richard West said. "I tried to rectify this through a county social worker. She had no power. I tried to bring it to the state Medicaid waiver office. They did nothing. I called the Medicaid hotline for fraud and they said we'll look into it. No one ever did anything. That's why I had to go out of state to find my lawyer."

Dow issued a news release detailing the settlement before federal officials outlined it at a press conference. In response, Childers said in a statement: "The state played a limited administrative role in this case. It is troubling and disappointing that they would take credit for years of tireless work done by federal agents and prosecutors, particularly concerning an issue so important to the people of New Jersey."

Nine Pleaded

The nine who pleaded guilty included three who worked as regional accounts manager: Gregory Munzel, 35, of Charleston, South Carolina; Bryan Lee Shipman, 38, of Athens, Georgia; and Matthew Skaggs, 39, who worked in Texas, according to the Justice Department and court records.

Others who pleaded guilty are Donna Ocansey, 49, of Medford, New Jersey, a director of clinical services; Marion Morton, 45, of North Charleston, South Carolina, a home health aide; Andrew Sabbaghzadeh, 29, of Clay, New York, an account manager; Jason Bouche, 27, of Paradise Valley, Arizona, a recruiter; and Mary Shelly Janvier-Pierre, 42, of Lake Worth, Florida, a licensed practical nurse, according to the Justice Department and court records.

The mother of a former pediatric patient, Sandy Cave, 39, of West Palm Beach, Florida, also pleaded guilty, according to the Justice Department and court records. Skaggs and Morton already have been sentenced to probationary terms.

The case is United States v. Maxim Healthcare Services, 11-mj-6107, U.S. District Court, District of New Jersey (Newark).

-- Editors: Mary Romano, Stephen Farr

To contact the reporter on this story: David Voreacos in Newark, New Jersey, at dvoreacos@bloomberg.net.

To contact the editor responsible for this story: Michael Hytha at mhytha@bloomberg.net.

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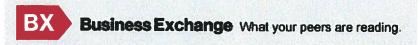
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Attachment I Medicare Timeline

PDA

CONVERSATION LOG

DATE: <u>4/10/12</u> **TIME**: <u>10:00 am</u> **PDA Job #**: <u>6006-12</u>

SUBJECT: Medicare Payment

INITIATED BY: TA

WITH: Shandreca -Palmetto GBA

AGENDA

o Discuss Medicare-Certified home health agency Medicare payments.

NOTES

- O TA asked Shandreca how long it takes to get a tie-in notice once an agency has been recommended for certification.
- O Shandreca stated that it varies by provider but she has seen it taken one to three months.
- O TA asked Shandreca if an agency can expect back payments from the date an agency is recommended for certification.
- O Shandreca stated that a provider cannot bill for services provided until a provider number is issued but a provider can expect to be reimbursed for all services provided from the date an agency is recommended for certification.

Comments on Competing CON Proposals for a New Medicare-certified Home Health Agency in Mecklenburg County UniHealth Home Health (UniHealth), Project ID # F-10011-12

Attachment J

PDA

CONVERSATION LOG

CLIENT: Pruitt Corporation PROJECT: Mecklenburg Home Health CON

SUBJECT: CareAnyware EMR Inquiry INITIATED BY: Connie Tran

WITH: Jenny Andrews COMPANY: CareAnyware

PHONE #: 866-260-4630

Below is a summary of the questions asked by Ms. Tran and Ms. Andrews' answers.

1. Can you tell me about your products?

- a. Web-based system, don't need server equipment on site
- b. The only hardware that needs to be purchased are computers
- c. An application is downloaded to a laptop/tablet
- d. Provider notes are synced back to main system
- e. Any updates or developments come directly from an agency online website
- 2. What is the cost?
 - a. Monthly subscription
 - b. Pricing is dependent on the agency and their census level
 - c. Up front installation fee and training fee
 - d. Monthly subscription based on the number of patients loaded onto system
 - e. If grow, the pricing goes up overall but per subscription is saving money
 - f. Focus more on Medicaid and Medicare
 - g. Not focused on private insured not as big ROI, and focus on hourly visits rather than shift work
- 3. If I start out with one agency and I add a second agency, what costs will be incurred? I.e. new software licenses?
 - a. Pricing based on census count. If you grow past your base, your pricing will grow
 - b. Pricing does not charge based on addition of new physicians or new computers added onto subscription only number of patients
 - c. If you have several additional locations, there may be installation fee to get hardware set up it's minimal but if it's only a few computers then there's no cost
- 4. Zach Brown is the inside sales rep in NC; 866-260-4630 ext. 206; Jenny's is 234

PDA

CONVERSATION LOG

CLIENT: Pruitt Corporation PROJECT: Mecklenburg Home Health CON

SUBJECT: Simione Financial Monitor Inquiry INITIATED BY: Connie Tran

WITH: Rob Simione COMPANY: CareAnyware

PHONE #: 203-415-7193 (cell); Robsimione@simione.com

Below is a summary of the questions asked by Ms. Tran and Mr. Simione's answers.

1. Can you tell me about your products?

- a. Financial benchmarking product
- b. Automated financial dashboard
- c. Will pull data and full financial software and give you benchmark data
- 2. What hardware is needed?
 - a. No software involved, the product is web-based
 - b. Upload your financials on a website
 - c. Every quarter or month (depending on subscription) you upload and generates a report depends on their metric
- 3. What is the cost?
 - a. Flat yearly fee that is based on the number of agencies you have I.e. how many Medicare provider numbers
 - b. If you acquire another Medicare provider number your cost will increase.